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Gentry Therapy LLC

OUTPATIENT SERVICES CONTRACT
CONFIDENTIALITY, INFORMED CONSENT & OFFICE POLICIES

Welcome to my psychotherapy practice. This document contains important information about my professional services and business policies. This form provides you (client) with information that is additional to that detailed in the form entitled "HIPAA Notice of Privacy Practices." Please read it carefully and identify any questions you may have to discuss. Please initial each paragraph in the space provided indicating that you have read and understood the content of that paragraph. When you sign this document, it will represent a legally binding agreement between us.

THE PROCESS OF THERAPY: Psychotherapy is a process in which the therapist and the client discuss a variety of issues, events, experiences, and memories for the purpose of creating positive change so the client can experience life more fully. It provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties one may be experiencing. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participation in therapy can result in a number of benefits to the client, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improvement in interpersonal relationships, increased comfort in social, work and family settings, increased capacity for intimacy, increased self-confidence as well as resolution of the specific concerns that led you to seek therapy. Psychotherapy requires your very active involvement, honesty, and openness in order to change. As your therapist, I will ask for your feedback and views on your therapy, your progress, and other aspects of the therapy process. Although therapy typically has a positive outcome, there is no guarantee that therapy will yield all or any of the benefits listed above.

Initial: _____

Participating in therapy may also involve some discomfort, including remembering or talking about painful memories, unpleasant events, feelings, and/or thoughts. The process may evoke difficult feelings of sadness, anger, fear, shame, anxiety, depression, etc. At times, I may challenge some of your assumptions and/or perceptions and propose different ways of looking at, thinking about, or handling situations that can result in you feeling upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing perceptions, beliefs, behaviors, employment, substances use, schooling, housing, or relationships. Sometimes, a decision that is positive for one family member can be viewed negatively by another family member. Personal growth and change may be easy and swift at times, but it may also be slow and even frustrating. I will strive to help make your therapeutic experience as productive as possible.

Initial: _____

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the HIPAA Notice of Privacy Practices that you received along with this form.

Initial: _____

When disclosure is required by law: Some of the circumstances where disclosure is required by law are: when there is a reasonable suspicion of child, dependent, or elder physical or sexual abuse and/or neglect; and where a client presents a danger to self, to others, or is gravely disabled (see also HIPAA and Notice of Privacy Practices form).

Initial: _____

When disclosure may be required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation, the other parties may have the right to obtain the psychotherapy records and/or testimony by your therapist. In couples and family therapy, or when different family members are seen individually,

confidentiality and privilege do not apply between the couple or among family members. Your therapist will not release records to any outside party unless he is required to do so by legal compulsion, or if disclosure is authorized by **all** adult family members who were part of the treatment.

Initial: _____

Confidentiality of Records & Health Insurance: Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), your clinical file contains two types of information, Protected Health Information (PHI) and a Designated Record Set. The Designated Record Set refers to information in your health record/file that can identify you. The PHI is your clinical record which includes information about your reasons for seeking therapy, a description how your problem impacts your life, your diagnosis, your treatment goals. Your medical, social and psychological history, your treatment history and treatment records that I receive from other providers, reports of professional consultations, your billing records, and reports that have been sent to anyone including your insurance carrier.

Initial: _____

I keep a set of progress notes. These notes are for my use and are designed to assist me in tracking your treatment and providing you with the best treatment. While progress notes vary from client to client, they can include the contents of our conversations, my analysis of our conversations and how they impact on therapy.

Initial: _____

Your health insurance carrier may require disclosure of confidential information when using your PPO coverage, or other third-party payer, to process the claims. Only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly, the progress notes will not and cannot be disclosed to your insurance carrier. Your therapist has no control or knowledge over what insurance companies do with the information they submit or who has access to this information. Be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information, including a diagnosis, is entered into insurance companies' computers and will also be reported to the Congress-approved National Medical Data Bank. Any computer or database is subject to unauthorized access.

Initial: _____

Client files and records are securely stored at my Scottsdale office. I practice in the same office with other mental health professionals. I do not share Protected Health Information with these other professionals in my office. Nonetheless, all mental health professionals are bound by the same rules of confidentiality. Client files are kept for six years after the case is completed or until a child reaches the age of 21 if the child received treatment. After the records have been stored for the scheduled amount of time, the records will be shredded and disposed of in compliance with HIPAA. In the event of my death or my inability to authorize the release of your records, Sue Powers, LPC, is authorized to retrieve and release the records with appropriate written authorizations. She can be reached at 480- 229-6674; sushijoy74@gmail.com; 8115 E. Indian Bend Road, Suite 119, Scottsdale, Arizona 85250.

Initial: _____

Confidentiality of Digital Communication via Cell Phone, Video-conferencing, Email, Text Messages, Fax, Etc.: It is very important for you to be aware of the confidentiality risks inherent in the various forms of digital communication which we may use. Though it may seem unlikely, these forms of communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of your digital communications can be compromised. Computers and cell-phones can be monitored by unauthorized persons. Video-conferencing or video-telephony platforms (e.g., Zoom, Skype, Facetime, GoogleMeet, Doxy.me, and the like) can be hacked by unauthorized persons. Emails, in particular, are vulnerable to unauthorized access because servers may have unlimited and direct access to all emails that go through them. Faxes, text messages, and emails can be sent erroneously to the wrong address. Please notify me immediately if you wish to avoid or limit in any way the use of any or all of the above-mentioned communication methods. Please do not use e-mail or faxes for emergencies.

Initial: _____

REMOTE SESSIONS: We may at times mutually agree to conduct remote sessions either by telephone (audio only), or by video-conferencing/video-telephony platforms such as, Zoom, Skype, Facetime, GoogleMeet, Doxy.me, and the like. In the event we have remote sessions without video (audio only), I may ask you to state some uniquely identifying

information (such as date of birth, emergency contact name) to ensure confidentiality. If you choose to have a remote session with me, please be aware of the risks and limitations associated with remote sessions, including but not limited to the following: there are confidentiality risks inherent in electronic communications (as discussed in the preceding paragraph); there is potential for technology failure and unreliable digital connection may make communication difficult or impossible; remote sessions may be inappropriate, less effective, or ineffective for treatment of some conditions, such as very acute and/or complex mental health and addiction issues which necessitate in-person interventions; remote sessions tend to lack the intimacy and intricacy of in-person interactions due to difficulty reading non-verbal cues, body language, facial expressions, vocal signals, etc., and I may get a less clear picture of your feelings, thoughts, moods, and behaviors; and you may have insurance reimbursement problems if your insurer does not cover remote sessions.

Initial: _____

CONSULTATION: At times I find it helpful to consult with other professionals regarding a client and/or case; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained. This is done to provide you with the best care possible.

Initial: _____

DISCUSSION OF TREATMENT PLAN: Together we will develop an individualized treatment plan that outlines the primary issues you want to address, identifies treatment objectives and goals and potential outcomes. If you have any unanswered questions about the course of your therapy, the possible risks, or about the treatment plan, please ask for further explanation. You also have the right to ask about other treatments for your condition and their risks and benefits as well as referral for those services if needed or wanted. During the course of therapy, I am likely to draw on various psychological counseling approaches according in part to the problem being treated and the assessment of what will best benefit you. Sometimes more than one approach can be helpful in dealing with a certain situation. These approaches may include, but are not limited to: NeuroAffective Relational Model (NARM), Somatic Experiencing (SE), cognitive-behavioral therapy (CBT), developmental/relational trauma models such as the Meadows Model, family systems/family-of-origin focus, experiential interventions, existential therapy tools, bibliotherapy, and psycho-education.

Initial: _____

CLOSURE/TERMINATION: You have the right to end therapy at any time. Ideally, this happens when the goals of therapy have been met. A closure session is recommended to review your accomplishments and to discuss supports available to maintain your growth. If you voluntarily withdraw or refuse treatment, there can be consequences to your mental or physical health (*i.e.*, your condition may worsen, you may become suicidal). If you have any such concerns, I will gladly discuss them with you. If at any point during therapy I believe I am not being effective in helping you reach your therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such cases, I would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the new psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and with your written consent will provide him or her with the essential information needed.

Initial: _____

DUAL RELATIONSHIPS: A dual relationship exists when you have some type of relationship with your therapist outside the clinical setting. This may include civic and philanthropic groups, religious communities, mutual-help and twelve-step recovery group participation, sports leagues, etc. Dual relationships are not unethical if appropriate boundaries are maintained. Therapy never involves sexual or any other dual relationship that can be exploitative in nature, or impairs your therapist's objectivity, clinical judgment, and/or therapeutic effectiveness. If a dual relationship occurs, I will discuss with you the potential difficulties that may be involved in dual relationships and will discontinue the dual relationship if it interferes with the effectiveness of the therapeutic process.

Initial: _____

TELEPHONE & EMERGENCY PROCEDURES: I am often not immediately available by telephone. If you need to contact me between sessions, please leave a message on my voice mail. I will typically respond to messages within 24 hours, or on the next business day that I am in the office. In case of medical emergency, or when there is immediate

danger or potential for harm, please call 911. If you have an emotional/behavioral health emergency, please call the **Maricopa County Crisis Response Network at 800-631-1314**, or the **La Frontera/EMPACT Crisis Hotline at (480) 784-1500**.

Initial: _____

OUTPATIENT LEVEL OF CARE: I am a sole practitioner providing private practice psychotherapy at the outpatient level of care only, in the form of regularly-scheduled, time-limited counseling appointments. My practice is not equipped to provide a higher level of care such as emergency, urgent care, or crisis counseling services. I cannot provide emergency support to my clients outside of our regularly-scheduled appointments. If you need urgent or crisis level care, please call the **Maricopa County Crisis Response Network at 800-631-1314**, or the **La Frontera/EMPACT Crisis Hotline at (480) 784-1500**. I also do not provide psychotherapy services by text or email, though do I use text and email for administrative (non-clinical) purposes such as scheduling appointments and sending reminders.

Initial: _____

APPOINTMENTS, FEES & PAYMENTS: I reserve 50 minutes for each appointment with a client unless otherwise discussed with client. If you are unable to keep a scheduled appointment, please notify me as soon as possible. Missed appointments and late cancellations disrupt and hinder the effectiveness of my practice, and they usually make it impossible to offer the appointment time to someone else. **Therefore, missed appointments and cancellations made less than one full business day (24 hours) in advance of the scheduled appointment will result in you being charged in full for your reserved appointment time.** Payment is expected at the time of service, unless other arrangements have been agreed upon. The cost of therapy services is your responsibility. The standard fee for a 50-minute initial intake assessment, an individual, conjoint or family counseling session is $185.00. Extended sessions, telephone conversations over 15 minutes, report writing and reading, attendance at meetings with other professionals you have authorized, and time spent performing other services you have requested of me, etc., will be charged at the same rate, unless indicated and agreed upon otherwise in advance. Unpaid services or balances past due over 90 days may be referred to a collection agency.

Initial: _____

INSURANCE: I am not a contracted provider of your insurance or managed care provider. I am considered an out-of-network provider with your insurance company. Some insurances provide for reimbursement of expenses paid for out-of-network care. It is recommended that you contact your insurer to find out whether and how much they will reimburse. At your request, I will provide you with a statement which you may submit to your insurance or managed care provider to seek reimbursement of the fees you have paid. It is your responsibility to pay the fees and seek reimbursement from your insurer.

Initial: _____

I have read the foregoing Outpatient Services Contract, Confidentiality, Informed Consent & Office Policies carefully; I understand the terms and agree to comply with them.

_____

Client Signature Name (print) Date

_____ Relationship to patient: _____

Client Representative (if any) Name (print) Date

_____

Michael A. Gentry JD LCSW Date
Gentry Therapy LLC

A COPY OF THIS FORM IS AVAILABLE UPON REQUEST