SYSTEMIC
Therapy Solutions LLC

Therapy Agreement, Policies, and Consent to Treatment

NOTICE OF PRIVACY & CONFIDENTIALITY

The cornerstone of therapy is that discussions between a therapist and client are confidential and private. This means that anything that is said in therapy is protected under Florida law, and may not be revealed to a third party without written authorization from you. However, as a **mandated reporter for the state of Florida**, I am legally bound to disclose information in certain cases, with possible exceptions to confidentiality. Included but not limited to the following situations, **confidentiality will be broken if any of these instances occur:**

1. **Child Abuse (Florida statute 39.201)**: Child abuse and/or neglect, which includes but is not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, sexual exploitation, etc. If you reveal any information relative to child abuse or child neglect, I am required by law to report this to the appropriate authority.

2. **Elderly or Vulnerable Adult/Disabled Person Abuse/Neglect (Florida statute 415.1034)**: If at any point in session you reveal any information relative to vulnerable adult/disabled or elder abuse, I am required by law to report this to the appropriate authority.

3. **Harm to Self (Florida statute 491.0147 & Chapter 394)**: This includes threats, plans, or attempts to harm oneself. I am permitted under such instances to take steps to protect your safety which may include the disclosure of confidential information.

4. **Harm to Others (Florida statute 491.0147)**: This includes threats regarding harm to another person. If you threaten bodily harm or death to another person, I am permitted by law to report this to the appropriate authority.

5. **Court Orders & Legally Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone and send you an email or letter (if I cannot get in touch with you by phone). If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am legally required to comply with a court order. (This applies to child custody cases, suits in which mental health of a party is an issue, a negligence suit brought by client against the therapist, or the filing of a complaint with the state licensing board or any other regulatory board.)

6. **Court Ordered/Mandated Therapy**: If you are in therapy ordered/mandated by the court, and the court requests records or documentation of your participation in services, the information/documentation to be discussed/sent on your behalf will be discussed with you prior to that information being sent to court.

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HIPAA - Health Insurance Portability and Accounting Act of 1996

For all clients, I keep records describing client clinical condition and treatment, but I avoid documenting potentially embarrassing personal information if I can do so in a manner consistent with medical responsibility. Psychotherapy notes will have a higher level of protection under the HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy regulations that took effect in April 2003. Their contents may not be divulged without your specific authorization, and not permitted to be required as a condition of insurance coverage. (Other exceptions to the special protection of psychotherapy notes under law are to prevent harm to the patient or others, for the therapist's defense in legal actions, regulatory actions, regulatory oversight of the therapist's professional status, confidential supervision in training situations, or investigation by a medical examiner in the event of a client's death.)

I keep electronic records. All electronic files are triple password protected to protect your information. You have the right to view your general records, but not psychotherapy notes. Records will be retained at least as long as required by law. If you give consent for release of information from your therapeutic record, in compliance with HIPAA, I will disclose only the minimum amount of information necessary to serve the purpose for which the request has been made. Also under HIPAA regulations, I will provide you with a notice of privacy practices.

Written Request: (Florida Statute 456.057 & HIPAA Privacy Rule): Your specific request, in writing, to disclose information regarding your psychotherapy to you or to a third party. In the case of notes documenting or analyzing the contents of conversation during a private counseling session, progress notes, I reserve the right to provide to you or the authorized third party a report of examination or treatment in lieu of copies of the actual records, unless the third party is a treating psychotherapist. If therapy sessions involve more than one party, ALL parties over the age of 18 MUST consent to release of requested information prior to information being released.

I believe that it is important for the therapist-client relationship to offer you the choice of giving or withholding consent, rather than assuming that you accede to the HIPAA regulation's automatic consent. Under HIPAA, your consent is not required for physicians to release information for treatment, payment, or healthcare operations. However, I have the right to offer you the opportunity to withhold consent for release of any or all information, with the understanding that if you withhold consent, it may not be possible for me to communicate with your doctors, submit insurance claims, or give supporting clinical information without further action on your part to give consent.

If you have any questions about confidentiality, you should bring them to my attention so that we can discuss the matter further. By signing this consent form, you are giving your consent to me to share confidential information with all persons mandated by law and with the agency/party that referred you. You are also releasing and holding me harmless from any departure from the right of confidentiality that may result.

Policies

Couples Counseling & "No Secret" Policy: When working with couples, all laws of confidentiality exist. I request that no separate party of the couple attempt to triangulate me into keeping a "secret" that is detrimental to the goal of therapy for the couple. If one party of the couple requests that I keep a "secret" in confidence, I may choose to end the therapy and give you referrals for other therapists as our work and your goals then become counterproductive.

Dual Relationships & Public Settings: My relationship with you is strictly professional. In order to preserve this relationship, it is imperative that we do not have any relationship outside the counseling relationship such as a friendship, business, or social relationship. If we have contact in a public setting, I will not acknowledge you in any way that could potentially jeopardize your confidentiality. Should you choose to acknowledge me, I may not be able to protect your confidentiality.

Social Media: If you choose to connect with me on any of my professional (not personal) social media outlets such as Facebook, LinkedIn, Pinterest, Instagram, or Twitter, you do so at your own risk. I will do my best to protect your identity. However, if you choose to comment on my pages or posts, you do so at your own risk and I cannot be held liable if someone identifies you as a client.

Electronic Communication: Email offers an easy and convenient way for therapist and client to communicate, but can also introduce unique challenges into the therapist–client relationship. Below are some guidelines for contacting me using email.

A. Emails should not be used to communicate sensitive medical or mental health information, as emails are not confidential.

B. Be aware that if you send emails from your work, your employer has the legal right to read your email.

C. Texting is not confidential. It also introduces some of the same challenges as email. Texting is not a substitute for seeing me or making an appointment. Because phones can be lost or stolen, it is imperative that you do not communicate information of a sensitive nature over a text.

Further, I cannot know the person who is texting is actually you, rather than another person who has possession of your phone.

Client 1 Signature: _____

Client 1 Printed Name: _____

Client 2 Signature: _____

Client 2 Printed Name: _____

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Fee Schedules and Policies

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment you have scheduled with me. In signing this, you agree to adhere to the following policy: If you are not able to honor a scheduled appointment, you MUST notify me 24 hours in advance. If I do not receive a 24-hour advance notice, you will be responsible for paying half of the fee for the session you missed. Payment is due at the time of the session end for cash clients, in the form of Zelle.
I reserve the right to terminate our counseling relationship if more than 2 sessions are missed without proper notification. **For no call, no show's at the time of our scheduled session, I charge a flat rate of$100.**

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I will, from time to time, take time off for vacation, to attend seminars, and/or become ill. I will attempt to give you adequate notice in advance and will arrange coverage for any emergencies by a colleague. If I am unable to contact you directly due to circumstances out of my control, I will have a colleague contact you to cancel or reschedule an appointment. I charge my hourly rate $120 per hour in quarter hours for phone calls over 15 minutes in length, as well as for email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission and signed release form) for continuity of care.

Fee Disputes: In the case of a credit card dispute, I reserve the right to provide the needed and adequate documentation, i.e. your signature, on the "Therapy Agreements and Consent" that covers the cancellation policy to your Bank or Credit Card Company should you dispute a charge that you are financially responsible for. If you have a financial balance, you will be sent a bill to the home address on the intake form unless you advise me otherwise.

TRIAL, COURT ORDERED APPEARANCES, AND LITIGATION: Rarely, but on occasion a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. Please know if I get called into court by you or your attorney, which I strongly suggest not being involved in court in order to protect your confidentiality, you will be charged $120 per hour which will include travel to and from the courthouse, time in court, waiting for the court hearing, preparation for documents, etc. A proposed invoice will be drawn up and you will be required to pay prior to the appearance. Any amount that is due to Joely Spencer, Ph.D., LMFT or needs to be returned to you after the appearance will be due/returned within two calendar weeks.

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The Therapeutic Process

BENEFITS/OUTCOMES: Participating in therapy can result in numerous benefits, including improving intrapersonal and interpersonal relationships, which are many times the shifting concerns that can lead you to therapy. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific concern. A major benefit that may be gained from participating in therapy includes a reduction in distress and a better ability to handle or cope with stressors from personal, relational, family, work, and other concerns one may be struggling with. Another possible benefit may be gaining a greater understanding of personal and relational goals and values; this may lead to greater maturity and happiness as an individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy. I will do my best to assess progress on a regular basis and solicit your feedback regarding the therapeutic process to help provide you with the most effective therapeutic services. That being said, I can make no guarantees as to the ultimate outcome of therapy, but know that you will not be judged, and that this is considered a safe space to talk.

WHAT TO EXPECT: Doing work outside of the counseling sessions is an integral component toward the therapeutic process overall, and its effectiveness. Tasks may be assigned between sessions that are related to your goals, or where you have indicated you would like to see change. My commitment as your therapist, is to help you in your path toward discovering your goals by finding your way toward them. Together, we will collaborate to identify your therapeutic goals and continually check in regarding your progress toward them.

RISKS: In working to achieve these potential benefits, the therapeutic process requires that actions be made to change and which also may involve experiencing discomfort. Therapeutically resolving unpleasant events and relationship patterns may arouse intense, unexpected feelings, some of whom are more prepared to deal with than others. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that had not been of the original intention. Collaboratively, we will work together toward a desirable outcome; however, there is a possibility that the goals of therapy will not be met. We will review your progress at regular intervals and modify our treatment plan as needed.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 55 minutes, depending upon the nature of the presenting challenges. It is difficult to initially predict how many sessions will be needed, but we will collaboratively discuss continuation of therapeutic services on a frequent basis.

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Phone Contacts & Emergencies

It is necessary that Joely Spencer, Ph.D., LMFT has someone to contact on your behalf in the case of an emergency. Please provide one emergency contact name and phone number below. Your signature will agree to allow Joely Spencer, Ph.D., LMFT to contact this person in the event of an emergency.

Full Name _____ **Relationship** _____

Phone Number _____ **Signature** _____

Consent

I have read and understand the information contained in the consent and therapy agreement. I have discussed any questions that I have regarding this information with Joely Spencer, Ph.D., LMFT. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize Joely Spencer, Ph.D., LMFT to provide counseling services that are considered necessary and advisable.

Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Joely Spencer, Ph.D., LMFT to provide treatment to my minor child(ren). If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to Joely Spencer, Ph.D., LMFT prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name of Minor Child: _____

DOB: _____

Signature: _____

Printed Name: _____

Date: _____

Witness: _____

Joely Spencer, Ph.D., LMFT _____