Embracing Imperfections, Inc.

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CLINICAL CONTRACT

Welcome to my practice. Thank you for choosing me as your mental health care provider. This document contains important information about my professional services and business policies. In addition, it explains some basic "ground rules" that will enhance the therapeutic process. Please read it carefully and jot down any questions you might have so that we can discuss them during our initial meetings. Our mutual understanding and adherence to these ground rules and administrative policies will aid in the most effective use of our time and efforts. It will also reduce the possibility of future misunderstandings that might interfere with the therapeutic process. When you sign this document, it will represent an agreement between us.

PSYCHOTHERAPY

Psychological services cannot be easily described in general statements. Psychotherapy practices vary depending on the specific training and orientation of the therapist, the individual personalities of the therapist and the client, and particular problems and diagnoses shown by the client. What all mental health professionals seem to agree on is that psychotherapy is a process of growth, based on honesty, openness, and a willingness to try new behaviors. This process is best facilitated in an emotionally safe atmosphere that is based on mutual trust and understanding. In addition, for psychotherapy to be effective, it requires a highly active effort on your part. Our collaboration in addressing your problems will be enhanced by the amount of time and effort you devote to our work outside of our therapy sessions as well as during our appointments.

Psychotherapy can have benefits and risks. Engaging in therapy often involves discussing unpleasant aspects of your life. Therefore, you may experience uncomfortable feelings like frustration, sadness, guilt, anger, loneliness, and helplessness. On the other hand, psychotherapy can help you change your unhealthy or maladaptive thoughts and behaviors. Consequently, you may benefit by minimizing your overall distress, learning more effective problem-solving strategies, and experiencing more rewarding interpersonal relationships.

APPOINTMENTS AND CANCELLATIONS

Your appointment time is reserved for you. In order to achieve your treatment goals in the most effective way, my experience has proven that consistency of sessions is recommended. You will be billed for the total charge of any sessions that you miss or cancel without prior notice of 24 hours. Please be aware that most insurance companies will not reimburse you for missed appointments.

OFFICE SPACE

Please note that I share an office suite with several mental health colleagues. My practice is completely separate from those of my colleagues in this suite. I am not responsible for the actions of any non-affiliated therapists who share this office suite space. It should also be noted that I have a service dog named Bella that comes to work with me every day. She is an integral part of my private practice.

THE INTAKE INTERVIEW

The intake interview typically extends over three sessions. During these sessions, we will discuss your reasons for seeking treatment and some basic background information about you. Policies, fees, and scheduling will also be discussed in these meetings. To the extent possible, I will be able to offer you some first impressions of what our work will include and an individualized treatment plan to follow. You are encouraged to participate fully in the planning of your treatment goals. Following the completion of our intake sessions, you should evaluate this information along with your own opinions to determine whether you feel comfortable working with me. Therapy involves a noteworthy commitment of time, money, and energy. You should be very thoughtful about the therapist you select. If you have questions or doubts about participating in therapy at the present time or specifically with me as your therapist, please talk to me about your concerns. I will be more than happy to help you set up a meeting with another mental health professional for a second opinion.

ENDING THERAPY

My goal is to provide a quality service in the briefest period of time that is necessary for you to derive benefit from the therapy. You have the right to withdraw from treatment for any reason at any time. I ask that you agree to have a final session after you notify me of your voluntary termination of treatment, so that I may responsibly review and evaluate your reasons, and make recommendations related to the termination of treatment.

CONFIDENTIALITY

All aspects of your treatment are confidential, and I will need your written permission if you wish me to discuss your treatment with anyone else, including your insurance company. Without your written permission, I cannot reveal any information about you or your treatment. Even the fact that you are a client in my practice is protected by confidentiality. However, there are three important exceptions to confidentiality protections:

1. If I believe, in my professional opinion, that you are <u>an imminent danger to yourself or to someone else,</u> then I must attempt to ensure the physical safety of those involved, even if this means breaking confidentiality.
2. If you give me information pertaining to the <u>abuse or neglect of a child, or vulnerable adult, past or present</u>, I am required to report this information to the local authorities, even without your permission. I am required to report even a <u>suspicion</u> of child abuse to the local authorities.
3. I may also be required to discuss aspects of your treatment without your permission if I am <u>subpoenaed or court-ordered</u> to do so.

These situations are rare, but if one of them does occur, I will make every effort to fully discuss it with you before taking any action. I occasionally engage in professional consultation with other therapist's regarding some aspect of a client's treatment. In so doing, I do not name the client and I make every effort to avoid revealing any identifying information about the client. The psychologist I consult with is also legally bound to keep the consultation confidential.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential issues, it is important that we discuss any questions or concerns you have. I will be happy to discuss these issues with you, but if you need formal legal advice please consult an attorney.

PROFESSIONAL RECORDS

The law and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. I can generally prepare a summary for you instead. Because these are professional records, they can be misinterpreted and / or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents.

PAYMENT AND INSURANCE

My standard fee is $160.00 per individual 45-minute session, $180.00 for an extended (60-minute) individual therapy session, $180.00 for a conjoint (couples or family) session, and $200.00 for the initial intake interview session. I accept Cash, PayPal, Venmo, Cash App, Zelle, Credit Card or Checks as payment. Understand some of these forms of payment may not be HIPPA compliant.

In addition to weekly appointments, I charge for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals that you have authorized, preparation of records or treatment plans, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, even if I am called to testify by another party, you will be charged for my preparation, travel, and attendance time. Because of the difficulty of legal involvement, I charge $250.00 per 60 minutes.

If do not participate in your health insurance plan, I will provide you with a monthly statement of services provided and fees paid, which you may then submit to your health plan for possible reimbursement. You should also be aware that most insurance companies require that you authorize me to provide them with a clinical diagnosis. Sometimes they will not reimburse you unless I provide clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. 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. I will provide you with a copy of any report I submit, if you request it.

DELINQUENT ACCOUNTS AND COLLECTIONS

You are responsible for payment of your therapy fees, regardless of whether or not they are covered by your insurance carrier. You agree to the costs of any action necessary to collect your portion of the fee due. This includes court and attorney fees and an interest rate equal to the statutory amount at the time of the debt. You will receive appropriate notice of efforts to obtain this debt. You agree that a failure to comply and respond to such request within the statutory period for an answer will result in a confessed judgment against you for the amount of the debt and any fees required to collect the debt.

CONTACTING ME

I am usually not immediately available by telephone, as I do not answer the phone when I am engaged in therapy sessions. When I am unavailable, my telephone is answered by voice mail that I monitor throughout the day on weekdays, and at least daily on weekends. I will make every effort to return your call on the same day that I receive it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. Please note that in case I will be unavailable for an extended time, such as for a scheduled vacation, I will provide you with the name of a colleague to contact if necessary.

EMERGENCIES

In the event of a psychiatric emergency, please CALL 911 or go to the nearest emergency room and ask to be evaluated by a psychologist or psychiatrist on call. For less urgent matters or for scheduling issues, please leave a message on my voice mail and I will return your call as soon as possible.

TELEHEALTH SESSIONS

I conduct all telehealth sessions via https://doxy.me/angelawilliams. This is a secure, HIPPA compliant video conferencing website. Best if used via Chrome, no downloads or app's to install. Simply type the above link into your browser on your computer, laptop or smartphone and you will be taken to my virtual waiting room to begin our session.

SEVERABILITY

If any of the provisions of the Agreement shall be held to be invalid or unenforceable, all other provisions shall nevertheless continue in full force and effect. The Agreement shall be interpreted in accordance with and controlled by the laws of the State of Maryland in effect at the time of the execution of this Agreement.

I/WE:_____, HAVE READ, UNDERSTOOD, AND HAD OPPORTUNITY TO QUESTION, AND I/WE AGREE TO THE ABOVE CONDITIONS AND POLICIES.

_____

CLIENT SIGNATURE DATE

_____

CLIENT SIGNATURE DATE

_____

ANGELA WILLIAMS, LCPC DATE

CLIENT INTAKE

THIS FORM IS CONFIDENTIAL -- PLEASE PRINT CLEARLY

Name: _____
First Middle Last

Home Phone Number: _____ May I contact you at home? Yes No
Work Phone Number: _____ May I contact you at work? Yes No
Cell Phone Number: _____ May I contact you on your cell phone? Yes No

Address: _____

City:_____ State: _____ Zip:_____

Date of Birth:_____ Age:_____ Religion:_____

Occupation: _____ Level of school completed:_____

In school in the last 3 months? _____ # of arrests in the last 30 days:_____

Single Married Separated Divorced Widowed Any history of addiction:_____

Insurance Provider: _____ Insurance #_____

Referred by: _____ (name of individual, website, or referral service)

Current medications: _____
_____
_____

Previous Therapy: Yes No

_____
Therapist's Name(s) Phone # Dates & Number of Visits

How do you hope therapy will help you?_____
_____
_____

What is bothering you the most right now?_____
_____
_____

Emergency Contact Person: _____ Phone Number: _____
Address: _____ Relationship: _____

I give permission for Angela Williams to contact this individual in case of an emergency.

_____
Signature of Client Date

AUTHORIZATION/CONSENT FOR THE RELEASE/EXCHANGE OF INFORMATION

Individual/Insurance Company
Organization/Doctor/School
_____
_____

Client's Name: _____

DOB: _____

I freely give my consent to Embracing Imperfections, Inc. / Angela Williams, LCPC and the addressee to exchange the information presented below. This information is to be kept confidential and may not be released to any other agency without my consent.

The purpose of this release is to provide continuity of care and to assist Embracing Imperfections, Inc. and the addressee in planning and providing services to me. In no way will this information be used to discriminate against me or deny me service at Embracing Imperfections, Inc.

___ Verbal exchange between Embracing Imperfections/Angela Williams, LCPC and Addressee

Addressee to release
___ Demographic Information
___Social Assessment/History
___Treatment Plan & Reviews
___ Psychiatric/Psychological Evaluation
___Medication Record
___ Somatic History
___ Physical Examination Results
___ Immunization Records
___ Transfer/Discharge Summary
___ Physician's Recommendations for
___ Psychiatric Rehab. Services
___ Aftercare Plan

Angela Williams, LCPC to release
___ Demographic Information
___ Intake Assessment
___ Disposition
___ Entitlement Information
___Rehabilitation Assessment
___ Individual Treatment Plan
___Transfer/Discharge Summary
___ Psychiatric Evaluation
___ Psychological Evaluation
___ Diagnostic Evaluation
___ 6-Month Treatment Plan Review

My signature below indicates my permission for Embracing Imperfections/Angela Williams, LCPC to release and/or exchange information with the above named addressee, for the purposes of treatment coordination. I understand that I have the right to rescind this permission at any time for any reason.

Other Instructions/Notes: _____
_____

End of Treatment:
Date Consent Expires

_____
Client/Guardian Signature Date

_____
Client/Guardian Signature Date

_____
Angela Williams, LCPC Date

CREDIT CARD AUTHORIZATION

Please indicate the card you wish to use for services rendered through this practice. Charges for services rendered will be deducted from the card designated below when necessary.

Client Name: _____Date of Birth: _____

Address: _____City:_____

State: _____Zip: _____Mobile Number: _____

Email: _____

If different from client information above, please indicate the billing information associated with the credit/debit card you wish to use:

Name: _____
Address: _____ City:_____
State:_____ Zip: _____Email: _____

I authorize all service fees to be deducted from the card ending in: _____

(last four digits of the card). Please enter the CVV code: _____(three digit code on back of the card). I authorize the use of this card for all services and fees at the time they are rendered for the following parties: Full Name(s):_____

I understand that this form authorizes Angela Williams to charge this card for varying session types, across multiple dates of service. This includes missed appointments (appointments not cancelled 24 hours in advance). This authorization will remain in effect for the duration of treatment with Angela Williams, LCPC, unless I request to cancel it.

*By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____

Cardholder Signature Date

Card (circle one): Visa MasterCard Discover AMEX

Card Number: _____CVV code:_____ Exp. Date: _____

TREATMENT PLANNING IDEAS

It can be hard to think of things to work on in therapy. Some people are aware of so much 'stuff' in their life they have difficulty deciding which bits to work on. Others struggle to find any ideas. This list is to help you identify general areas (like 'interpersonal skills') and specific problems ('finding more useful ways to argue'). What we work on is not limited to this list, of course.

Simply circle or highlight the items you might want to work on and we'll talk about them

I feel inadequate	How do I not use again?	I want to get my body in shape
Anger	Moods – feeling 'down'	Am I ever going to find love?
Communication	I have a lot of stress	A chronic medical problem
How do I find a job?	Being a parent is tough!	People misunderstand me
I am too busy	Life has no meaning	How do I grieve (& not 'lose it')?
Sleep problems	I do not need to be here!	I have few (or no) hobbies
Legal problems	Setting Boundaries	My mental health "stuff"
Who do I want to be?	Having (sober) fun	I have no/few real friends
I have little hope	I tend to be impatient	DWI arrest/convictions(s)
How do I relax?	Relapse prevention plan	I obsess about _____
Anxiety	Assertiveness training	With my record how do I get work?
Who am I now?	Money management	People bother me so much
Sadness	What are defenses?	A traumatic thing happened
Fear(s)	I have medical problems	What have I done to my body?
My life is a mess!	Family relationships	I am a bit shy around people
Sexual stuff	My spiritual life is 'shot'	How do I deal with my defenses?
Been clean, lost it	'Codependent' thinking	I think I have a gambling problem
I need a place to live	I have little motivation	I really miss _____
Childhood memories	I don't trust anyone	Impulsive/Risky behaviors
Ways to cope better	Overwhelmed	I have obsessive thoughts
Handling feelings	I am not worth much	I know that I am different
I can't say no	I worry all the time	What am I doing with my life?
Guilt/Shame issues	I need someone to talk to	I feel like I can't do anything right
Toxic relationships	I sometimes overreact	My self-esteem is really low
I am never really happy	Have good reasons to use drugs / alcohol	It is too hard to stop using drugs/ alcohol
I want a good career	I need a new type of job	What has addiction done to my brain?

INFORMED CONSENT & TELE-MENTAL HEALTH

1. The laws that protect privacy and confidentiality of medical information also apply to Tele-Mental Health Video Tele-Conferencing services, (TMH-VTC, referred to hereafter as TMH) and that no information obtained in the use of TMH, which identifies the client, will be disclosed to researchers or other entities without my written consent.
2. There are two sites participating in a client consultation (the client's location and the provider's location). There are roles and responsibilities for each site regarding confidentiality. Both client and provider agree to make every effort to insure uninterrupted privacy during consultation time.
3. Current TMH regulation requires the provider to be licensed in the state where the client primarily resides. For this reason, at this time, TMH services can only be provided to MD.
4. Provider and client agree to identify everyone who is participating in the consultation encounter. There will never be anyone else in the room at the provider site, except if explicitly pre-arranged and agreed upon.
5. If the client has any confidentiality or privacy concerns, the client agrees to address those with the provider.
6. Sessions will NEVER be recorded, neither by the client nor the provider, without prior written approval.
7. The client has the right to withhold or withdraw consent to the use TMH at any time.
8. Client may expect the anticipated benefits from the use of TMH in his or her care, but that no results can be guaranteed or assured.
9. Healthcare information may be shared with other individuals for billing reimbursement purposes only with prior written consent.
10. There are inherent risks a given telecommunication technology may pose in both equipment (hardware, software or other equipment components) and the processes used for providing TMH services. A HIPAA-compliant platform will always be used for TMH. In accordance with Specific regulations set forth during the state of emergency due to Covid-19 Telehealth may be performed, if no other means are available, by non HIPAA approved platforms; such as FaceTime, Zoom, Skype.
11. There is the risk of technical failure during a consultation. In this case, provider will telephone the client to make arrangements.
12. As with face-to-face encounters, the client agrees to implement safety measures in case of imminent danger to self or to another person.
13. The use of Tele-Health services with clients is at my discretion. If I feel that a client is not well suited for this type of therapy and I am unable to see the client in the office I have the right to refuse to accept the client and make an appropriate referral.

Consent Agreement

By signing below you agree to information listed in "INFORMED CONSENT FOR TELE-MENTAL-HEALTH VIDEO TELECONFERENCING SERVICES".

I have read and understand the information provided above regarding TMH-VTC and all of my questions have been answered to my satisfaction. I understand the risks and benefits of TMH consultation, and I hereby give my informed consent to participate.

Client Signature: _____ Date: _____

Printed Name: _____