HIGH DESERT COMMUNITY HEALTH PSYCHOLOGICAL CENTER, LLC
5600 EUBANK BLVD NE STE 160
ALBUQUERQUE, NM 87111
505-221-6007

CONSENT FOR TREATMENT & PATIENT AGREEMENT

Welcome to my practice. Your therapy is an important joint venture in which you and I (and/or your child/family) will work together to understand the problems that you are having and to explore your options and obstacles in resolving those problems. This document contains information about my professional services and business/confidentiality policies. Should you have any questions about my practice policies and services, I will be happy to answer them.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on many factors, including the personalities of the patient and psychologist, your early experiences, your life stage, and your goals. There are several different approaches that can be used. Psychotherapy requires an active effort on your part and a working relationship with me in which together we identify the issues you would like to resolve. Psychotherapy can have both benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings and changes in your behaviors/thoughts. This is a normal part of the therapy process. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful. It often leads to a significant reduction of feelings of distress, better relationships, and resolutions of specific problems.

Our first few sessions will involve an evaluation of your needs (or your child's needs). I will assess if I can be of benefit to you (or your child). I do not accept patients who, in my opinion, I cannot help. In such a case, I will provide you with a referral. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include, a diagnosis, and a verbal treatment plan if we agree that treatment will continue. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them when they arise.

As you make progress, we should reevaluate your treatment. Usually, we will come to a mutual understanding that you have reached your treatment goals and consolidated your gains. You do, however, have the right to stop treatment at any time and I will provide you a referral to another qualified professional. Also, if at any point during psychotherapy I assess that I am not effective in treating you, I will inform you and, if appropriate, terminate treatment. In such a case, I would provide you with a referral if clinically warranted.

CONFIDENTIALITY

With certain specific exceptions described below, you have the right to the confidentiality of your therapy and your mental health records. The following are legal exceptions to your right to confidentiality.

- If I reasonably suspect that a person under 18 or over 65, or a disabled person, is being abused or has been abused, I must file a report with the appropriate state agency.

- If a patient threatens to harm him/herself, I may be obligated to seek hospitalization for the patient, or to contact family members or others who can help provide protection.

- If a patient communicates a serious threat of physical violence against an identifiable victim, I must take protective actions, including notifying the potential victim and contacting the police. I may also seek hospitalization of the patient, or contact others who can assist in protecting the victim.

- If you are involved in a court proceeding and a request is made for information about the services that I have provided you and/or the records of them, such information is protected by psychologist-patient privilege law. I cannot provide any information without your written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where I do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information or release records regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition, to the worker's compensation insurer.

- I may find it helpful to consult with professional colleagues about my work from time to time. In these consultations, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS

If you or I seek reimbursement from your health insurance carrier, disclosure of confidential information may be required by your carrier in order to process the claims. Please refer to the Federal Health Insurance Portability and Accountability Act (HIPAA) form with regard to the use and disclosure of your Protected Health Information (PHI). By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposes of treatment and payment. HIGH DESERT has no control or knowledge over what insurance companies do with the information we submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.

APPOINTMENTS
Psychotherapy appointments are usually scheduled once a week for 45-50 minutes per visit, although sometimes visits can be more or less frequent. We agree to meet here and to be on time. If I am ever unable to start on time, I ask for your understanding, and I assure you that you will receive the full time agreed to. If you are late, we will probably be unable to meet for the full time. I will provide advanced notice of my planned absences. For short absences and therapist illness, I will attempt to reschedule your appointment as soon as possible.

CANCELLATION POLICY
Because the scheduling of an appointment involves the reservation of time set aside specifically for you, a minimum of ***24*** *hours* notice is required for rescheduling or canceling an appointment. The full session fee will be charged for sessions missed without such notification. A cancellation message may be left at **(505) 221-6007**.

PROFESSIONAL FEES/PAYMENTS

My fee per 45-50-minute psychotherapy or consultation visit is $_____

For insurance clients; your co-pay due each visit is $_____

Fees (co-pays/deductibles/payments) are to be paid at the time of each visit by the patient in the form of cash/check/credit card. Having your payment ready at the beginning of the session allows for full use of your session time.
When fees are not paid for services rendered, a collection agency may be used and given appropriate billing and financial information. If a payment by check results in insufficient funds a $50 fee will be assessed.

CLIENT LITIGATION
I will not voluntarily participate in any litigation, or custody dispute in which a client or client's representative, and another individual, or entity, are parties. I have a policy of no communication with a client's or client representative's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a client, you will be charged for all of my professional time, including preparation and travel time, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $400 per hour for preparation for, travel to and from, and attendance at any legal proceeding. In cases of separated or divorced parents, one parent must assume full financial responsibility for all services.

MINORS AND PARENTS
Un-emancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless I determine that access would have a detrimental effect on my professional relationship with the patient, or to his/her physical safety or psychological well-being. Because privacy in psychotherapy is often crucial to successful progress, particularly with adolescents, and parental involvement is also essential, it is usually my policy to request an agreement with minors and their parents about access to information.

PROFESSIONAL RECORDS
Except in unusual circumstances in which disclosure would physically endanger you and/or others or makes reference to another person (unless such other person is a health care provider), you may examine and/or receive a copy of your clinical record, if you request it in writing. You will also be charged a fee for any preparation time which is required to comply with an information request.

TELEPHONE/FAX, ELECTRONIC, AND MAIL CONTACT:
Ordinary privacy precautions such as pin codes, voice mail boxes, and locked fax, mail, and secured computers are by no means foolproof, so that your confidentiality is always compromised when communicating by electronic devices or mail. Nor is deletion or shredding of private material a totally safe means of disposal, so that you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication with HIGH DESERT COMMUNITY HEALTH PSYCHOLOGICAL CENTER, LLC constitutes implied consent for reciprocal use of electronic and mail/phone/fax communications. By signing this consent form, you agree to and understand the following:

- I understand that HIGH DESERT cannot guarantee an e-mail response due to time constraints in her practice. I also agree that I will not use email for emergencies. Instead I will utilize e-mail correspondence with HIGH DESERT for scheduling and non-clinical matters.

- Many people feel comfortable communicating via email, because they have installed programs designed to detect spyware, viruses, or other dangerous software. However, there is no guarantee that such programs will work 100%.

- Sent and received emails are stored on both HIGH DESERT'S and your computer until deleted. HIGH DESERT may or may not delete such emails. Any saved emails will be kept in a password-protected account that only HIGH DESERT staff has access to.

- In addition, whenever you send an email, it is stored in cyberspace. It is possible for authorities and system administrators to locate and read such emails under various circumstances. This is not a policy of HIGH DESERT, but is due to the nature in which email is transmitted using the internet and other services/networks. For more information on this, please contact your Internet Service Provider or email service.

Please sign below to acknowledge your informed consent to this agreement.
I have read the above information, received a copy of this form, and have had an opportunity to ask questions which clarify the conditions under which I consent to treatment. I give permission to:
HIGH DESERT COMMUNITY HEALTH PSYCHOLOGICAL CENTER, LLC to provide psychotherapy, evaluation, consultation, and/or testing for myself or my child/family.

Name of patient

Signature of patient Date

For parents of minors:

Name of parent or guardian

Signature of parent or guardian Date

Name of parent or guardian

Signature of parent or guardian Date