Candlelight Counseling PLLC
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Welcome to my practice. The following guidelines should answer most of your questions about my policies and procedures. Please read it carefully and discuss any questions you have with me. When you sign this document, it will represent your informed consent for evaluation and treatment services Evaluation and Treatment Information: All clients are here voluntarily for their mental health care. It typically takes 2 sessions to conduct an evaluation, to determine if I am the best person to help you, and to develop a treatment plan. Regularly reviewing our work toward meeting treatment goals is in your best interest, and it is important for you to play an active role in this process. Psychotherapy has both benefits and risks. While it is empirically demonstrated to have beneficial effects on emotions, behaviors, and relationships, at times it can also arouse distressing thoughts, feelings, and behaviors. The practice of psychotherapy is not an exact science and no guarantees can be made as to the results of therapy. It is important to keep me informed of any concerns you have about your response to treatment.

Professional Fees and Payment policy:
My fee is $150 for a 60-minute psychotherapy session. Phone calls greater than 15 minutes in length will be billed to you and are not covered by insurance. Payment is due at the time of each appointment, or payments can be made on a monthly basis. If you have health insurance with which I participate, I will bill the insurance and you will be responsible for the co-pays and any deductible on a monthly basis. You are also responsible for insuring that your health insurance remains in effect. I will assume responsibility for getting appropriate authorizations if preauthorization is required for your health insurance. Unpaid balances will be turned over to a collection agency if attempts to resolve the problem are unsuccessful.

Cancellation policy:
I am committed to providing you with high quality treatment. Success in therapy depends on many factors, one of which is regular, consistent attendance. A 24-hour notice is requested when canceling an appointment regardless of the reason for cancellation. Cancellations under 24 hours will be charged on the following fee schedule: first cancellation $40, second cancelation $80, third and any subsequent cancelation $150 (full session fee). Keep in mind that this is an expense that insurance companies do not reimburse.

Availability:
My office phone number is 810.295.1738 and I check for messages at least once a day. In case of emergency, you should go to the nearest hospital emergency room. You may use e-mail for routine scheduling and rescheduling of appointments but should not use it for emergencies. Please be aware of the limits on privacy inherent in e-mail usage and use caution in exchanging treatment related information.

Privacy Practices:
Your mental health information will be maintained in a confidential manner as required by state and federal law, as well as the ethics of my profession. In most situations, I can only release your protected health information (PHI) to others if you sign a written authorization form that meets certain legal

requirements imposed by HIPAA (HIPAA is the Health Insurance Portability and Accountability Act, which went into effect on April 14, 2003). However, some situations, described in the bullets below, require only that you provide written, advance consent. Your signature on this Agreement provides consent for the following situations:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- In the event of a complaint or lawsuit, I may disclose relevant information in the context of those legal proceedings.

- If I am being compensated for providing treatment to you as a result of your having filed a worker's compensation claim, I must, upon appropriate request, provide information necessary for utilization review purposes.

In addition, your insurance company, if you use one, requires a diagnosis be given in order to reimburse for services rendered. They may also request additional information, and this will be provided as needed (see the section on Client Records below). Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier. 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 therapist-patient privilege law. I cannot provide any information without either your written authorization or a court order. You should consult with your attorney to determine whether a court would be likely to order me to disclose information if you are involved in or contemplating litigation.

There are three additional situations in which I am legally obligated to take actions. These rare situations only occur when I believe others are in harm's way as a result of your actions. If this happens, I may have to reveal some information about your treatment. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

- If I have reasonable cause to suspect you of child abuse or neglect, the law requires that I file a report with the Department of Human Services. Once such a report is filed, I may be required to provide additional information.

- If I have reasonable cause to suspect the "criminal abuse" of an adult, I must report it to the police. Once such a report is filed, I may be required to provide additional information.

- If you communicate a threat of physical violence against a reasonably identifiable third person and I judge you to have the apparent intent and ability to carry out that threat in the foreseeable future, I may have to disclose information in order to take protective action. These actions may include notifying the potential victim (or, if the victim is a minor, his/her parents) contacting the police, and/or seeking hospitalization for you.

- I take your safety very seriously. If I have reason to suspect that you are not safe from serious self-harm, I will take measures to provide for that safety, including but not limited to alerting your relatives (or emergency contact) or arranging for you to be transported to the nearest emergency room for a psychiatric assessment and possible inpatient hospitalization. Please feel free to discuss this further with me if you have questions or concerns.

Record Keeping:

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in your clinical record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. You have a right to examine and/or receive a copy of your clinical record if you request it in writing, except in unusual circumstances, as follows:

- where disclosure would physically endanger you and/or others,
- when your record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person,
- where information has been supplied to me confidentially by others

Terminating Treatment:

You may stop your treatment with me at any time. It is most often helpful to have at least one termination session for closure, but this is not mandatory. You will be responsible only for paying for the services you have already received. I reserve the right to stop your treatment, and if requested, assist you with a referral to another therapist or clinic if payment for clinical services is not made.

Informed consent:

My signature below shows that I understand the information provided in this document and that I consent to evaluation and treatment. It also serves as an acknowledgment that you have been offered a copy of this document to keep.

Printed Name _____ Date of Birth_____

Signature (of client)_____ Date_____

Witness: I have discussed the issues above with the client. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Printed Name: Christopher Sanderson LMSW

Signature:_____ Date_____