Sonia Bhatia, Psy.D., LMFT, Resolve Counseling LLC
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PSYCHOTHERAPIST-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your therapist, I have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. However, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will often be given "homework assignments" to work on between sessions. It is important that you complete this "homework."

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments are 50 minutes in length. We can also arrange for longer appointments for an additional fee. We will typically meet once per week at a time we agree on. Some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, please provide me with 24 hours notice. (E.g. a 10 am Monday appointment must be cancelled by 10 am on Friday.) If you miss a session without canceling, or cancel with less than 24 hour notice, you will be billed for the session. In specific instances the fee might be waived at my discretion. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

The standard fee for a session is $125. Longer sessions are $175 for 80 minutes. You are responsible for paying at the time of

your session. Payment must be made by check, cash or credit card. Any checks returned to my office are subject to an additional fee of up to $35.00 to cover the bank fee that I incur.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. There is a charge of $350/hour for preparation and attendance at any legal proceeding.

INSURANCE

I do not accept insurance. You will pay me for each session in full directly. If you choose to use your mental health insurance benefits, I will provide you with a superbill to submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-IV. There is a copy in my office and I will be glad to show it to you. 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. In some cases, they may share the information with a national medical information databank.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. I maintain a "paperless" office. Your files are stored in a HIPPA-approved, secure and password protected cloud-based software. All hard copy records will either be filed in accordance with HIPPAA guidelines or scanned into the database and shredded.

Information contained in email and text messages is typically not secure. Please be aware that this information can be intercepted. Your use of email or text to communicate information to communicate information indicates that you acknowledge and accept the possible risks associated with such communication.

Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional , which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and your signature means that you understand the issues. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to

provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and I will return your call as soon as possible. It may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist on call. I will make every attempt to inform you in advance of planned absences. I am out of town several times a year for professional trainings and travel. I will inform you ahead of time of any extended absence.

ENDING THERAPY WELL

I want to make your therapy as successful as possible. For that reason, it works best to find a rhythm and structure to the beginning stages with sessions that meet regularly. To support your leaving, I request several weeks of notice prior to your actual leaving to allow you to have an experience of leaving well, with a sense of completion. If I initiate terminating you from our therapy, it will be because I feel that I am not able to be helpful to you any longer. My ethics and license requires that I offer quality service and have my clients' needs as paramount in my treatment planning. I will offer referrals to other sources of care, but cannot guarantee that they will accept you for therapy or how they will approach your treatment.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

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NOTICE OF PRIVACY POLICIES

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, goals, prognosis and progress. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. Limits of Confidentiality

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality.I am presenting this information to you as we begin therapy, and you may reopen the conversation at any time during our work together.
I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· **Emergency:** If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Florida law to report the matter immediately to the Abuse Hotline at 1-800-96-ABUSE.

· **Adult Abuse Reporting**: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Florida law to immediately make a report and provide relevant information to the Abuse Hotline at 1-800-96-ABUSE

· **Court Proceedings:** If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you. If there is a criminal or civil case being pursued or considered, I ask that you inform me of this as it increases the likelihood of my records being requested by the court and may affect your response to the therapeutic work we are undertaking

· **Serious Threat to Health or Safety:** Under Florida law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the

magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult. There will be a charge for my professional services during this process.

· **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

· **Records of Minors**: Florida has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

· **Right to Request Restrictions**-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· **Right to an Accounting of** Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process

· **Right to Inspect and Copy** – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. Please be advised that since all your records are stored in the cloud and much of the information can only be accessed by "scrolling down" the small window provided by the software, this can be difficult. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· **Right to Amend** – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· **Right to a copy of this notice** – You have the right to a paper copy of this notice. You will receive a paper copy when we start therapy, and may ask me to give you a duplicate copy of this notice at any time.

Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for information I already have about you as well as any information I receive in the future. The notice will contain the effective date . A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: January 2016

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CONSENT FOR PSYCHOTHERAPY

Your signature below indicates that you have read the Psychotherapist-Client Service Agreement and agree to the terms:

_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	_____
Signature of Client	Printed Name of Client	Date

_____ _____
Signature of Therapist Date

CLIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of Dr. Sonia Bhatia's Notice of Privacy Practices.

I have read these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	_____
Signature of Client	Printed Name of Client	Date

_____ _____
Signature of Therapist Date

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CREDIT CARD AUTHORIZATION FORM

PLEASE PRINT OUT AND COMPLETE THE AUTHORIZATION AND BRING IT WITH YOU TO YOUR APPOINTMENT. ALL ACTIVE CLIENTS ACTIVE CLIENTS MUST HAVE A CREDIT CARD ON FILE. All information will remain confidential.

Cardholder Name as it appears on card (please print):

_____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Card Identification Number (last 3 digits located on the back of the credit card): _____

Expiration Date: _____

Charge this card automatically for appointments? (Please check one of the following)

_____ YES Always, for all appointments
_____ SOMETIMES If I do not have a check or cash for the specific appointment
_____ NO I will be paying with cash or check – only use this card for missed appointments without 24hr notice

I authorize Sonia Bhatia, Psy.D. LMFT, Resolve Counseling LLC to charge the agreed service charge to my credit card provided herein. I understand my card will be charged the full service fee for missed appointments if 24 hours notice is not given. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement.

Cardholder – Print Name, Sign and Date Below:

Name: _____

Signed: _____ Dated: _____

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CONFIDENTIALITY CONTRACT FOR FAMILY THERAPY

This contract is an agreement between the interested parties that neither party shall for any reason attempt to subpoena my testimony or my records to be presented in a deposition or court hearing of any kind for any reason, such as a divorce case.

Both parties acknowledge that the goal of psychotherapy, wheterindividual or marital or couples therapy, is for the sole purpose of the amelioration of psychological distress and that the process of psychotherapy depends on trust and openness during the therapy sessions.

Therefore it is understood by both parties that if they request my services as a psychotherapist, they are expected not to use information given to me during the therapy process against the other party in a judicial setting of any kind, be it civil, criminal, or circuit.

The signatures below reflect that the parties agree to the terms set forth above.

_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	_____
Signature of Client	Printed Name of Client	Date
_____	_____	_____
Signature of Client	Printed Name of Client	Date

_____ _____

Signature of Therapist Date

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Family Therapy Form
(to be filled out by each adult participating in family therapy)

INSTRUCTIONS: Please fill out this form individually, as fully and openly as possible. We encourage all adults attending sessions to fill out separate intake forms. Your answers provide invaluable information during your time in family therapy.

Today's Date: _____ Your Name: _____

D.O.B: _____ Age:_____

Address: _____

_____

Home Phone:_____ May I contact you at your home? YES NO

Cell Phone: _____ May I contact your cell phone? YES NO
May I text your cell phone? YES NO

E-mail Address:_____ May I contact you via email? YES NO

Preferred Method of Contact*:___email __text __phone call __any of these
*Please note: Email correspondence and texting is not considered to be a confidential medium of communication.

How did you hear about this practice/referred by: (please select one)
__ Psychology Today ___Good Therapy ____Google Search __ Website ___Comraderie Foundation
__ Mental Health Alliance __ Word of Mouth/Friend __ Other: Please indicate_____

Marital Status & Children

Current marital status of parents:

___Married ___Engaged ___Living Together ____Dating ___Separated ___Divorced
Number of Marriages_____ How long have you and your partner been together? _____

List names and relationships of all adults currently living in the household:

Name	Age	Relationship

List names, ages and grade level of siblings, step-siblings and minors living in the household:

Name	Relationship	Age	Grade

List names and ages of siblings and step-siblings not currently living in the household and why:

Name	Relationship	Age	Living where and reason

Additional parents not living in this household: names and relationship to child/children

Name	Relationship to child/children

Are any children in the family adopted YES NO
If yes, which child/children _____ At what age _____
Does the child/children know about the adoption? YES NO

Are any children in the family fostered? YES NO
If yes, which children _____ Since what age? ___

Circumstances surrounding the adoption/fostering process:

Custody: Please indicate who has custody of each child in the family, if full/joint, and the terms of joint custody

What is going on?

Please describe the present difficulties that bring you to counseling:

What solutions have you tried to deal with the problems?

Have you or other members of the family sought psychotherapy for this issue before? Please provide an overview of the experience – how long ago, for how long, what was the result?

What would you like to accomplish out of your time in treatment? What are your goals?

Who do you expect will attend treatment sessions (names):

Family background

What is your family's cultural/ethnic heritage?

Are any languages other than English spoken in the family? (including ASL, if applicable) By whom?

Do you or any members of your family practice a faith-based religion or spiritual pursuit? Please describe

Have you or any of your family members ever been deployed overseas or served in a combat zone? Please describe:

The family you grew up in as a child

What did you enjoy about growing up in your family?

What was hard about growing up in your family?

When you were growing up, who disciplined you and how?

This family, now

Please list 5 of your strengths as a parent:

1.
2.
3.
4.
5.

What would you like to do better as a parent? List as many as applicable

What methods of discipline are typically used in the family?

Who is the main person in the family who does administers the discipline?

What has worked with discipline?

What has not worked with discipline?

Describe the way(s) in which different family members express love in the family:

Describe the way(s) in which different family members express frustration in the family:

Describe the way(s) in which different family members express anger in the family:

Have any family members had physical confrontations in the home or with others: (please describe)

Medical and Psychiatric History

Please describe any major events that have affected the family and when they occurred (divorce, moving, birth of sibling, loss, death, abuse, illness, etc.):

Please describe the current medical issues/special needs present in the family:

Is anyone in the family experiencing these symptoms? In the past, did anyone experience these symptoms? Was treatment received?

Anxiety:

Depression:

Difficulty sleeping – too little, too much, poor quality:

Mood swings:

Uncontrollable intrusive thoughts

Eating disorder, diagnosed or undiagnosed

Self-harming behavior

Thoughts of suicide, attempted suicide

Addictive patterns – alcohol, drugs, sex, gambling, video games, porn

Please list daily alcohol consumption and describe alcohol/substance use and abuse by all members of the family living at home:

Please describe any family involvement with the court system (other than divorce-custody)

Please list all medications each family member is taking for psychiatric issues:

And finally,

Please describe any additional stressors on the family:

Are there any hesitations, fears, or concerns about seeking treatment?

What additional information you would like to share:

_____	_____	_____
Client name (printed)	Client Signature	Date
_____	_____	_____
Counselor name & Credential	Signature of Counselor	Date