CLIENT/THERAPIST AGREEMENT - Client Copy

The following information may be helpful in answering your questions, and clarifying the policies and procedures for my practice.

OFFICE HOURS

I generally work Monday, Wednesday and Friday between 10 am and 6 pm; Tuesday and Thursday between 11 am and 8 pm; and every other Saturday. You can expect that your phone call will be returned within 24 hours for normal scheduling and general issues. However, if you have an urgent concern or a same day/Saturday cancellation, please call me on my cell phone at 480-510-1312.

FINANCIAL AGREEMENT

My fee for private pay clients is $130.00 for a 60-minute session. However, your fee may be a contracted rate with your managed care company. Please check with your insurance company as to your portion of the fee (i.e. deductibles, co-pays, percentage covered). Many insurance companies may require an authorization prior to beginning treatment. Most managed care companies reimburse for a 45-50 minute session. Although I will assist in billing your insurance, you are responsible for knowing the limits of your insurance. My billing staff will bill your insurance company for the balance due me. If you have any questions with regard to your statement, please contact the office and leave a message in box #4. **In the event of an insurance denial of payment, you are personally financially responsible for your sessions.** Your co-pay or fee is payable at the beginning of each session. I accept cash, checks or Mastercard and Visa. There will be a **$25 charge for any returned check**. Balances older than 45 days may be submitted to a collection agency, and you will be responsible for the collection's commission in addition to the fee owed me. All other professional services, such as requests for letters, filling out of forms, providing copies, extended phone or in person contacts with other professionals, preparation of reports, etc. are also subject to charges at a prorated basis. In unusual circumstances where I may become involved in a legal matter, you will be responsible for my professional time including preparation, travel, and attendance at $250 per hour.

PHONE CALLS

If your situation requires attention outside of regular working hours, please call my cell phone at 480-510-1312, and I will respond as soon as I am able. If this is a life- threatening situation, contact 911, or the 24 hour Empact Crisis Line at 480-784-1500. I reserve the right to charge you for telephone consultations pro-rated on my private fee.

NO SHOWS/LATE CANCEL POLICY

Because your appointment time is held exclusively for you, **there will be a charge of $100.00 for any appointments missed or canceled with less than 24 hours notice. Insurance does not cover this fee**. We would appreciate your call as soon as possible. If this is a same day or Saturday cancellation, please contact me on my cell phone @ 480-510-1312

CONDUCT OF THERAPY/RECORDS

I adhere to the Code of Ethics as a psychologist and to the laws of Arizona as they pertain to client-therapist relationships. All records are retained for a period of seven years after a client's last visit, or seven years past the client's 18th birthday. In the event of closing my practice, I will notify active clients by letter, and inactive clients may contact me through the Arizona State Psychological Association. I will respond to all requests for records within a 30 day period when reasonably possible. All records will be kept in a secure location, and disposed of after the legally specified time. In the event that circumstances require, I will forward record access and responsibility to a specified professional who will respond to record requests in accordance with legal and professional standards.

CONFIDENTIALITY

The content of all professional interactions in my practice will be held in confidence unless you waive this confidentiality in writing. However, confidential information can be subpoenaed by court order. Additionally, information concerning current child or elder abuse, physical violence, or threats to others or self is REQUIRED BY LAW to be reported to the designated authorities. Therefore, this kind of information will not be kept confidential.

EMERGENCY COVERAGE

Dr. Howell has a professional duty to make arrangements for your continuing care in the event Dr. Howell becomes unavailable due to incapacitating illness or death. Accordingly, should Dr. Howell become unavailable due to incapacitating illness or death, a designated professional with credentials at least equivalent to those of Dr. Howell will notify you. At your request, that professional will provide a referral for further care. The professional will also inform you where your records will be stored and what you will need to do if you wish to access them.

By signing permission line number one (1) below, you give Dr. Howell permission to provide your name, address, and phone number, information about your case and access to your records to the professional who will be responding should Dr. Howell become unavailable due to incapacitating illness or death.
Access to information about your case and to your records would be very helpful to this professional in referring you to other appropriate health care providers who may be able to provide you with continuing care in the event Dr. Howell cannot continue to provide you with care. This professional will keep confidential all information obtained about you from Dr. Howell, obtained from you in speaking with you and obtained in reviewing your records just as Dr. Howell has kept that information confidential.

If you do not want Dr. Howell to allow this professional to have any information about you other than your name, address, and telephone number, so you can be notified of Dr. Howell's incapacitating illness or death, or to have any access to your records, please so confirm by signing permission line numbered two (2) below.

Permission Lines:

1. I give Dr. Howell permission to provide my name, address, and phone number information about my case, and access to my records to the professional who will be responding should Dr. Howell become unavailable due to incapacitating illness or death.

Name_____ Date_____

OR

2. I give Dr. Howell permission to provide my name, address, and phone number only to the professional who will be responding should Dr. Howell become unavailable due to incapacitating illness or death.

Name_____ Date_____

SOCIAL MEDIA POLICY
This outlines my office policies on how I and/or my staff conduct ourselves on the Internet, and how you can expect this office to respond to various interactions that may occur on the Internet.

- Email notices for the purposes of individual and/or group reminders will be all the interaction used via the Internet.
- Please do not use mobile phone text messaging or messaging on social network sites such as Twitter, Facebook, or Linkedin to contact me. These sites are not secure. Engaging with me this way could compromise your confidentiality.
- If you need to contact me between sessions, the best way to do so is by phone.

I HAVE READ AND UNDERSTAND THIS INFORMATION SHEET, AND HAVE BEEN GIVEN A COPY OF IT TO TAKE WITH ME.

Signature_____ Date_____
Client/Guardian

Signature_____Date_____
Libby Howell, Ed.D., LMFT
Licensed Psychologist, #1935