AGREEMENT AND CONSENT FOR PSYCHOTHERAPY SERVICES

Please read the following information carefully and sign where indicated below:

I. ABOUT YOUR PSYCHOLOGIST: Dr. Todd E. Linaman earned his B.A. in Psychology from the University of Arizona, his M.A. in Marriage, Family and Child Counseling from Azusa Pacific University, and his Ph.D. in Clinical Psychology from The Fielding Graduate University. He is a Licensed Psychologist (Ph.D.) and Licensed Marriage and Family Therapist (LMFT). Dr. Linaman is not a physician, so if medication is requested or recommended, you may be referred to a medical doctor or clinic for that component to your therapy.

II. CONFIDENTIALITY: Information disclosed within sessions and written records pertaining to those sessions are confidential and may not be revealed to anyone without the patient's/legal guardian's written permission, except where disclosure is required by law or in emergencies affecting your safety, the safety of others or national security. NOTE: We cannot be responsible for the confidentiality or privacy practices of any third party, agency or provider with whom we legitimately share information. Most instances of when the law requires disclosure with or without your permission are described in more detail in our HIPAA Notice of Privacy Practices (see page 3).

III. THE PROCESS OF THERAPY/EVALUATION: Psychotherapy can result in various benefits, including improving interpersonal relationships and resolution of the concerns that led you to seek therapy. Effective therapy requires your active involvement, honesty, and openness to changing your thoughts, feelings and/or behavior. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing discomfort or strong feelings like anger, sadness, worry or fear, or experiencing anxiety, depression, insomnia, etc. Therapy can, at times, result in changes that were not originally expected or intended, and sometimes a decision that is positive for one participant is viewed quite negatively by another. Change will sometimes be easy and swift, but more often it will take time and may even feel frustrating. There is no guarantee that psychotherapy will yield positive or desired results, however research has shown that psychotherapy in many cases is beneficial.

A. Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, Dr. Linaman will discuss with you his working understanding of the problem, treatment plan, therapeutic objectives, and his view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, Dr. Linaman's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that Dr. Linaman does not provide, he will make recommendations or provide referrals as appropriate.

B. Refusal/Termination: Dr. Linaman does not accept patients he does not believe he can help, but will offer referrals to an appropriate source of help if he must refuse. Once you begin working with Dr. Linaman, if at any point you or he assess that your therapeutic goals are not being met, he will discuss it with you and, if appropriate, terminate treatment. You have the right to terminate therapy at any time, and if you wish, Dr. Linaman will provide you with names of other qualified professionals whose services you might prefer. If at any time you want another professional's opinion or wish to consult with another therapist, Dr. Linaman will help you find someone qualified, and, with your written consent, he will provide her/him with the essential information needed.

C. Dual Relationships: If you are in contact with Dr. Linaman outside the office, either personally or in business context, he will never acknowledge working therapeutically with you without your written permission. If contact outside of therapy is desired or unavoidable, he will discuss with you the potential complexities, benefits, and/or difficulties that may be involved prior to entering into the dual relationship. If the dual relationship becomes

uncomfortable for you in any way, or if Dr. Linaman finds it interfering with the effectiveness of the therapeutic process or the welfare of the patient, it will be critical for you and him to discuss the situation and possibly discontinue the dual relationship.

D. **Children/Distractions:** Please make appropriate child care arrangements prior to your appointments. Our office does not provide supervision or facilities for children and it is not recommended that young children accompany parents during the session. Not only does it create a distraction that diminishes the effectiveness of the session for the patient(s), but therapy may include discussions which may be unsettling or inappropriate for children. We also recommend silencing all phones and messaging during the session, if possible.

IV. **COMMUNICATION:** Good communication between you and Dr. Linaman is vital to the therapeutic process and is handled as securely as possible.

A. **Telephone and Emergency Procedures:** If you need to contact Dr. Linaman between sessions, please leave a message at (520) 219-8377 and your call will be returned as soon as possible. Messages are checked regularly every day, including days the office is closed. Please indicate it clearly in your message if the situation is urgent. In case of emergency, you can call the Help on Call 24-hour crisis line at (520) 323-9373. In the event of a life-threatening emergency, dial 911 first.

B. **Emails, Text Messages, Computers and Faxes:** It is important to be aware that computers and email messages can be relatively easily accessed by unauthorized users, which can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable as Internet servers have unlimited and direct access to all e-mails that go through them. While you may be comfortable making or modifying appointments, requesting statements, etc., via email, we do not recommend sending highly sensitive information or any information related to your therapy via email. Faxes are more secure, however they can be sent to incorrect addresses so caution is recommended. Similarly, text messages are also vulnerable to being sent to the wrong number, so extra caution is recommended. Important messages received through any electronic method may become part of your clinical record.

C. **Social Media:** Please do not use social networking sites such as Twitter, Facebook or LinkedIn to contact Dr. Linaman. He will not compromise the therapeutic relationship by engaging in communication with patients via social media or online chat sites, and further, he may not see the message in a timely fashion. “Friending”, “Linking” etc. could violate confidentiality and our respective privacy. We have not posted our practice on any websites except www.DrLinaman.com and if we are listed elsewhere, it is generated by that organization or directory (such as Yelp) and not a solicitation for reviews on our part.

V. **FINANCIAL RESPONSIBILITY:** Patients are expected to pay for services at the time they are rendered unless other arrangements have been made. The standard fee is **$250.00 for the initial diagnostic 75-minute evaluation, then $200.00 per 50-minute session thereafter**, but charges may vary depending on services provided. Telephone calls, site visits, report writing/reading, consultation, release of information, longer sessions, travel time, etc. may be charged at the same rate as appropriate. Please notify Dr. Linaman if any problem arises during the course of therapy regarding your ability to make timely payments. There is a $20.00 fee for returned checks.

A. **Cancellation:** It is your responsibility to remember your appointments and arrive on time. The only appointment reminders we deliver are automated emails, which you will receive about 48 hours in advance if you provide an email address and authorize its use. Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or canceling an appointment. Appointments missed, canceled with less than 24 hours notice, or shortened because of late arrival, will be charged at the full session rate.

VI. **LEGAL PROCEEDINGS:** Dr. Linaman does not engage in counseling that is court-mandated and is not available to attend legal proceedings related to his therapeutic work with a patient or on behalf of others in regard to the patient, unless agreed upon prior to the beginning of therapy.

HIPAA Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your privacy: Relational Advantage, Inc. is dedicated to maintaining the privacy of your Personal Health Information (PHI) and we are required by law to maintain the confidentiality of your PHI. It is our policy never to disclose any information about you without your written permission unless required by law to do so, such as in circumstances outlined below. Written permissions may be revoked or amended, except in circumstances where information has already been disclosed under the original authorization.

The following circumstances may require us to use or disclose your PHI with or without your permission:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. In response to a court order or if required to do so by a law enforcement official (such as in cases involving child or elder abuse).
3. When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
4. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
5. To federal officials for intelligence and national security activities authorized by law.
6. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
7. For Worker's Compensation and/or similar programs.

Your rights regarding your PHI:

1. You can request that we communicate with you about your PHI, including appointment reminders, in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate all reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosures of your PHI to only certain individuals involved in your care or the payment for your care, such as family members, friends, or insurance/EAP plan representatives. We are not required to agree with your request, however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. You may change your restrictions in writing to: Relational Advantage, Inc., 7355 N. Oracle Rd., Ste. 106, Tucson, AZ 85704-6326.

3. You have the right to inspect and obtain a copy of your PHI that may be used to make decisions about you, including medical records and billing records, but not including psychotherapy notes. Requests must be made in writing to Relational Advantage, Inc., 7355 N. Oracle Rd., Ste. 106, Tucson, AZ 85704-6326.

4. You may ask us to amend your PHI if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. Requests must be made in writing to: Relational Advantage, Inc., 7355 N. Oracle Rd., Ste. 106, Tucson, AZ 85704-6326. You must provide us with a reason that supports your request for amendment. We may refuse under certain circumstances as long as we provide you a written response stating the reason for the denial and notify you of your right to file a written objection and request that your objection be attached to all future disclosures.

5. You may request a list of disclosures that have been made of your PHI by our practice except those covered by prior authorization (e.g. if you signed an authorization for release of information or payment of insurance benefits) or those which affect national security. Records are available for seven years.

6. You are entitled to request and receive a copy of this notice at any time. We have the right to make changes to this notice.

7. If you believe your privacy rights have been violated, you have the right to file a complaint to the Secretary of the Department of Health and Human Services. To file a complaint with our office, submit a written complaint to Elizabeth Bailey at Relational Advantage, Inc., 7355 N. Oracle Rd., Ste. 106, Tucson, AZ 85704-6326 or Liz@RelationalAdvantage.com. You will not be penalized for filing a complaint.

Signature Page for Agreement, Consent, and Privacy Notice

OPTIONAL: List anyone with whom you authorize us to discuss or disclose information regarding your appointment times or billing. Note: Disclosure of clinical or medical records or private information requires a separate authorization.

Name / Relationship

______________________________________/____________________

______________________________________/____________________

______________________________________/____________________

X CONSENT: I/We have read the above Agreement carefully. I/We agree to its terms, understand all personal and financial responsibilities and hereby consent to treatment with Dr. Linaman:

____________________________________	____	
Print Patient #1 / Responsible Party Name	Signature	Date
____________________________________	____	
Print Patient #2 / Responsible Party Name	Signature	Date
____________________________________	____	
Print Patient #3 / Responsible Party Name	Signature	Date

X PRIVACY POLICY: I/We have reviewed and understand the HIPAA Notice of Privacy Practices.

____________________________________	____	
Print Patient #1 / Responsible Party Name	Signature	Date
____________________________________	____	
Print Patient #2 / Responsible Party Name	Signature	Date
____________________________________	____	
Print Patient #3 / Responsible Party Name	Signature	Date