

AGREEMENT FOR THERAPY SERVICES

Susan Lessley Counseling
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612.581.7381

Welcome to the therapeutic practice of **Susan Lessley, MA, LMFT**. This document contains important information about my professional services and business policies. It also contains information about my policies and practices to protect the privacy of your health information. Please read this document carefully and let me know if you have any questions or concerns. By signing this document, you will be stating that you were provided with this information and it will represent a binding agreement between us.

Psychotherapy Services: Psychotherapy varies depending on the therapist, the client and the client's particular situation and goals. There are many different methods which may be used to deal with a particular situation, goals, and objectives. For the best outcome, each client must choose to invest energy in the process and work actively on relevant topics both during and between sessions.

Psychotherapy can have benefits and risks. The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety or frustration when discussing aspects of life. Psychotherapy has been shown to have benefits that can include better relationships, solutions to specific problems, increased life satisfaction, improved physical health, and significant reductions in feelings of distress. However, there are no guarantees as to what each client will experience.

What to Expect: The first few sessions will involve an evaluation of your situation including needs, goals, and objectives to work toward. Psychotherapy can involve a significant investment of time, energy, and money. It is important to select a therapist with whom you are comfortable working. If at any time you have questions about therapy, please discuss them with me as they arise. If you decide to discontinue therapy, I will provide referrals to other therapists or other appropriate resources if requested.

Sessions: I schedule 50-minute sessions. If you would like longer sessions, the price will be pro-rated according to the length of appointment we agree upon. If you arrive late for an appointment, the remaining time of our scheduled session is available to you if you have called to state you will be late. If you have not called, I may not be available after 15 minutes from the scheduled start time. At times, it may be appropriate to meet more or less than once per week if that is consistent with the agreed upon treatment plan.

If you need to cancel a scheduled therapy session, you must do so at least 24-hours in advance. If you do not cancel a scheduled appointment with at least 24-hours notice, or if you fail to attend a scheduled session, you agree to pay the full fee for that session, unless it is agreed upon that the absence was due to uncontrollable circumstances.

Professional Fees: Fees are listed on the Counseling Fees document. Package rates are available which can be found on my website (www.SusanLessleyCounseling.com). In addition to regular sessions, it is policy to charge the therapy rate on a pro-rated basis for other professional services required. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals which have been authorized, preparation of records or treatment summaries, and time spent performing any other professional service. Often, it is not helpful to participate in a legal process concerning any therapy that may have been given. Therefore, I will decline if asked to participate in any legal or court hearings. If it becomes necessary to participate, the rate for my preparation and participation in a court hearing or other legal proceeding will be \$350 per hour. You will also be charged this rate for travel time, waiting time and agree to pay any additional necessary fees (for example, parking fees). Pre-payment of expected fees will be required one week (7 days) in advance of legal proceedings. You understand you will be billed for any remaining amount.

Billing and Payments: You will be expected to pay the full agreed upon fee at the time of each session unless other arrangements have been made. Payments may be made by check, cash, or credit card via PayPal. Payment schedules for other professional services will be agreed upon when/if they are requested. If a payment by check does not clear due to insufficient funds or any other reason, you will be expected to reimburse Susan Lessley Counseling in full for any related bank fees.

Insurance Reimbursement: To provide you with the most personal and confidential therapy services, I do not submit billing to insurance organizations. Your insurance provider may pay for out-of-network therapy services, depending on your plan. Alternatively, you may use your FSA or HSA to cover services. Please check your coverage carefully.

Contacting Me: Because I do not take calls during sessions, I may not be immediately available by telephone. A **confidential voicemail may be left at 612-581-7381**. Every effort will be made to return calls within 24 hours, more promptly if possible.

If you are in an emergency situation, you may either call your therapist and follow the instructions for emergencies, or immediately call the **Crisis Connection at (612) 379-6363**, the **St. Paul Ramsey Crisis Intervention Center at (651) 221-8922**, your local emergency services at 911, or call or go to the nearest hospital emergency room, telling them of your emergency. You understand that you are NOT to wait for me to return your call in an emergency situation.

Social Media Policy: I do not interact or accept “friend” requests via social media sites (Facebook, LinkedIn, etc) because it has the potential to compromise privacy and complicate our therapeutic relationship.

Emails, cell phones, computers and faxes: Computer, email, text, and cell phone communications can be relatively easy to access by unauthorized people and hence, can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Additionally, emails are not encrypted, and faxes can be sent erroneously to the wrong address. Our computers are equipped with a firewall, a virus protection and a password, and we also back up all confidential information from computers on to CDs on a regular basis. The CDs are stored securely. If you communicate confidential or highly private information via email, text, or cell phone, I will assume you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters via electronic means. You agree that electronic communications are part of your medical record. You agree to not use electronic communication for emergencies. Due to computer or network problems, electronic communications may not be deliverable or in a timely manner.

Professional Records: The laws and standards of the therapy profession require that treatment records are retained and kept for a period of 7 years after the last point of contact. You are entitled to examine and/or receive a copy of your record if requested in writing, unless it is believed that seeing them information would be emotionally damaging, in which case they will be sent to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to people who are not mental health professionals. Susan Lessley Counseling reserves the right to charge \$.75 per page for the cost of copying and \$25.00 for administration costs.

Confidentiality: In general, the law protects the privacy of all communication between a client and a mental health provider. I may only release information about your treatment to others if you sign a written authorization form. You may revoke any such authorizations at any time, which must be in writing. However, in the following situations, your authorization is not required to release your personal information:

- Therapist’s duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
- Therapist’s duty to report suspicion of abuse or neglect of children or vulnerable adults.
- Therapist’s duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, amphetamine or their derivatives, THC, and excesses and habitual use of alcohol.
- Therapist’s duty to report the misconduct of mental health or health care professionals.
- Therapist’s duty to provide a spouse or parent of a deceased client access to their child or spouse’s records.

- Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.
- Therapist's duty to release records if subpoenaed by the courts.
- Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan.)

If an emergency happens to my therapist causing my therapist to be unable to provide services, my protected health information may be shared with a colleague, Lynn Harris Luetgers, MA, LMFT, for both clinical and administrative purposes, such as billing, scheduling, and quality assurance. She is bound by the same rules of confidentiality as your therapist. By signing this document, I am agreeing with the release of my health information to Ms. Harris Luetgers if the need arises.

While I am not an attorney, please discuss any questions or concerns you have about confidentiality with me at any time. If you have specific legal questions about the laws regarding confidentiality, the exceptions, and how it may relate to your situation, please seek formal legal advice from an attorney.

Other Client Rights: You agree that you understand the following:

- I have the right to request and receive confidential communication of my protected health information by alternate means or at alternative locations. For example, clients may request the therapist send any correspondences to an address other than the clients' home address if not wanting family members to know about therapy.
- I have the right to request that the therapist change information in my record. I understand I am required to make such requests in writing along with reasons for the requested changes. The client's request will be noted.
- I understand I generally have the right to receive an accounting of any disclosures the therapist has made of protected health information, which did not require client authorization.
- I understand my therapist may use or disclose my health information for treatment purposes including presentation of my case in consultation with other professionals or consultants who are bound by the legal framework of privacy and confidentiality for professional development and guidance purposes. This case consultation may include case consultation with other therapists at Susan Lessley Counseling or with therapists and supervisors outside of Susan Lessley Counseling. In most cases, outside consultation will be undertaken without the use of any identifying information.
- I understand my therapist may use or disclose my health information for the purposes of payment and health care operations including internal administration, participating in periodic file review, and normal business accounting procedures.

Changes in Services or Fees: Susan Lessley Counseling reserves the right to change the policies, practices, procedures and fees described in this document. You will be notified within 30 days of any such changes.

Minors: If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is my policy to request an agreement from your parents that they consent to give up access to your records. If they agree, I will provide them only with general information on how your treatment is proceeding as well as a summary of your treatment when it is complete. However, if I feel that there is a high risk that you will seriously harm yourself or another, I will notify them of my concern. Before giving your parents any information, I will discuss the matter with you.

Safety: I strive to provide a safe environment for all. Please let me know immediately if you have concerns for your safety while at my office. You agree that if you engage in verbal, written or physical behavior that is threatening to a therapist or a therapist's family, or any other person at Susan Lessley Counseling, any therapist at Susan Lessley Counseling may identify you to the police, explain that you are a client at Susan Lessley Counseling, and report the threatening behavior using your personally identifying information. Further, if needed, you agree that any therapist or other at Susan Lessley Counseling may take other legal action to ensure safety for any therapist and any therapist's family or other people at Susan Lessley Counseling using your personally identifying information.

Information Received & Services Requested: The following materials pertaining to therapy (please check each) have been reviewed. Copies of these materials are available on my website.

Confidentiality Statement
 Privacy Information (HIPAA)

Fee Information
 MN Bill of Rights

I understand the basic goals, ideas, and methods of this therapy. I have no important questions or concerns that the therapist has not discussed with me. I understand that reaching the agreed upon therapy goal is not guaranteed. I understand that therapy is successful for some people, moderately successful for others, and for some not successful at all. I further understand that the initial symptoms or problems that were presented to the therapist may initially become more intense.

I am agreeing to participate in the following types of services, while acknowledging that the course of therapy may change, and the participants may change, by agreement of all parties.

Individual Therapy
 Couples Therapy (partner name) _____
 Family Therapy (family names) _____
 Group Therapy

If I am participating in couple or family therapy I understand that:

- I do not have an individual file. Instead we share a couple or family file that holds all of the sessions regardless of who participates in any particular session.
- All people participating in therapy need to consent for information to be released from a couple or family file.
- When I am a participant in couple or family therapy and come to a session without all of the other participants listed above, I am giving my consent for my therapist to verbally share information from that session that the therapist deems pertinent to our work together with the other people participating with me in therapy.

Conclusion and Signatures: By signing below I am indicating I have received and read the information in this document, have discussed the contents with my therapist to my satisfaction, and agree to abide by its terms during the course of therapy. I understand I may request a copy of this document.

Client 1 - Print Name Signature Date

Client 2 - Print Name Signature Date

Susan Lessley, LMFT

Signature Date