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CLIENT SERVICE AGREEMENT, PRACTICE POLICIES, & CONSENT FOR TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains a summary of 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 and sometimes complex, 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.

THERAPEUTIC 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 therapy, 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. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. The process of therapy often requires discussing the unpleasant aspects of your life. However, therapy 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. There are no guarantees of what will happen, however. Therapy requires a very active effort on your part. In order to be successful, you will have to work on things we discuss outside of sessions.

The first 1-3 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.

By initialing here and signing this document, you agree that you understand the "Therapeutic Services" section and agree to its terms. ***(Initial)_____***

APPOINTMENTS

Appointments will ordinarily be 45-55 minutes in duration and once per week at a time we agree on. This varies depending on your funding type. Some insurance companies allow longer sessions, while other only allow shorter. 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, you must provide 24 hour-notice via voice-message or text. If you miss a session without canceling or cancel with less than 24-hour-notice, my policy is to collect fee—up to $25.00 [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. Your credit card on file will be charged for any outstanding balances and missed appointment fees. If it is possible, I will try to find another time to reschedule your appointment. 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.

By initialing here and signing this document, you agree that you understand the "Appointments" section and agree to its terms. ***(Initial)_____***

PROFESSIONAL FEES

The standard fee for the initial intake is $200.00 and each subsequent session is $150.00-$200.00 depending on the time unless we have agreed upon a different amount. For CBIT clients, the fee for subsequent sessions is $200.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash, credit, debit card, Paypal, Venmo, Square or Zelle. Any checks returned to my office are subject to an additional charge of $50.00 to cover the bank fees that I incur. Your credit card on file will be charged for any outstanding balances. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. You WILL NOT be allowed to book any future appointments with any outstanding balances.

Prior to your first session, you will receive a written document via e-mail of your costs for intake and each subsequent session. This document will also outline other less common expenses and how you will be charged. It is very important that you understand this document.

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 anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

By initialing here and signing this document, you agree that you understand the "Professional Fees" section and agree to its terms. ***(Initial)_____***

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible

in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs may require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your therapy.

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-V. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable. Sometimes I have to provide additional 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. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you are responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

PLEASE NOTE: YOU WILL BE RESPONSIBLE FOR THE REMIANING BALANCE ON ANY CLAIMS DENIED BY YOUR INSURANCE COMPANY.

By signing this document, you are authorizing me to contact your insurance provider for any purposes that may be necessary for obtaining authorization or claims.

By initialing here and signing this document, you agree that you understand the "Insurance" section and agree to its terms. ***(Initial)_____***

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location. 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. 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.

By initialing here and signing this document, you agree that you understand the "Professional Records" section and agree to its terms. ***(Initial)_____***

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 it is your responsibility to review that document. I will go over the document during the first intake session. Please remember that you may reopen the conversation at any time during our work together.

By initialing here and signing this document, you agree that you understand the "Confidentiality" section and agree to its terms. ***(Initial)_____***

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, 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.

By initialing here and signing this document, you agree that you understand the "Parents & Minors" section and agree to its terms. ***(Initial)_____***

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine. Telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and I choose to use information technology for some or all of your treatment, you need to understand that: (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. (2) All existing confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

By initialing here and signing this document, you agree that you understand the "Electronic Communication" section and agree to its terms. ***(Initial)_____***

CONTACTING YOU

It is my policy's practice to contact people via phone messages, texts, e-mails, and written communication sent to a home address. I make every effort to provide anonymity when contacting patients, but there are risks involved in any forms of contact through these methods. Risks include but are not limited to: someone else besides you opening mail or mail being accidentally delivered by Post office to the wrong address; Someone other than yourself seeing a text message or e-mail communication; someone other than yourself listening to a voice message. I make every effort to protect anonymity when contacting patients. I will never leave voice

messages with sensitive material and keep my contacts brief. If you wish to not be contacted in a specific form, please notify me and I will honor your wishes. For emergency purposes, however, I will need at least two methods of contacting you, one of which must be written. If you are uncomfortable with this, please discuss this with me prior to our working together and I will make reasonable accommodations to the best extent possible.

By initialing here and signing this document, you agree that you understand the "Contacting You" section and agree to its terms. ***(Initial)_____***

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 voicemail and your call will be returned as soon as possible, but 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) go to your local hospital emergency room, or 2) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my practice when I am unavailable. In addition to contacting me, please see my policies on social media as outlined below.

SOCIAL MEDIA

While I appreciate people finding me on social media platforms, as a LCSW, I am not allowed to contact (i.e. "friend") or respond to any patient with whom I am currently engaging in clinical services by any forms of social media. I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Snapchat, Instagram, Twitter, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and your respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

If you are inclined, you can "like" my "Lenny Gallo, LCSW" page on Facebook or leave a review of my services on Health Grades, Google, Facebook, or other platforms. While they are greatly appreciated, I will never solicit a "review" from you or ask you to "like" a page. Please know that should you choose to engage in these practices may expose your anonymity may be compromised. While some services allow you to remain anonymous, others will require a name or will utilize your profile information. I cannot control who sees your information on the web and if anonymity is a concern, I ask that you refrain from these practices and not engage in social media platforms connected to me.

By initialing here and signing this document, you agree that you understand the "Contacting Me & Social Media" section and agree to its terms. ***(Initial)_____***

UNEXPECTED THERAPIST ABSENCE

In the event of my unplanned absence from practice, whether due to injury, illness, death, or any other reason, I maintain a detailed Professional Will with instructions for an Executor to inform you of my status and ensure your continued care in accordance with your needs. The Executor of my Professional Will is Talila Marcus,

LCSW, and the Secondary Executor (i.e., the person who would take on the Executor role if the named Executor is unavailable) is Ramona Tranculov, LCSW, LCADC. The Third executer is Kristina Oyarzun, LPC. You authorize the Executor, Secondary Executor, and Third Executer, to access your treatment and financial records only in accordance with the terms of my Professional Will, and only in the event that I experience an event that has caused or is likely to cause a significant unplanned absence from practice.

By initialing here and signing this document, you agree that you understand the "Unexpected Therapist Absence" section and agree to its terms. ***(Initial)_____***

SCHEDULING EVERY-OTHER-WEEK/TOUCH-UP SESSIONS/TERMINATION

I only see people in my practice on a weekly basis and do not accommodate every-other-week sessions. Eventually as individuals feel better there is a natural inclination to want to shift sessions to every-other-week (biweekly). When this happens, I like to review the progress we have made and reassess your goals for therapy to decide if therapy is still productive for you. If you find that you're in a position where you would like to slow down with therapy, then I request that you take a break from therapy. Please note when you are ready to take a break from therapy, your spot will not be held. Should you wish to come back, you will have to reserve a new space if one is available.

Similarly, when we feel that you are ready for touch-up sessions (once a month or less), you will not have a reserved spot. I make every effort to try and accommodate touch-up sessions on an as needed basis, but please note that touch-up sessions are given on a first-come-first-serve basis when space is available and cannot be guaranteed. In the event that you want to see a therapist regularly on a once-a-month basis, you and I can work together to find someone who can accommodate that level of frequency.

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I will bring up termination during our first session. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued. When your case is terminated you will receive a letter at your home address that documents that our services have terminated.

By initialing here and signing this document, you agree that you understand the "Scheduling Every-Other-Week/Touch-Up sessions/Termination" section and agree to its terms. ***(Initial)_____***

OTHER RIGHTS

If you are unhappy with therapy services, I hope you 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.

By initialing here and signing this document, you agree that you understand the "Other Rights" section and agree to its terms. ***(Initial)_____***

CONSENT TO THERAPY

You have the right, as a patient, to be informed about your condition, diagnostic information, and interventions used in your treatment to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with me about the purpose, potential risks and benefits. If you have any concerns regarding any treatment recommended, I encourage you to ask questions.

I, _____, voluntarily request that Lenny Gallo, LCSW, LCADC, ACT, CBIT, to perform reasonable and necessary treatment for the condition which has brought me to seek care at this practice. I understand that if additional care is needed, I will be referred to an appropriate practitioner. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Your signature below indicates that you have read this Agreement and agree to the terms.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

Date: _____

Description of Personal Representative's

Authority:_____

_____