LINDA M. CALLAHAN MSW, LCSW
6224 NW 43RD ST. 4 A
GAINESVILLE, FLORIDA 32653
352-505-6330

THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Heath Insurance Portability and Accountability Act (HIPPA), 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 psychotherapy, 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.

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

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration and frequency will be mutually determined. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with

24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you may be charged for the full amount of your session unless it's considered an emergency.

PROFESSIONAL FEES

The standard fee for the initial intake and subsequent sessions is $130.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment may be made by check, cash or credit card. However, using a credit card will add a $5.00 fee for processing.

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. Shorter phone calls and/or e mails will not require a fee.

INSURANCE

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. 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. I am a provider with many health insurance carriers, but it will be your responsibility to explore how much reimbursement you might receive from your provider. My VIN # is Z1608 and that may help you explore the coverage with your individual provider.

I am able to provide information in written form for you to file with your insurance for any reimbursement you may secure. I would suggest attaching a claim form that you can download or receive from your individual network and attach the form I give you with it for each individual session.

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.

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.

PROFESSIONAL RECORDS

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.
If there ever was a data breach and you might be affected, I would notify you of it as soon as I was aware of it.

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. Please remember that you may discuss any of this with me at any time during our work together. You may request a copy of it at any time.

PARENTS AND 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.

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 voice mail and your call will returned as soon as possible. If you'd rather communicate through e mail contact me at LINMSW@cox.net. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and feel you cannot wait for a return call or if you feel unable to keep yourself safe, please contact the Alachua County Crisis Center at 352-264-6789.

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 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. If I see you outside the counseling or coaching office, out of respect for client confidentiality, the decision will be yours as to whether we acknowledge one another.

CONSENT TO PSYCHOTHERAPY OR LIFE COACHING

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

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Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority_