Dragonfly Counseling

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PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

This form has been developed to provide you with information about psychotherapy procedures and practices. It contains information about the Health Insurance Portability and Accountability Act (HIPPA) Privacy rule, and some professional ethical codes relevant to therapy. You may choose to revoke this agreement at any time, which will mean you no longer consent to treatment, however, some parts may still be enforced.

PSYCHOTHERAPIST-CLIENT RELATIONSHIP

It is not appropriate for a Psychotherapist to engage in any relationship other than a Therapist-Patient relationship with a client or former client, and it is inappropriate to give or receive gifts.

APPOINTMENTS

Services are available by appointment. Please try to be on time as I may have someone scheduled directly after you. If you need to cancel a session, please do so 24 hours in advance by calling 813-541-6619. **Missed appointments or appointments canceled with less then 24 hours notice will incur a charge of $75.00 which must be paid at the next meeting.**

CONFIDENTIALITY AND PRIVILEGED COMMUNICATION

The law protects the privacy of all communications between a patient and a psychotherapist. In most situations, information about treatment can only be released if you sign a written authorization that meets certain requirements imposed by HIPAA. There are exceptions to this rule, such as plans to harm yourself, harm someone else, or abuse of an elderly person or minor child. In addition, in order to insure the highest standard of care, I may consult with other HIPPA compliant therapists regarding your case. During this consultation I will leave out any identifying information.

MINORS & PARENTS

Patients under 18 and their parents should be aware that the law may allow parents to examine their child's treatment records. Children between the ages of 13 and 17 may independently consent to, and control access to, the records of diagnosis and treatment in a crisis situation. Because privacy in psychotherapy is crucial to successful progress, particularly with teenagers, we (the therapist, parent and teen) will discuss confidentiality and what will work best in your particular situation.

I understand the HIPPA regulations that are displayed in the office and have been offered a copy.
____________________ **(Initial)**

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTOOD
THIS AGREEMENT, AND THAT YOU HAVE HAD A CHANCE TO DISCUSS ANY CONCERNS OR QUESTIONS AND ACCEPT THE TERMS.

It is OK to email me regarding seminars. Yes No email____________________________________

____ ___________
Signature (client) Date

____ ___________
Signature (client) Date

02/25/2017