Informed Consent for Treatment for Better Together Counseling

For the purposes of this informed consent for treatment:

- Elisa Horton, LMFT, LMHC, NCC, Inc.'s DBA Better Together Counseling will now be abbreviated as follows "EH".
- The person(s) seeking treatment/being seen in EH's counseling office and/or the parent/the guardian thereof will now be abbreviated/referred to collectively and or interchangeably as "the client".

About Elisa Horton LMFT, LMHC, NCC, Inc. Responsibilities

EH will:

- go over the client's goals, symptoms, &/or diagnosis with clients and suggest various types of treatment.
- explain the advantages & risks of therapy as necessary/appropriate.
- ensure that another licensed therapist will be made available to the client via telephone in the event of a client having an urgent need when EH goes on vacation or has some type of other situation in which she'd be unreachable or unavailable for more than 24 hours of EH's business hours.
- adhere to all state & federal laws pertaining to the practice of mental health & marriage & family counseling services.
- adhere to all codes of ethics of any professional association the therapist is involved with.
- keep scheduled appointments with clients unless there is an unforeseen emergency – in which case clients will be informed as soon possible.
- inform clients in writing if there are to be any changes to this agreement.

Client(s) acknowledge understanding and acceptance of this section's contents by signing below:

_____ _____ on _____/_____/_____.

Client Responsibilities

The client will:

- pay for services at the time services are rendered unless otherwise agreed upon/discussed with EH
- notify EH of any changes to the client's address, phone number(s), medical conditions, medications, employment, symptoms & credit card information.
- be on time to appts. & to call EH if running behind.
- schedule appts with full intention of keeping them regardless of the client's right to CX or RS within 48 hours.
- give EH as much notice as possible if the client's appointment needs to be CX or RS and understand that the 48 hr notice is the minimally acceptable amount of time to give unless there are "valid excuses."
- leave the client's name, *an acceptable phone number to call back (&/or leave a message at)* and the reason for the message so EH can get back to the client. EH is not responsible for returning inaudible messages – so please speak slowly and clearly and leave the number twice. When messages are inaudible, EH cannot return the calls.
- reserve contact with EH outside of session for urgent issues or scheduling purposes only (non-urgent issues should be journaled & presented at the next scheduled session).
- understand EH is NOT an emergency or crisis treatment provider. If the client has an urgent situation that arises, the client will leave a brief but detailed message & can expect a call within 24 business hours (EH will always attempt to respond to the client as soon as is possible).
- call 911 (not EH) if having a life threatening emergency (or if appropriate the client can go to the nearest ER) or dial 888-468-5600 for the mobile crisis unit &/or crisis help line or 211 if having a mental/emotional emergency
- be responsible for and active in their own treatment.

- understand that no other professional sharing office space with EH or that is otherwise in affiliation with EH will be held responsible for any aspect of the client's on-going treatment.
- ask questions if not understanding the treatment plan or any aspect of treatment.
- understand that therapy does not guarantee resolution of circumstances/problems/issues (i.e. couples counseling does not guarantee that the couple's relationship will be saved).
- understand that therapy can run the risk at times of creating uncomfortable feelings & can even sometimes worsen symptoms/circumstances as sometimes change does (i.e. discussing past traumatic situations can elicit painful feelings on the way to feeling relief).
- communicate with EH if expected changes are not being seen or felt within a reasonable amount of time. Typical couple or family therapy can last anywhere from 15 sessions to over 35 depending on the severity and complexity of the the symptoms/issues.
- inform EH if there is any possibility that the client may become involved in a legal situations in which the client's therapy could be implicated.
- understand that EH is not an expert witness under any circumstances, is not a custody evaluator, does not make fitness for duty or disability determinations of any kind, & does not appear in court unless subpoenaed by a judge. As such EH will not provide records or testimony unless compelled to do so. EH will generally not write or sign letters, reports, declarations, or affidavits to be used in any of the above matters nor communicate with attorneys.
- understand that it is therefore agreed that should there be legal or disability type proceedings neither the client, nor the client's attorney, nor anyone else acting on the client's (collective of those signing) behalf will call on EH to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.
- communicate with EH about the desire to terminate therapy & to discuss with EH questions or disagreements about the therapy process. The client agrees, at minimum, to a closing phone call but understands the best way to properly terminate a therapeutic relationship is by all therapeutic participants to engage in a closing session.
- understand EH (when done ethically and legally) may terminate therapy at any time with any client.
- understand that if there are no future appts. booked & there has been no contact between the client & EH for a period of 14-30 days that the client's case will be considered closed/non-active. Should the client desire for the client's case to be reopened, the client will need to reestablish contact with EH.
- understand and agree to the fact that under no circumstances shall either party (client nor EH) record sessions without express written authorization between client and EH that indicates the purpose and scope of the recording. If the client authorizes to record themselves their own session, the client understands that EH can no longer be held responsible for the confidentiality of that recorded session as the client now has possession of the recording and may store it in non-HIPAA compliant ways.
- ensure that any minor's or vulnerable adults involved in therapy with EH understand this contract in full.

Client(s) acknowledge understanding and acceptance of this section's contents by signing below:

_____ _____ on _____/_____/_____.

About Fees & Payments

- EH provides 1.25-1.5 hour sessions at $150.
- EH reserves the right to periodically adjust these fees. The client will be notified for any fee adjustments in advance if known.
- Payment is due at the time of session unless otherwise discussed & agreed upon ahead of the session in question.
- The client understands that EH prefers cash or check but also accepts credit cards.
- The client understands that if the client's check bounces, the client may be asked to pay cash from that point forward for any further sessions & may be asked to pay any fees charged by EH's bank for the bounced check (typically $30).

- The client understands that the will be held responsible for the following fees should they occur and that the client will be notified ahead of time by EH if the client is to be charged:
  - ➢ $300 an hour if EH is forced to appear in court on the client's behalf via a subpoena with a minimum retainer fee of $1200.
  - ➢ $25 per quarter hour with a quarter hour minimum for outside of session contacts with EH (i.e. phone calls, texts, emails, etc. initiated by the client) surpassing 15 minutes in length or that are excessive in nature.
  - ➢ $25 per quarter hour should EH be requested or required to write up case summaries to other professionals/ parties regarding the client's care. Charges associated with these services will be due prior to the other professionals/parties receiving said documentation.
  - ➢ $1 per page should the client's records be requested to be faxed, mailed, &/or emailed to other professionals/parties regarding the client's care. Charges associated with these services will be due prior to the other professionals/parties receiving said documentation.
  - ➢ $25 per quarter hour for any travel expenses EH's incurs on the client's behalf
  - ➢ postage to send said documents to other parties.
- The client understands that if the client does not fulfill the client's financial obligations within 30 days (unless otherwise arranged with EH), that EH has the right to pursue payment via a collections agency (i.e. www.olddebts.com) &/or EH has the right to report outstanding balances to the credit bureaus.
- The client understands that failure to pay EH's fees will result in immediate termination of treatment without exception.

Client(s) acknowledge understanding and acceptance of this section's contents by signing below:

_____ _____ on _____/_____/_____.

About Appointment Cancellations, Reschedules and No Shows

The client understands appointments must be cancelled or rescheduled with a ***minimum*** of 48 hours notice. Notice of cancellations and reschedules within 48 hours of the scheduled appointment need to be made via telephone/leaving a voicemail. The client understands that if the client does not provide 48 hours notice (CX/ RS< 48 hr) or the client no shows (NS) for an appt. without a valid excuse, the client will be charged $150 – if this happens more than twice, EH reserves the right to terminate the therapeutic relationship and will provide referrals to other appropriate clinicians and the client will be responsible for paying the resulting fees for the offending NS/RS/CX. **(***For clarification, a "valid excuse" would be if there was an act of nature/God preventing the client's arrival, a severe communicable illness (i.e. flu, etc – <u>for which the client was unable to call ahead of time to inform EH of the illness</u>), if the client were hospitalized (or otherwise medically incapacitated), if the client were involved in an emergency, or if any of these things happened to a close family member that the client takes care of and the client was unable to contact EH due to the circumstances.)*

- The 48 hour notice is in place in order to give other clients and EH the chance to fill the appointment time productively. EH is an appointment based business and therefore cannot book more than 1 client at a time making it important that each appointment time be utilized effectively.
- Clients will schedule appointments with EH with the sole intent of keeping their scheduled appointments with EH & checking to ensure there are no prior or conflicting obligations prior to scheduling with EH.

Client(s) acknowledge understanding and acceptance of this section's contents by signing below:

_____ _____ on _____/_____/_____.

Communications and Relationships Outside of Session, (Including Social Media, Texting, etc)

- EH cannot/will not be a personal "friend", a personal "link", or other such personal connections on social media sites as it: can cloud the therapeutic relationship, breaks confidentiality, and presents possibilities for dual relationships.

- EH may have a professional/company/business "page" or the like on social media platforms in a professional capacity that clients may find useful to "follow".
- EH currently has cellular business phones.
- EH discourages texting cellphone to cellphone. If the client elects to text EH, the client is consenting to the breach of HIPAA and understands the possibility that whatever is texted could be intercepted by unintended persons/entities.. EH will not text with a client on a cellphone unless the client texts EH first. The client understands if the client is choosing to text that the text will not contain clinical or sensitive information (e.g. the client will only text about benign topics such as scheduling).The client understands EH will return text during her office hours (within 24 business hours of receiving a client text). This is an important boundary issue EH requires to ensure proper work life balance. EH reserves the right not to text back. The client will need to specify in writing to EH if ever the client no longer wishes to receive texts once texting has ensued. EH recommends HIPAA compliant communication via the client portal on Therapy Appointment.
- EH reserves the right to refuse and/or block inappropriate contacts (via text or social media) if boundaries cannot be respected.
- EH will ensure client confidentiality outside of session/in public - if the client wishes to say hello outside of session and/or disclose the nature of the relationship with EH that is their right. EH excepts the client's lead/ precedent.
- EH utilizes a secure, encrypted, and password protected email system through TherapyAppointment.com. All email communications are considered a part of the client's clinical record and, thus, subject to all privacy regulations and limitations as discussed in the HIPPA Notice of Privacy Practices.
- EH maintains a secure communication system via fax (772-781-8388). EH may utilize this the fax in order to send treatment-related documents (per client request with a signed authorization to release/exchange information).

Client(s) acknowledge understanding and acceptance of this section's contents by signing below:
_____ _____ on _____/_____/_____.

About Appointment Reminders via PsychSelect/Therapy Appointment

EH's current electronic health record's system, Therapy Appointment by PsychSelect, offers appointment reminders through their automated system (EH is not sending these messages – do not reply to them – contact EH directly with appointment related concerns).

These appointment reminders are helpful and elective - they not HIPAA compliant and therefore require your authorization. By filling in the information below, you are agreeing to receive these reminders. These reminders are a complimentary service and are not guaranteed so please document your appointment times in your calendar when you book them.

I would like to receive my 48 hour in advance appointment reminder by (check one only):

_____ Text message at (_____)_____-_____ (_____)_____-_____
_____ Email message to _____ _____
_____ Automated telephone message to (_____)_____-_____ (____)_____-_____
_____ N/A. I'll remember my appointments on my own. (Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Additionally, by signing below, I acknowledge that:

• Information sent by Elisa Horton, LMFT, LMHC, NCC, Inc. can be intercepted by people other than me but that I accept this risks as self-evident (i.e. someone opens my mail, hacks my or the therapist's email or cell, reads my text message, etc.).

• Emails, cell phones, and Wi-Fi connections can be unsecured/unencrypted forms of communication – engaging with Elisa Horton, LMFT, LMHC, NCC, Inc. over these types of technologies puts client communications at risk.
• I am responsible for keeping my information updated with Elisa Horton, LMFT, LMHC, NCC, Inc. at all times to avoid unintended disclosure of PHI (i.e. a change in phone number or email address).
• I can withdrawal/change my mind about these preferences in writing to Elisa Horton, LMFT, LMHC, NCC, Inc. at any time.

Client(s) acknowledge understanding and acceptance of this section's contents by signing below:

_____ _____ on _____/_____/_____.

In the Event of EH's Incapacitation or Death

In the even of EH's incapacitation or death, EH has a professional will (as required by AAMFT's ethics) that will go into effect that appoints 2 licensed therapist as EH's proxies (a primary proxy and a back up proxy should the primary proxy be unable to fulfill their duties). These proxy's will act on EH's behalf in order to ensure the careful, professional, legal, and ethical handling of EH's confidential business affairs including assisting clients during their transition into another therapist's care and the proper handling of their records thereafter.

Client(s) acknowledge understanding and acceptance of this section's contents by signing below:

_____ _____ on _____/_____/_____.

Supervision and Peer Consultation

EH participates on a regular basis in professional peer consultations and paid supervision to improve the quality of services delivered to her clients. When this occurs care is taken not to reveal any identifiable information unless the client has given consent (via a signed authorization to release or exchange information). Professional peer consultation and paid supervision take place with other licensed or intern level mental health professionals who must follow the same laws of confidentiality that EH abides by. Care is taken to ensure that if there is a client that may be known by a fellow peer that that peer excuses themselves during the discussion of that case unless there has been authorization granted by the client.

Client(s) acknowledge understanding and acceptance of this section's contents by signing below:

_____ _____ on _____/_____/_____.

Acknowledgement of/Agreement to Informed Consent for Treatment

The undersigned/the client have had the opportunity to ask any questions that the client may have about Better Together Counseling's/Elisa Horton, LMFT, LMHC, NCC, Inc's informed consent for treatment. By signing this informed consent the client is agreeing to adhere to all of its contents and is voluntarily choosing to enter into a therapeutic relationship with Elisa Horton, LMFT, LMHC, NCC, Inc. and may terminate services at any time.

_____	_____	_____	_____
Adult Client Name (Printed)	Date of Birth	Signature	Date
_____	_____	_____	_____
Adult Client Name (Printed)	Date of Birth	Signature	Date
_____	_____	_____	_____
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date
_____	_____	_____	_____
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date
_____			_____
Signature of Elisa Horton, LMFT, LMHC, NCC			Date

"No secrets" Policy

This written policy is intended to inform you, the participants in therapy, that **when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient.** For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to *a third party* (i.e. anyone outside of the treatment unit) unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____(couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with our therapist, and that we enter/continue couple/family therapy in agreement with this policy.

_____	_____	_____	_____
Adult Client Name (Printed)	Date of Birth	Signature	Date
_____	_____	_____	_____
Adult Client Name (Printed)	Date of Birth	Signature	Date
_____	_____	_____	_____
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date
_____	_____	_____	_____
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date
_____			_____
Signature of Elisa Horton, LMFT, LMHC, NCC			Date

Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. T

he law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.

2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.

- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Adult Client Name (Printed)	Date of Birth	Signature	Date
Adult Client Name (Printed)	Date of Birth	Signature	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date
Vulnerable Adult/Minor Name (Printed)	Date of Birth	Guardian Signature & relationship to client	Date
Signature of Elisa Horton, LMFT, LMHC, NCC			Date