LIN HALEY
LMFT # 92501
LPCC # 7091

TREATMENT AGREEMENT FOR TEENS / CHILDREN

FEES: The fee per 50-minute session is $__130_____ This is payable at the time of our session unless I am billing your insurance (see below for insurance billing information).

CANCELLATION: Sessions are by appointment only. While I dislike charging for missed sessions, I do reserve that time for you. Therefore, you will be charged $_130 or your contracted insurance rate _____ (not just a copayment) for missed sessions or for those cancelled without 24-hour notice, except in medical or other emergency.

INSURANCE: It is essential that you tell me about all possible insurance plans you have that might cover my services (ex. if a child might have coverage through both parents' plans). Please be aware that I will be required to provide a diagnosis on invoices and claims, and coverage may be limited to certain mental conditions. Even if you have coverage for unlimited sessions, health plans may review treatment, limit coverage, and request treatment notes. While I may check coverage for you, you are responsible for verifying and understanding the limits of your coverage. Although I am happy to assist you in obtaining reimbursement, I am unable to guarantee whether your health plan will provide payment for the services provided.

If I am a provider with your plan: I will submit claims for you, but at our session you must pay copayments and any portion not covered by your plan. There may be a deductible (an annual amount you will need to pay out of pocket before your plan begins to cover sessions). If insurance does not pay as expected, you remain responsible for the balance.

If I am NOT a provider for your plan: You will pay me in full at the session. I can give you an invoice if you wish to seek reimbursement from your plan, though many plans do not cover sessions with a provider who is not in their network.

Please sign the following, if using your insurance plan

1. "*I authorize the release of any information necessary (Including notes, treatment summaries and diagnosis) to process claims, to prove medical necessity for treatment, to request additional sessions, or to comply with treatment reviews or mandated administrative chart reviews from the insurance plan.*

   (Parent or Guardian: Sign here:) X_____

   (If applicable, Second Parent signature:) _____

2. "I authorize payment of benefits to be made to my therapist for services provided."

   (Parent or Guardian: Sign here:) X_____

CONFIDENTIALITY: Client attendance, information, and records are protected and confidential. Since openness and trust are essential to effective therapy, it is important that a teen or child feels s/he has privacy to discuss all the issues that are troubling them. While parents have a right to know about their child's progress in therapy, I will limit disclosures to parents to what I feel is in the child's best interest, what the child has given me permission to share, or when there are safety issues. Since the goal is to build trust and minimize secrets, clients will be made aware of any communication with family members.

Exceptions to confidentiality include when your records are subpoenaed for legal reasons, and when reporting is required or allowed by law, such as suspicion of child/elder abuse or neglect, extreme danger to self, suspected danger to others, or when there is downloading, streaming, or accessing material in which a child is engaged in an obscene or sexual act. See other exceptions outlined in my *Notice of Privacy Practices.*

IN AN EMERGENCY: Please go to the emergency room or dial 911.

ENDINGS: If you or your child is unhappy with any aspect of therapy, please don't just leave – I ask that you talk to me to see if we can work it out. Even if we can't, endings usually feel better this way. Of course, you may end therapy at any time, and I am happy to assist with referrals. It is my ethical duty to provide therapy only when I feel you are actively participating and benefiting from the sessions. I may end treatment if there have been repeated no-shows, late-cancellations or other treatment interruptions.

E-MAIL/SOCIAL MEDIA: In general, text or e-mail are the quickest ways to reach me. I use text and e-mail to arrange/change appointments. I do not do therapy by e-mail or video. Please do not e-mail me information related to your therapy, as e-mail is not completely confidential, and important issues should be reserved for sessions. Be aware that e-mails between us become part of your legal record. I do not accept friend requests or contact requests from clients on social networking sites (Facebook, LinkedIn, etc.) out of concern for your confidentiality and my privacy. It may also blur the boundaries of our therapy relationship.

REFERRALS/GROUP: A referral to another provider may become necessary if it becomes clear in my opinion that your child's issues would be better treated by a professional with different expertise. It is unethical for me to practice beyond the level of my competence, education, training, or experience. I am not responsible for the care received from professionals to whom I refer you.

SIGNATURES: By signing below, you acknowledge you have read this Agreement, and you acknowledge receipt of my *Notices of Privacy Practices*. My *Notice of Privacy Practices* provides information about how I may use and disclose your private health information. I encourage you to read it in full. My *Notice of Privacy* Practices is subject to change. If I change my Notice, I will give you a revised Notice. If you have left treatment, you may obtain the revised notice from me at the above address and phone number. If you have any questions about the Notice, or any of the above, please feel free to ask.

X_____ _____ _____

Signature, minor client | Printed Name, client | Date

X_____ _____ _____

Signature, Parent or Guardian | Printed Name, Parent or Guardian | Date

X _____ _____ _____

Signature, Second Parent, if applicable | Printed Name, Second Parent | Date