



Phone 760-576-5822

www.pierviewcounseling.com

Informed Consent

Client-Counselor Service Agreement

Welcome to my practice. The success of psychotherapy depends upon a high degree of trust between you and your therapist. This document has been prepared to fully inform you about what to expect from therapy and from your therapist. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Goals of Counseling

There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the quality of your life or learning to live with mindfulness and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior, improving self-confidence and self-acceptance. Whatever the goals for counseling, they will be set by the clients according to what they want to work on. I may make suggestions on how to reach that goal but you decide where you want to go.

Risks/Benefits of Counseling

Counseling is an intensely personal process, which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. It is important to recognize that therapy is not magic, and change does not occur overnight. Your persistence in carrying out homework assignments and your willingness to be invested in your treatment plan will have a determining role in how much you accomplish. In



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particular, the extent to which you are open and honest about yourself will play a role in how quickly you and your therapist can move on together to achieve your goals.

There can be discomfort involved in participating in psychotherapy. You may remember unpleasant events, or have aroused feelings of anger, fear, anxiety, depression, frustration, loneliness, helplessness, or other unpleasant feelings. If you are in couple's therapy, you and your partner may have difficult conversations as you work towards finding resolution to your problems. In some cases, couples may decide during the course of therapy that they no longer wish to remain united. In these situations, the goal of therapy may change to working towards a harmonious and cooperative separation. If distressful emotions arise during your therapy, talk to me about your feelings. I will help you effectively manage these feelings and identify support systems to assist you during these transitions. Additionally, you may find it helpful to take notes during your therapy session or keep a journal of the skills and tools you will gain from working with your therapist.

Appointments

Appointments will ordinarily be 50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with **24- hours' notice**. If you miss a session without canceling, or cancel with less than 24-hour notice, **you will be charge the cancellation fee of \$65 per session**. However, I reserve the right to make an exception at my discretion.

It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible the cancelation fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Confidentiality

I will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. If you are using insurance to pay for therapy sessions, your insurance provider has the right to review your records at any time. I may also consult with a supervisor or other professional counselor in order to give you the best service. In the event that I consult with another counselor, no identifying information such as your name would be released. Counselors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If I receive a court order or subpoena, I may be required to release some information. In such a case, I will consult with other professionals and limit the release to only what is necessary by law. If you do not



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want me to disclose information in your records, I reserve the right to bill you for all necessary attorney's fees in my efforts to fight a subpoena of your records.

Confidentiality and Group Therapy

The nature of group counseling makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that I cannot guarantee that other group members will maintain your confidentiality. However, I will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. I also have the right to remove any group member from the group should I discover that a group member has violated the confidentiality rule.

Confidentiality and Technology

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via Skype, telephone, email, text or chat. Due to the nature of online counseling, there is always the possibility that unauthorized persons may attempt to discover your personal information. I will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in and outside of counseling sessions.

Record Keeping

I may keep records of your counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either through electronic health record keeping methods or in a paper file kept in locked/secure storage.

Professional Fees

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash. If you do not pay your debt, I reserve the right to use an attorney or collection agency to secure payment. Fees are subject to change. Your appointment is reserved exclusively for you. If you miss your appointment or cancel later than 24 hours of a scheduled appointment, you are subject to a **\$65.00 missed appointment fee.** Checks are to be written out to **Pier View Counseling.**



Patient Litigation

I will not voluntarily participate in any litigation or custody dispute in which patient and another individual, or entity, are parties. I have a policy of not communicating with patients' attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in patient's legal matter. I will generally not provide records or testimony unless compelled to do so by law.

Termination

Termination of therapeutic services occurs for different reasons. Ideally, you and I will have mutually agreed that services are no longer needed after having achieved your goals in therapy. In other cases, such as one of the following examples, you may be relocating, not interested in working with me as a therapist any longer, are not able to comply with the agreed upon treatment plan, or payment for services rendered has not been paid in **30 days**. If I do not have contact or communication from you for a period of **60 days**, I will assume that you no longer intend to remain active in this therapeutic relationship and your case will be closed.

Contacting Me

I am not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. You may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. Please only text my work line if you need to reach me for scheduling purposes. I will not respond to any texts that contain personal and confidential information aside from schedule details. If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital, or call 911, or call the San Diego Crisis and Access Line at #888-724-7240.

Consent to Counseling. Your signature below indicates that you have read this Agreement and agree to its terms.

Client Name _____ **Date** _____

Client Signature _____ **Date** _____



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Schedule of Fees

This document outlines the schedule of fees, and must be agreed to by the client, and by Lydia Lombardi Good, hereafter referred to as the *Therapist*.

Hourly Charge: The hourly fee for therapeutic session is \$_____ This fee is payable by the end of each session. Sliding scale fees are sometimes available for reasons of financial hardship. This must be discussed up front and agreed to with the Therapist. _____ (Initial)

Insurance / Co-pays: Lydia Lombardi Good is an in-network provider with an Insurance company. If we are billing to insurance, the Client is responsible for any co-pay amount by the end of each session. For clients seeking reimbursement through their insurance for an out-of-network provider, a Superbill will be provided monthly upon request. _____ (Initial)

Insurance Card: The Client must present a current Insurance Card at the time of your first visit, and is responsible for updating the Therapist to any changes in Insurance. _____ (Initial)

Lapsed Insurance: If your insurance lapses, or if you do not have active insurance coverage, you are responsible for all charges incurred while you are without insurance. _____ (Initial)

Billing for Balances Due: The Client will be billed for any balances due stemming from, but not limited to: unpaid co-pays, cancellation fees, remaining balances after insurance reimbursement or the cost of therapeutic sessions. Payment for Balances Due is required within 30 days from the invoice date. _____ (Initial)

Cancellation Fees: 24 hour notice via text message or voicemail to 760-576-5822 is required to avoid a late-cancellation fee. *Failure to provide 24 hour notice to cancel an appointment, or failure to show without notice for a scheduled appointment will result in a \$65 cancellation fee.* This fee is not covered by Insurance. _____ (Initial)

Returned Check Fees: If your payment is by check made out to "Pier View Counseling" and the check is returned for any reason by your bank, you will be responsible for the amount of the check, plus an additional \$50 that is assessed for returned checks. _____ (Initial)

By signing below, I attest that I understand and agree to the fee schedule listed above.

Signature: _____ Date: _____