Attune LLC
161 East Avenue, Suite 14C
Norwalk, CT 06851

AGREEMENT FOR SERVICE / INFORMED CONSENT

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.

Please read this document carefully. When you sign it, this document will represent an agreement between us.

Therapist Background and Qualifications. I have a Master of Arts in Marriage and Family Therapy. I have a License to practice as a Marriage and Family Therapist in the state of Connecticut. I have worked for 12 years as a therapist, my practice focuses primarily on adolescents ages thirteen and older, adult couples, individuals and families.

Risks and Benefits of Therapy. Participating in therapy can result in several benefits to you, including a deeper understanding of yourself and your personal goals, improved relationships with others, and resolution of the specific concerns that are your motivation for beginning therapy. However, therapy can have risks as well as benefits. While the primary goal of therapy may be to improve your well-being, it can also result in considerable discomfort. You may experience uncomfortable feelings such as sadness, guilt, anger, shame, frustration, loneliness, and helplessness. Should you have any concerns regarding your progress in therapy, it is important to let me know.

Records and Record Keeping. The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead.

Confidentiality. The information disclosed by you in therapy is generally confidential and will not be released to others without your written consent. However, there are a few exceptions. Exceptions to confidentiality, include:

- If there is reason to believe a child, elderly person, or dependent adult is or has been abused.
- If you threaten to commit serious bodily harm to yourself or another person.
- If I am presented with a subpoena or court order that has been signed by a judge.

In any of the above circumstances, I will only reveal the minimum information that is necessary, and I will do my best to inform you of the information being disclosed and to whom it will be provided before I do so.

Minors and Confidentiality. If you are a minor, under the age of 18, your parents/guardians may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential. See Adolescent Consent Form on Page 4.

Fee and Fee Arrangements.

- The standard fee for the initial intake is $250.00
- Each subsequent 60-minute session is $200.00
- Sessions longer than 60-minutes are charged for the additional time.

If I need to adjust my fees in the future, you will be notified of any fee adjustment in advance. Sliding scale fees are available on a limited basis.
All fees are due at the time of service. Please ask if you wish to discuss a written agreement that specifies an alternative payment procedure.
If for some reason you find that you are unable to continue paying for your therapy, please let me know. I would be happy to help you to consider any options that may be available to you at that time.

Insurance. Currently, I accept: Anthem Blue Cross/ Blue Shield, Cigna, Medicaid (HUSKY). You should be aware that insurance companies require that some clinical information is shared in order to reimburse for services. All insurance companies require a clinical diagnosis. Some may require additional information such as treatment plans or treatment summaries. In these instances. I will disclose the minimum amount of information required for the requested purpose. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage, and that you are responsible for any and all fees not reimbursed by your insurance company. Please let me know if you have any questions or concerns.

Cancellation Policy. Standard policy for most therapists, myself included, is a 24-hour cancellation policy. If you do not show up for your scheduled therapy appointment and have not notified me at least 24-hours in advance, you may be charged $45 for the missed appointment. A total of two missed appointments without prior notification may lead to ending the therapy relationship.

Therapist Availability and Emergencies. I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee your call will be returned immediately. I am unable to provide 24-hour crisis service. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, please call 911, or go to the nearest local emergency room.

Social Media and Telecommunication. Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your

confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

Electronic Communication. I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. Threats to confidentiality include, but are not limited to: 1) the transmission may be intercepted; 2) the transmission may be sent to the wrong recipient; and 3) the e-mail or text message may be accessed by an unauthorized person. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Termination of Therapy. Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment, after appropriate discussion with you, if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. You also have the right to terminate therapy at your discretion. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for four consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

CONSENT TO TREATMENT

I, _____, have read *Agreement for Services/Informed Consent*. In signing below, I consent to treatment and agree to abide by its terms during the course of therapy.

Client Name (please print)

_____

Client Name (please sign)

_____

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Adolescent Consent Form & Parent Agreement to Respect Privacy

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor Signature _____ Date_____

Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

/__/ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

/__/ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

/__/ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Minor Signature _____ Date_____

Parent Signature _____ Date_____

Therapist Signature _____ Date_____

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.