Julia Clowney LICSW, LLC
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Saint Paul, MN 55104
651-797-4359

Service Contract, Informed Consent and Financial Agreement as of 1/1/2018

Client name: ____ DOB: _________________

Welcome to my psychotherapy practice! This document is intended to help answer your practical questions, and I am are more than happy to discuss any remaining concerns in person at your initial appointment.

CONSENT FOR SERVICES

I acknowledge that I have accepted a copy of (or know how to access) and understand the Notice of Privacy Policy regarding my privacy rights per federal HIPAA laws.

With enough knowledge, and without being forced, I enter into psychotherapy with this provider. I will keep my provider fully up to date about any changes in my feelings, thoughts, and behaviors. When difficulties arise, I will let my provider know so that we can address them in an honest and direct manor. I understand the basic goals and methods of psychotherapy and that my provider may use different methods of helping me and my family and/or minor child based on the unique factors associated with the presented needs. I have no important questions or concerns that the provider has not discussed with me. I understand that reaching the agreed upon therapeutic goal(s) is not guaranteed and that psychotherapy has varying levels of effectiveness for different individuals. I also understand that my therapeutic goal(s) may evolve and change based on new insights and/or changes to my life situation.

I am agreeing to participate in individual and/or couples' psychotherapy, while acknowledging that the course of psychotherapy may change, and the participants may change, by agreement of all required parties.

Risks and Benefits: I further understand that the initial symptoms or problems presented may initially become more intense because confronting important questions about who I am and who I want to be may at times cause internal conflict. I understand the psychotherapy requires an active investment of various resources (emotional, time, financial, and others) that may lead to uncomfortable feelings like sadness, anger, or frustration. On the other hand, I understand psychotherapy has also been shown to have many benefits. Psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. I understand there are no guarantees of what I as an individual and/or my family or minor child will achieve as outcomes.

Alternatives: I understand there are many viable alternatives to psychotherapy, such as, but not limited to, self-help books, support groups, medication and other medical interventions, and psychotherapy interventions other than what is offered by Julia Clowney LICSW and that I am welcome to discuss any options with my provider at any time.

Couples' Psychotherapy: I understand that couples' psychotherapy can be beneficial in maintaining healthy family relationships that can positively impact the physical and mental health of individual family members. However, couples' psychotherapy can also pose unique challenges because more than one person is involved in the process. I agree to the following regarding couples' psychotherapy:

- Information discussed is for therapeutic purposes and is not intended for legal purposes
- Signing this agreement means that I will not subpoena information from psychotherapy and try to use it later in legal proceedings
- Phone calls, texts, or emails between sessions should be used primarily for scheduling purposes only and not to communicate information to the therapist that I do not want other family members to know, unless that information is related to my safety.
- Sometimes in the course of couples' psychotherapy, the provider will have sessions that do not include all family members. In such cases, the provider will not report back to other family members what was discussed without the permission of the family member who shared the information. However, anytime the provider believes that the couple or family cannot make progress toward their stated goals, he or she reserves the right to terminate psychotherapy. While the provider will not pass information between family members when specifically asked not to, if the unwillingness to engage in open communication will hinder goals, psychotherapy will not continue. Providers are not secret-keepers in family systems.
- If a couple or family breaks up and a family member contacts this provider for individual services, this provider reserves the right to proceed according to her clinical judgment. Referrals for some family members may be provided when the provider anticipates a potential conflict of interest. The decision of which family member(s) continue in psychotherapy with this provider is at the provider's discretion.

TERMINATION OF SERVICES

I understand that I can terminate therapeutic services at any time. When doing so I agree to notify my provider and schedule a final session. I understand that if I miss three appointments in a row without informing my provider, she will begin the process of terminating my psychotherapy. If my provider believes there to be a conflict of interest, she may terminate services with me but will not do so without providing me with viable alternatives to seek treatment from another qualified professional.

PSYCHOTHERAPY FEES

Services	Fee
90791 Intake – First session (60 min)	$200
90832 Psychotherapy 30 (16 to 37) min	$88
90834 Psychotherapy 45 (38 to 52) min	$130
90837 Psychotherapy 60 (53 +) min	$175

*If these fees are a financial hardship for you, please ask me about discounted services.

FINANCIAL AGREEMENT
I understand that if I am a parent seeking psychotherapy for a minor child, I am the financial guarantor of my child's account. If I am an adult seeking services for myself, I am the financial guarantor of my own account. By signing below I agree to the above fee schedule and understand payment (cash, check, Visa, MasterCard) is due in full (including copays) at the beginning of each counseling session.

I understand that Julia Clowney LICSW will not track my coverage or benefits. Submitting in network and out of network claims is a courtesy provided. If your insurance company denies your claim for any reason, you are responsible for the unpaid balance.

(Should you become involved in any legal action in which you or someone else require the provider's participation, Julia Clowney LICSW, LLC charges $250 per hour for all time spent to meet my obligations, including but not limited to personal preparation, professional consultation, travel to and/or attendance at any legal proceeding. The extra fee is due to the complex nature of preparation and the extra costs that can be incurred for a provider while preparing. Clients will need to pay in advance of any legal preparation.)

CANCELLATION POLICY/NO-SHOW POLICY
I understand I am welcome to come to any part of my scheduled session, even if I have to be late. If I am running late, I will call or text message my provider to let her know. If I need to cancel or reschedule an appointment, I will give my provider twenty-four (24) business hours' notice (Monday through Friday 9 to 5)**. I understand failure to attend a session without giving 24 business hours' notice will result in a fee of $120.00 and that this fee cannot be billed to my insurance meaning I will be responsible to pay it in full**. I understand that I will not be charged if I have a death in my immediate family or an emergency hospitalization for myself or an immediate family member. I also understand that insurance will not cover the payment for a missed appointment or a late cancel fee.

I understand that if I deem it useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication, I need to be informed that these methods, in their typical form, are not confidential means of communication. If I use these methods to communicate with Julia Clowney LICSW LLC, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in my home or other environments who can access my phone, computer, or other devices that I use to read and write messages
- My employer, if I use my work email to communicate with Julia Clowney LICSW LLC
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

I consent to allow Julia Clowney LICSW LLC to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

Check off all that you agree to:
O Information related to the scheduling of meetings or other appointments
O Information related to billing and payment
O Completed forms, including forms that may contain sensitive, confidential information
O Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
O My health record, in part or in whole, or summaries of material from my health record
O Other information. Describe: ______________________________________

BY THE FOLLOWING NON-SECURE MEDIA:
O Unsecured email
O SMS text message (i.e. traditional text messaging) or other type of "text message"

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time. I authorize Julia Clowney LICSW, LLC to communicate with me via unsecured email and SMS text messaging as described above for the purposes described above (scheduling, billing, sending forms or records, communicating about clinical information). I also understand that I incur the risk involved in transmitting clinical information through non-secure electronic means.

EMERGENCY PROCEDURE
In the event of a life-threatening emergency, call 911. If I have another crisis that can not wait I am aware I can go to the nearest emergency room.

My signature on this AGREEMENT FOR PSYCHOTHERAPY SERVICIES/INFORMED CONSENT means I have reviewed, understand, and consent to everything above and indicates my consent to participate in psychotherapy at Julia Clowney LICSW, LLC.

Client Signature: ____ Date: _____________

Parent/Guardian Signature: _____________________________________ Date: _____________

Provider Signature: ____ Date: _____________