FINANCIAL, APPOINTMENTS, AND CREDIT CARD AGREEMENT

FINANCIAL AGREEMENT

The responsible party is the person who is ultimately responsible for payment for psychotherapy services. By signing this agreement, you are indicating that you are the responsible party and that you agree with the following:

- Payment for services is expected at the time of your visit.
- Appointments must be canceled at least 48 hours in advance to avoid incurring a charge. The 48 hours are within business hours and do not include weekends or holidays.
- The fee for a late cancellation or failed appointment is equal to the charge for a full session.
- There will be a $25 service fee on all returned checks.
- You are responsible for any charges incurred if legal or collection services are required or delinquent accounts.
- Services such as letters written on behalf of clients, written reports or assessments, appearance at meetings with schools or social workers are subject to a fee based on the time involved.
- I am what is referred to as an "Out of Network Provider." I do not bill your insurance company and payment is due at each session. I will provide a "Super-bill" if you are eligible for reimbursement from your insurance company. Services may be covered in full or in part by your health insurance company or employee benefit plan.

CANCELLATIONS AND MISSED APPOINTMENTS

APPOINTMENTS

The length of a usual appointment is 50 minutes, except for the initial session, which may take up to an hour. Appointments are usually scheduled weekly and on a regular basis until you have accomplished the majority of your goals and other arrangements are made.

CANCELLATIONS AND MISSED APPOINTMENTS

A credit card number will be taken at the onset of your counseling. Appointments must be canceled at least 48 hours in advance to avoid incurring a charge. The 48 hours are within business hours and do not include weekends or holidays. Late cancellations or not showing up on the day of a scheduled appointment will be charged at the regular hourly fee to your credit card. If you have a true emergency, your credit card will not be charged.

CREDIT CARD AGREEMENT

Please note: new clients are required to keep a valid credit card number on file. Please complete following and provide your credit card information to me at your initial session.

Credit card type: MC Visa Amex Other _____
Name as shown on card _____
Credit card number _____
3-digit security code on back of the card _____
Billing zipcode associated with the card _____
Expiration date _____

This card may be charged for:

_____ Regular session fees (at your request, as a convenience to you)
_____ Fees for cancellation without 48 hours notices (according to policy)
_____ Fees for missed appointments (according to policy)
_____ Delinquent session fees (fees more than 30 days overdue)

Agreement:
"I, _____ (print name), have read and understand the terms of providing my credit card information to Kimberly Greene, MA, LMFT. I understand that my credit card may be charged for the reasons indicated above. Any questions I have about this practice have been answered."

I am the responsible party for psychotherapy services or acknowledge and consent to this financial agreement.

_____ Date _____
Responsible Party Signature

_____ Date _____
Kimberly Greene, MA, LMFT

CONSENT FOR TREATMENT

Therapy involves both benefits and risks. Risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Therapy may involve making changes that can feel uncomfortable to you and those close to you. Should you notice any negative effects, please tell me immediately. I will make every effort to remedy the situation or provide you with names of other therapists should you prefer a referral. Psychotherapy has been shown to have benefits for those who undertake it. It often leads to reduction of feelings of distress, and to better relationships and resolution of specific problems. The objective is to find more peace, joy, and healthier relationships.

CONFIDENTIALITY

As part of the counseling process, I am bound by ethical responsibilities to keep confidential the information shared during the sessions and I will not release any information without your written permission. There are important exceptions to the confidentiality of the counseling relationship. I am required by law to reveal certain information under the following circumstances:

a) **Disclosure of serious intent to do harm to self or others**
b) **Disclosure of child abuse or my suspicion of child abuse, elder abuse, or dependent adult abuse**
c) **If a court of law orders the release of specific information**

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PAYMENT

Payment is expected at each session unless other arrangements have been made in advance. Kimberly Greene is a psychotherapist with specialized training in individual, couples, family, and trauma therapy. You are responsible for payment for all services rendered either by a debit card, credit card, check or cash. All checks and credit cards will be paid to Kimberly Greene, MA, LMFT.

CHECKS/OVERDUE ACCOUNTS

There will be a $25 service fee on all returned checks.

TELEPHONE, TEXT AND EMAIL POLICY

Generally, I ask that clients reserve discussing problems that arise between sessions for the next scheduled appointment time. I encourage you to use resources you have and to reach out to your support system. Unless there is an emergency, our schedules do not permit us to talk on the phone, respond to lengthy texts or answer lengthy emails in between sessions. If you feel the need to text or email information beyond the routine scheduling of appointments, I will wait to discuss the content in our next scheduled session. If telephone calls are necessary for a client emergency, please schedule a time for a telephone consultation, which will be charged at our regular rate (in 15 minute segments). **Please do not text anything other than appointment times as confidentiality is not secure with texting.**

INSURANCE

I am what is referred to as an "Out of Network Provider." I do not bill your insurance company and payment is due at each session. However, I will provide a "Super-bill" if you are eligible for reimbursement from your insurance company. Services may be covered in full or in part by your health insurance company or employee benefit plan.

PHYSICAL EXAMINATIONS

I strongly recommend that each client obtain a thorough physical exam prior to commencing therapy. This is especially important if you are suffering symptoms of anxiety or depression, headaches, and/or weight gain/loss. Symptoms may be biologically caused or may be there for a protective reason.

EMERGENCIES

Counseling services are available only during scheduled office hours. In a crisis, you may utilize the Sacramento County Mental Health Crisis Service (916-875-1000).

If you have any questions about these policies or about psychotherapy, please ask before signing. Your signature indicates that you have read this policy and agree to enter therapy under these conditions. Further, it indicates your understanding that I may terminate therapy if you do not comply with the policies or if I feel you are not benefiting from treatment.

_____ Date _____

Client/Parent Signature

CONSENT FOR TREATMENT OF A MINOR

I, _____, give my consent that Kimberly Greene, MA, LMFT, may conduct psychotherapy with _____, (DOB _____).

I have been notified and understand that all materials discussed during my psychotherapy sessions are confidential and can be released only with my permission. I have also been informed of the limitations to the confidentiality in the INFORMED CONSENT AGREEMENT that I have read and signed. These limitations include reasonable suspicion of child or elder abuse or neglect, when the client presents a danger to himself/herself or others, is gravely disabled, or as a gravely disabled minor, pursuant to legal proceedings and when you have given permission to me to release information and signed a release of information form.

Privacy and trust are key components of the psychotherapy relationship. Special sensitivity may be required in releasing information that the minor discloses in session about certain topics such as drugs or sex. I expect the Kimberly Greene will maintain my minor's privacy and I will accept Kimberly Greene's judgment in regard to releasing or sharing information obtained during the course of the psychotherapy with the minor that may endanger or jeopardize the patient's well-being.

_____ Date _____

Signature of Client

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

As a psychotherapist, I am committed to protecting your privacy and confidentiality to the full extent of the law. This notice describes how psychotherapy and medical information about you may be used and disclosed. It describes protections and limitations on your privacy and how you can be informed about the use and disclosure of your medical information. This notice conforms to the Federal Health Insurance Portability and Accountability Act (HIPPA) effective April 14, 2013. It also conforms to the health care privacy laws of California.

New federal and state laws require psychotherapists to insure the privacy of your Protected Health Information (PHI) record. PHI includes, but is not limited to, information about your therapy such as dates, diagnosis, medications, crisis risk, symptoms, test results, billing and treatment plans.

Under certain circumstances, federal and California state laws allow psychotherapists and health care workers to use or disclose your PHI record for certain treatment, payment, and health care operations purposes without your authorization. If this happens, psychotherapists are to release the minimum amount of information possible. Disclosure of your PHI record without your authorization may include, but is not limited to, sending insurance billing case management and/or care coordination with your insurance company or HMO, and consulting with your family physician, previous psychologists or psychiatrists.

It is import to note that this use and disclosure does not include any detailed written progress notes I may keep about our work together. Progress notes are separate records and are given more privacy and confidentiality protection by law.

Any request for your PHI record outside of treatment, payment and health care operations requires your written authorization except as noted in the follow paragraphs. These are legal circumstances where a psychotherapist may use or disclose your PHI record without your written authorization or consent. These include the following situations:

CHILD ABUSE: Whenever I, as a psychotherapist, have knowledge of or observe a child that know or reasonably suspect has been the victim of child abuse or neglect, I must immediately report this to the appropriate agency, which may include the police, sheriff, welfare, probation or Child Protection Services. If I reasonably suspect or know that mental suffering has been inflicted upon a child or a child's emotional well-being is endangered, I may report this to one or more of the protective agencies.

ELDER, DEPENDENT ADULT AND DOMESTIC ABUSE: If I, as a psychotherapist, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced any of the above, I must report this to local law enforcement or adult protective services.

JUDICIAL OR ADMINISTRATIVE PROCEEDINGS: If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I may not release any information without your written authorization or the authorization of your attorney or personal representative. This privilege does not apply when there is a court order from a judge for your records. I will make reasonable effort to inform you in advance if this is the case. If I am served a subpoena to produce your records, I will make reasonable effort to contact you for your consultation and will only release records if ordered by a judge.

HEALTH OVERSIGHT: If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me and relevant to that complaint.

SERIOUS THREAT TO HEALTH OR SAFETY: If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police or sheriff. If I have reasonable cause to believe that you are in such a condition as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.

WORKERS' COMPENSATION: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of your initial treatment after the filing, and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission, in order to determine your eligibility for worker's compensation.

PUBLIC HEALTH AND NATIONAL SECURITY: A psychotherapist may be required to disclose PHI of military personnel and veterans under certain circumstances. Disclosure of PHI for any person may be required if directed by legal authorities in the interest of national security.

PATIENT'S RIGHTS AND PSYCHOTHERAPISTS DUTIES

To protect your privacy as much as possible, you have certain rights regarding your PHI.

You have the right to request an accounting of disclosures of your PHI record for which you have neither provided consent or authorization. You need to complete request form to receive this information.

You have the right to request restrictions on certain uses and disclosures of your PHI outside of treatment, payment and health care operation purposes. However, I am not required by law to agree to any such restrictions, unless a written agreement is signed by both parties.

You have the right to receive confidential communication about your PHI record by alternative means and at alternative locations. Please inform me if you do not want phone calls or messages left at certain locations or mail sent to certain addressees.

You have the right to inspect and/or obtain a copy of your PHI and/or billing records for as long as I legally maintain the records. Under certain circumstances, a psychotherapist may deny access to these records and you have the right to have this decision reviewed.

You have the right to request an amendment of your PHI record for as long as I maintain your records. On your request, I will discuss with you the details of the amendment process. Your request may be denied.

You have the right to a copy of this notice, either by paper copy, electronic mail or both.

To protect your privacy as much as possible, your psychotherapist has certain duties regarding your PHI.

A psychotherapist is required by law to maintain the privacy of PHI records and progress note records and to notify you as an active client of legal policies that may limit your privacy.

A psychotherapist is to have office and record keeping procedures that maximize your privacy. The psychotherapist is only to release the minimum amount of information necessary when required by federal or state law.

A psychotherapist may change privacy policies and practices described in this notice according to federal and state law, but must notify you as an active client of such changes.

If a psychotherapist revises any policies or procedures while you are an active client, you will be notified by email at your designated mailing or email address.

If you are concerned that your privacy rights have been violated or if you disagree with a decision made about access to your PHI records, you may contact the Department of Consumer Affair, Medical Board of California, at 800-633-2322 or write to them at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, DC.

The various forms mentioned in this notice are available from your psychotherapist.

I have read this notice and any questions or concerns I have about the privacy of my PHI record have been discussed with me.

_____ Date _____

Signature

_____ Date _____

Kimberly Greene, MA, LMFT