POSITIVE YOUTH CONCEPTS
Child and Adolescent Therapy
24 Front Street, Suite 302
Exeter, NH 03833
603-418-7480

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CLIENT CONTRACT

Welcome to Positive Youth Concepts - Child and Adolescent Therapy. The Board of Mental Health Practice requires all mental health professionals to provide clients certain basic information. Also, to avoid confusion and misunderstandings, I am providing additional important information about my practice for your review and agreement. Please read it carefully and jot down any questions that you might have so that we can discuss them during our meeting. Upon starting services you will need to sign this form, it will constitute a binding agreement between us.

CLINICAL SERVICES

Psychotherapy and counseling is not easily described in general statements. It varies depending on the personality of both the therapist and the client and the particular problems which the client brings. It requires an active effort on your part in order to benefit, and to be successful, you and your child will have to work both during our sessions and at home. Sessions are typically 45 mins long.

Psychotherapy has both benefits and risks. Psychotherapy has been shown to have benefits for people who undertake it. It often leads to a significant reduction in feelings of distress, better relationships or resolution of specific problems. There are no guarantees about the outcome, however. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy sometimes requires recalling unpleasant aspects of your history. You should be aware that there are alternative types of services other than those being offered by me. You may prefer to obtain counseling from someone other than me. You also have the choice not to obtain any counseling services. There are also risks and benefits associated with alternatives and with not pursuing any counseling. To the extent you are interested in alternatives, you should discuss this with me.

QUALIFICATIONS AND SCOPE OF PRACTICE

I am a New Hampshire Licensed Mental Health Counselor, governed by the Code of Ethics of the American Mental Health Counselors Association. My license is displayed in my office. A copy of the Code of Ethics is available upon request. I received my Master of Arts Degree from Rivier College in Nashua, NH in May of 2007. I will further provide information regarding my training, qualifications and experience upon request. My practice areas include individuals, children and families, adolescents, high functioning autism, and educational consultation.

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SESSIONS

The first session will be an evaluation which will take approximately one to two sessions and is typically called an Intake Session or a Psychiatric Evaluation. During an Intake or Psychiatric Evaluation, client and family history is collected along with current issues and reason for seeking services. At the end of the Intake/Psychiatric Evaluation a Clinical Diagnosis will be determined. The Diagnosis is what is reported to the insurance company to qualify for services and treatment. At this time, I will be able to offer some initial impressions of what our work will include and the areas as well as objectives we plan to work on. If you decide you feel comfortable working with me we will set up regularly scheduled sessions. Sessions typically start out on a weekly basis and gradually move to bi-weekly or monthly sessions as significant progress is made. Typically, when working with children I would require a monthly joint session (client and parent) or a parent session to discuss progress and updates of objectives. If you have questions about my procedures or approach, we should discuss them as soon as they arise. If your doubts persist or you feel uncomfortable with my approach, I will be happy to help you secure consultation with another mental health professional.

CONFIDENTIALITY

Confidentiality of all communications between a client and psychotherapist is protected by law, and I can only release information about our work together to others with your written permission. There are, however, certain exceptions:

Your insurance company requires that I provide them with information regarding the diagnosis and type of treatment before paying for or authorizing additional visits. They may also require additional clinical information such as a treatment plan summary or other details of your case. This information becomes part of the insurance company record and legally they are required to keep it confidential. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect you or others from harm, New Hampshire reporting laws which require licensed psychotherapists to report conduct to the appropriate authorities in certain instances. If we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate authorities. In the case of a client threatening serious bodily harm to themselves or another, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

I may occasionally find it helpful to consult about cases with other professionals. During these consultations, I make every effort to avoid revealing the identity of my client. A consultant is legally bound to keep information confidential as well.

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SPECIFIC ISSUES RELATED TO THE TREATMENT OF MINOR CHILDREN:

Prior to beginning treatment, it is important for you to understand our approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment.

Therapy is most effective when a trusting relationship exists between the psychotherapist and the client. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records. It is our policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. I will not share with you what your child has disclosed to us without your child's consent. Please keep in mind that if they are engaged in life threatening behavior, then I would be obligated to break confidentiality to keep them safe. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. At the end of your child's treatment, I can provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. I must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

In the case of divorced and divorcing parents I must have signed consent from both parents in order to treat the minor child. The only exception to this is that if one parent has no legal rights whatsoever and or is estranged from contact. If the estranged parent re-establishes contact and does not give consent to treat the minor child then services will have to cease until permission is granted by both parents or granted by a higher legal authority such as a court order. It is our belief that treatment proceeds best when both parents are involved.

One risk of child therapy involves disagreement among parents/caretakers and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that we can understand your perspectives and fully explain our perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, however I ask that you allow us the option of having a few closing sessions to appropriately end the treatment relationship with the client.

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PROFESSIONAL FEES

The fee for regular 45 minute psychotherapy session is $110 which will be billed to your insurance. Intake or Psychiatric Evaluations are typically 1 hour and can sometimes involve two 1 hour sessions. A co-pay may also be required by your insurance agency which will be collected at the end of each session. If you require other billing arrangements to be made I will be happy to work with you.

If you do not have medical insurance that will reimburse for psychotherapy, I am willing to arrange a "sliding fee scale" that will allow you to pay on a mutually agreed upon charge per session for this therapy.

The agreed upon "sliding fee" or co-pay is: $_____.

I have been hired to act as your/your child's therapist only. In the event you request or require me by subpoena to provide ancillary professional services relating to my role as your therapist or that of your child's therapist, services such as preparing copies of records, a summary, report writing, deposition or trial preparation and attendance, travel time, etc., will be charged at the rate of $200.00 per hour. Most insurance programs do **NOT** cover these expenses and it will be an **Out of Pocket Charge which you will be responsible for**.

TIME OF APPOINTMENTS

Unless we make other arrangements, our appointments are scheduled to last 45 to 50 minutes. If an appointment starts late due to our running behind, we will still keep the full 45 to 50 minutes. If you arrive late for an appointment, we will have to end the meeting within the original 45 to 50 minutes schedule window. The charge to you for these shortened meetings will be for the full amount. You will not be charged for a session if you cannot keep it and let us know at least **24 hours in advance**. You will be charged a $60.00 cancellation fee for any appointments that are cancelled with less than **24 hours notice,** or for which you do not show up. This $60.00 fee is generally not billable to insurance and will need to be paid by you directly.

MAINTAINING PROFESSIONAL BOUNDARIES

Licensed psychotherapists are obligated to establish and maintain appropriate professional boundaries (relationships) with present and past clients. These boundaries may differ depending on the circumstances, but certain boundaries must clearly never be crossed. For example, a therapist should not become sexually involved with a client. Reports of such conduct should be directed to the New Hampshire Board of Mental Health Practice, 49 Donovan Street, Concord NH 03301, (603)271-6762. Do not hesitate to raise any questions you may have regarding professional boundaries.

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BILLING PROCEDURES AND PAYMENTS

You will be expected to pay for each session at the time of the service unless we make other arrangements. If you have insurance coverage, you will be expected to make the co-payment at the time of the visit. Under unusual circumstances such as financial hardship, special fee arrangements may be negotiated.

Once an appointment is scheduled, you will be expected to pay for it unless you provide **24 hours Advance Notice** of cancellation or unless we agree that the appointment was canceled due to circumstances beyond your control. We have an extensive reminder system in place to aid you in remembering your appointments and canceling them within the **24 hour Advanced Notice Window**. The reminder system is as follows:

- An Email confirmation messages will be sent out after the scheduling of an appointment.
- A reminder Email of your appointment will be sent 14 days prior to your appointment.
- A Text message notification, an Email reminder, and a Voicemail will be sent 1 day prior to your appointment.
- A finale reminder will be sent via Text message 90 minutes prior to your appointment.

Appointments are, at times, in great demand, and your appointment is reserved only for you and cannot be filled without sufficient notice. The charge for a late cancellation will be billed to you and not your insurance company.

INSURANCE REIMBURSEMENT

In order to set realistic goals and priorities, it is important to evaluate the resources available to pay for treatment. If your health care insurance covers psychotherapy, I will submit claim forms directly to your insurer. By signing this agreement, you agree to release all the information necessary to the insurance company to obtain reimbursement for services. You will also irrevocably assign and transfer directly to me all benefits payable by the insurance company. While I will do everything I can to help you obtain your benefits from the insurance company, you retain the responsibility for these fees for services rendered. Insurance companies typically **WILL NOT COVER FEES FOR MISSED APPOINTMENT** and telephone consultations. Most managed care companies limit the number of sessions which will be fully or partially covered. Clients are encouraged to communicate directly with the managed care company about such limitations before starting treatment.

PROFESSIONAL RECORDS

I maintain a file for each client. This includes intake, diagnosis, treatment plan, billing, consent to treatment, treatment notes, discharge summary and any other written or electronic information I received from or about said client. Treatment notes include the date and number of the session, brief notes on what was discussed and brief treatment recommendations and the date of next session. The client is entitled to a copy of the records for a fee which covers copying and administrations costs. If you wish to see a copy of your records, I recommend that you review them with me so that we can discuss the contents.
In the event of my impromptu death or disability, your records will be administered by a colleague as determined by provisions in my professional will.

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CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office during regular hours every weekday, I am not able to answer the phone when I am with a client. When I am unavailable by telephone, Voicemail will activate and take messages. I will make every effort to return calls from you within 24 hours with the exception of weekends or holidays. If you are difficult to reach, please leave times and alternatives in terms of when I can most effectively reach you. I may also be reached by e-mail at **positiveyouthconcepts@gmail.com**. In the case of an emergency, please call 911 or your nearest emergency provider. Whenever I am planning to be unavailable for any extended period of time, I provide a name of a trusted colleague who is covering for me.

I have read and discussed the above agreement with my therapist. I understand and agree to all of the points discussed above. Your signature below indicates that you have read the all of the above information in this document and agree to its terms during our professional relationship. You were given a copy of this contract for your records.

_____ _____

Parent/Guardian Signature Date

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date