Meyer Therapeutics, PLLC
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Meyer Therapeutics, PLLC
Practice Policies & Informed Consent for Treatment

Welcome to Meyer Therapeutics, PLLC, the psychotherapy practice of Lauren Meyer, PhD, LP, NCSP. This document contains important information about my professional services and 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 and sometimes complex, it is very important that you understand them. Signing this document represents an agreement between us. We can discuss any questions you have when you sign or at any point in the future.

PSYCHOLOGICAL SERVICES

Treatment may include discussion of emotional issues, lifestyle issues, behavioral patterns, and family and/or relationship dynamics. Creating and working toward goals are an important part of staying on track in treatment and will be determined together. Methods may include the use of educational materials, expressive methods, and stress management techniques, and may involve referrals to other types of treatment, as indicated. Benefits of treatment may include reduction of symptoms, improved quality of life, emotional well-being, improved academic/work performance, and the resolution of specific issues. Risks of treatment may include uncomfortable levels of feelings such as sadness, guilt, anger, loneliness, and shame. Treatment may require you to face difficult issues to effect changes, may involve emotional distress, and will likely involve recalling unpleasant aspects of your life history or working through unresolved life experiences.

This process requires effort on your part and your active engagement in this process will largely influence the level of benefit you receive from your treatment. Therapeutic growth involves hard work during sessions and also at home. Although your satisfaction is very important to me, there is no guaranteed outcome. If for any reason you are not satisfied with my services or have questions / concerns about your treatment, please ask for clarification and bring this to my attention immediately. This information is essential in order to better meet our collective treatment goals. You can end treatment at any time for any reason. I encourage you to allow us time for closure in order to recognize your progress and provide you with appropriate referrals to continue meeting your mental health needs in the future.

In addition, when working with children and problem behaviors, parents may very well see the unwanted behavior(s) increase (gets worse) before they decrease. It is important to be consistent and supportive during the challenging transition.

APPOINTMENTS

I start therapy with an initial phone consultation, which lasts approximately 20-minutes. This is an initial consultation only where we can exchange information and determine initial fit. I normally conduct an initial evaluation that will last from 1 – 3 sessions. This includes one initial session at 90-minutes to two-hours followed by 1 – 2, 50-minute sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If

psychotherapy is initiated, I will usually schedule one 50-minute session per week at a time we agree on, although sometimes sessions will vary in frequency and duration.

TELEPRACTICE APPOINTMENTS

Please note that face-to-face sessions are highly preferable to virtual sessions. However, in the event that you are out of town, sick, or we are not able to meet in person due to extenuating circumstances, video or phone sessions are available. In the event that Telepractice meetings are requested, I will provide an additional "Informed Consent for Telepractice" Form, that thoroughly explains the details of engaging in virtual sessions.

CONFIDENTIALITY AND RECORDS

Your privacy is of utmost importance. I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. 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. Your records are maintained in a secured, HIPAA-compliant electronic medical records system that is highly safeguarded. The session content and all relevant materials to your treatment will be held confidential with only a few exceptions, listed below. The laws and standards of my profession require that I keep treatment records. Both the federal and state laws require appropriate handling of records. Laws governing confidentiality of mental health records apply to the maintenance, disclosure, and disposal of these records.

This information will not be released without your written consent, the consent of your parent or guardian if you are under 18 years of age (a minor), or unless required by law. You are entitled to receive a summary or copy of the records. Because these are professional records, they can be misinterpreted and/or upsetting to a client. I recommend you view the records in my presence so we can discuss the contents. There is a charge for the preparation and sending of records (if applicable) at the rate of $0.25 page and a $30/administrative hour. These charges will be billed directly to you.

LIMITS TO CONFIDENTIALITY

I am required by law to disclose your personal information in certain circumstances. Examples of these confidentiality exceptions include:

1. If a client (or guardian) authorizes a release of information with a signature.
2. If a client is threatening to seriously harm him/herself, hospitalization for the client or contact with a family member or others who help keep the client safe may be required.
3. If a client is threatening bodily harm to another, protective action must be taken which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization for the person.
4. If there is a reasonable belief that a child or vulnerable adult (elderly person or disabled person) is at risk for abuse or neglect, a report with the appropriate state agency must be made.
5. If a court of law issues a legitimate subpoena for information stated on that subpoena, I may be required to disclose this information.
6. If the Arizona Board of Psychologist Examiners is conducting an investigation, upon subpoena from the Board, I may be required to disclose client records.

7. If a client files a complaint or a lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

Occasionally I find it helpful to discuss your case with other professionals in a consultation setting in order to provide the best treatment for you. I make great efforts to avoid sharing any personal or identifying information. This is part of my ethical code to make sure I am providing the highest quality treatment for you.

If we see each other coincidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize this. However, if you acknowledge me first, I will be more than happy to say "hello."

MINOR CONFIDENTIALITY FOR THERAPY

In the case of child/teen therapy, it is most effective when a trusting relationship exists between the psychologist and the patient (i.e., the child or adolescent). Privacy is especially important in securing and maintaining that trust. It is often necessary for children to develop an environment of privacy whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records and agree to respect your child's disclosures with me and not to pressure your child/adolescent or therapist to disclose information discussed in treatment sessions.

It is my policy to provide you with general information about your child's treatment status and to encourage children to share directly with their parents/guardians. As your child's therapist, I will raise issues that may be affecting your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's assent. I will encourage your child to regularly provide you with a summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future. In addition, I will periodically request that you provide supportive information in order for me to best help your child and the family.

If your child is an adolescent, it is possible that he/she/they will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental/guardian intervention. If I ever believe that your child is at serious risk of harming him/herself/themselves or another, I will inform you. As mentioned above, information shared that leads me to conclude that your child or adolescent is at imminent risk of engaging in serious and potentially lethal self-harm behavior, high-risk behavior that could jeopardize your child's/adolescent's life, or aggressive behavior that could potentially seriously injure someone will not be kept confidential and will be shared with you and possibly others in an effort to prevent your child/adolescent from engaging in dangerous behavior.

EMERGENCY COVERAGE

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I have the professional duty to make arrangements for your continuing care in the event that I become unavailable due to incapacitating illness or death. Accordingly, should I become unavailable due to incapacitating illness or death, a designated professional with credentials equivalent to those of mine will notify you. At your request, that professional will provide a referral for further care. The professional will also inform you where your records will be stored and what you will need to do if you wish to access them.

By signing permission line numbered one (1) below, you give me permission to provide your name, address, and phone number, information about your case, and access to your records to the professional who will be responding should I become unavailable due to illness or death. Access to information about your case and to your records would be very helpful to this professional in referring you to other appropriate health care providers who may be able to provide you with continuing care in the event that I cannot continue to provide you with care. This professional will keep confidential all information obtained about you from me, obtained from you in speaking with you, and obtained in reviewing your records, just as I have kept this information confidential.

If you do not want me to allow this professional to have any information about you other than your name, address, and phone number so you can by notified of my incapacitating illness or death, or to have any access to your records, please so confirm by signing permission line numbered two (2) below.

Your signature indicates that you understand the information in this document and agree to abide by these terms during our professional relationship.

EMERGENCY COVERAGE – PERMISSION (SIGN JUST ONE, NOT BOTH)

1. I give Lauren Meyer, PhD, LP, NCSP permission to **provide my name, address, and phone number, information about my case, and access to my records** to the professional who will be responding should Dr. Meyer become unavailable due to illness or death.

Client Name: ____ Date: ______________

Guardian (if minor): ____

2. I give Lauren Meyer, PhD, LP, NCSP. permission to **provide my name, address, and phone number only** to the professional who will be responding should Dr. Meyer become unavailable due to illness or death.

Client Name: ____ Date: ______________

Guardian (if minor): ____

COMMUNICATION AND CONTACTING ME

Therapy is most productive when we discuss therapeutic content in session. However, if you need to contact me between sessions, you can contact me at 520-263-9379 and leave a message on my voicemail. I am often not immediately available due to my work schedule; however, I will attempt to return your

call in 1-2 days. I cannot be reached during holidays. If I am unavailable for an extended period of time (e.g., personal vacation), we will discuss resources for you to connect with during my absence if needed.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages or email. If you would like to communicate with me through electronic media around scheduling or cancellations, billing, or other administrative issues, I am happy to do so. While I will attempt to return messages in a timely manner, I cannot guarantee immediate response. Please do not use these methods of communication to discuss therapeutic content unless otherwise agreed upon. Do not use these methods to request assistance for emergencies. Occasionally, a client will reach out to me through social media and make a "friend" or contact request. Please be aware that I do not accept these requests due to it compromising our privacy, your confidentiality, and blurring boundaries of our therapeutic relationship.

CONTACT DURING EMERGENCIES

I am not available outside of normal business hours for emergency or crisis calls. If you are not able to get in touch with me during my typical business hours, you may try reaching out to your primary care physician or if applicable, your psychiatrist. If a true emergency situation arises, please call 911 or proceed to your nearest hospital emergency room. If concerns arise that you may be in crisis before meeting again, please bring this to my attention and I can provide you with additional resources including crisis centers and crisis-lines.

CUSTODY DISPUTES AND COURT APPEARANCES

Agreement Not to Involve Lauren Meyer, PhD, NCSP in Custody Disputes and Fees for Mandatory Court Appearances on A Client's Behalf:

When parents bring their children for therapy, it is important that both parents consent to treatment knowing that my role (Lauren Meyer, PhD, NCSP; the role of the clinician) is as the child/adolescent therapist, and not as an "expert witness." Although my responsibility to your child may require my involvement in conflicts between the parents, you agree that my (Lauren Meyer, PhD, NCSP's) involvement will be strictly limited to that which will benefit your child. This means that you agree not to involve me in any custody or visitation disputes, as this would not be in the best interest of your child's relationship with me and would be counterproductive to the therapeutic process.

In particular, you agree not to involve me in court proceedings regarding any treatment of your child now or in the future, nor to ask me to share your child's records regarding any such proceedings. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. Court appearance will likely result in the need to terminate therapy and refer you to another therapist due to creating a dual relationship, which can negatively impact client care.

In cases where I am ordered to testify by the court about my therapy/ assessment/treatment with your child and/or you (even by a third party), I will be monetarily compensated as set forth below.

In the event that it is necessary for me to testify before any court, arbitrator, or other hearing officer to testify at a deposition or to present any or all records pertaining to the therapeutic relationship to a

court official, the client agrees to pay me for my services. An initial $3,000 retainer is required to be paid in full 14 calendar days before testimony is scheduled or records are to be submitted to the court. Because of the difficulty of legal involvement, additional costs that are reimbursed to me at your expense include: travel time and travel expenses, meals, copies, parking, phone consultation, letter compilation, communication with my legal counsel, and record(s) review at the rate of $160 per hour, rounded to the nearest half hour. There is a minimum charge of eight (8) hours billed for each day that I am required to attend court, hearings, testimonies, and/or submit records to the court as all other clients will need to be cleared from my calendar for that day. The full day is billed to you even if the testimony, arbitration, hearing, or record submission is cancelled/postponed for that day or takes fewer than eight hours. Other letters and paperwork requested by the client will be assessed a charge of $160 per hour, rounded to the nearest hour, with a minimum 1-hour charge. This does include letters to court officials or attorneys, and any other documentation requested by the client. This does not include copies of your bill, missed work, or school letters, Release of Information Forms, nor any other documents used in the day-to-day operation of the office.

In signing this agreement, I acknowledge that there is a difference between the roles of treating therapist and expert witness, and I agree not to subpoena Lauren Meyer, PhD, or Lauren Meyer, PhD's, records, for use in litigation. I understand that the boundary between treating therapist and expert witness is necessary to maintain the integrity of the therapeutic relationships established in therapy.

THERAPY FEES & PAYMENT

Clients (or the responsible party) will be charged on the day of the session. My policy is that all clients keep a card on file through the Electronic Health Records system - TherapyNotes. The fee for the initial intake session is $210 and the fee for each 50-minute therapy session is $160. I do occasionally have a moderate fee increase which you will be made aware of with ample time to prepare. In circumstances of unusual financial hardship, I may be willing to negotiate a temporary fee adjustment or payment installment plan**.** Payments accepted: Cash, Check, Credit/Debit card, HSA/FSA.

I understand that there will be a monthly service charge of 0.75% of any unpaid fees (9%/year), and that balances not paid in a timely manner may be turned over to an independent agency for collection.

You will receive notification of a delinquent account at which point no routine sessions will be available until the account is paid in full. I will provide emergency assistance in a crisis to persons with delinquent accounts, but again, these accounts must be paid in full to resume regular services. I have the option of using legal means to secure payment and your account information will be forwarded to a collection service after 90 days of non- payment unless you have made arrangements for payments with me.

In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. All collection related costs, including attorney fees are your financial responsibility.

Clients who carry insurance should remember that professional services are rendered and charged to the clients and not submitted to the insurance companies. At your request, I will provide you with a copy of your receipt on a monthly basis (called a "Super Bill"), which you can then submit to your insurance company for reimbursement, if you so choose. Please be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt

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with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

There are at times demands for services outside of a standard clinical session. Please be aware that I charge for the following activities: telephone conversations lasting longer than 5-minutes (with an exception of a new client initial phone consultation), attendance of meeting with other professionals you have authorized, and oral or written communication with attorneys, physicians, school staff, etc. These activities will be billed at the standard individual session rate of $160.00/hour, but will be prorated for the amount of time used.

CANCELLATION/NO SHOW POLICY

If you need to change your appointment time, I will do my best to accommodate your request. I appreciate notice as soon as you are aware of a schedule conflict. However, scheduled appointment times are reserved especially for you. If you cancel an appointment with less than 24 hours' notice, or fail to show up, you will be charged a **$80** fee for the missed appointment via the card you have on file, unless we both agree that you were unable to attend due to circumstances outside of your control. The first cancellation is typically waived. The fee *will not* be waived if you or your child/teen does not show up for an appointment without a call, text, or email notification prior to the appointment time.

I understand that incurring this charge may be difficult especially when you may have a legitimate reason for missing a session. However, please understand when you make an appointment, you reserve time exclusively for you (in other words, that time is not available for others). If you are late for a session, that time cannot be made-up, and you will lose that amount of session time. Late session starts due to client tardiness are charged the full session fee.

Late Arrival

If you arrive late for an appointment, the appointment will end 50 minutes from the scheduled start time.

Multiple Cancelled or Missed Appointments:

- If you are a **weekly** client and you miss three scheduled appointments within a **three-month time period**, the therapeutic relationship may be terminated and appropriate referrals to other practices will be offered.
- If you are a **bi-weekly** client and you miss two scheduled appointments in a **two-month period**, the therapeutic relationship may be terminated and appropriate referrals to other practices will be offered.

RETURNED CHECK FEE

A $30.00 service charge will be charged for any checks returned for any reason for special handling. You are responsible for any bank fees I incur as a result. After two returned checks, this will no longer be a viable form of payment and payment must be rendered through other payment options I accept.

TERMINATION OF TREATMENT

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Ending therapy and the therapeutic relationship can be difficult and may arise for multiple reasons. The appropriate length of the termination depends on the length of treatment and the intensity of the treatment. 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 of payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of termination. 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 from a different 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.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with the greatest 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.

ACKNOWLEDGEMENT

If the patient is a minor, by signing below you are affirming that you are the parent or legal guardian and have the authority to consent to professional services. **In order to authorize treatment, you must have either sole or joint legal custody of your child. For guardians who have joint legal custody, per legal documentation, both guardians must consent to treatment. Guardians may be asked to show evidence of guardianship, as appropriate.**

Name of Client: ____ **DOB:** ___________________________

Client's Signature: ____

Date: ________________________

Name of Parent/Guardian (if client is a minor): ____

Parent/Guardian Signature: ____

Date: ________________________

Name of Parent/Guardian (if client is a minor): ____

Parent/Guardian Signature: ____

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Date: ______________________

____ **Date:** ____________________________________
Lauren Meyer, PhD, LP, NCSP