Megan Earles, LCSW, LLC PHONE (941) 564-3018 FAX (941) 296-7254

Therapy Agreement, Policies, and Consent for Treatment

Part 1: Communication Procedures and Policies

- **Office Hours & Phone Communication:** Office hours are from 9AM-5PM, Tuesday through Friday. If you need to contact me for any reason please call 941-564-3018, leave a voicemail, and your call will be returned within 1-2 business days. Phone calls are typically returned during office days and hours.

  My office is located in the Mind Body Medicine of Florida office in Pen-West Park office complex.

  2805 Fruitville Road, Suite 250, Sarasota, Florida 34237

  Emergencies: I am not available on-call or 24/7 for emergency or crisis calls.
  If you are having thoughts of suicide or homicide, or are experiencing any emergency, DIAL 911 or go to your nearest emergency room immediately! Below are community resources which are available for your assistance.

  ***Bayside Center for Behavioral Health:** 941-917-7760
  1650 South Osprey Avenue, Sarasota, Florida 34239

  ***National Suicide Prevention Lifeline: 24-Hour Hotline:** 1-800-273-8255
  ***Safe Place and Rape Crisis Center (SPARCC): 24-Hour Crisis Hotline:** 941-365-1976
  ***National Domestic Violence Hotline: 24-Hour Hotline:** 1-800-799-7233

- **Social Media:** I do not regularly monitor or utilize social media. As such, I do not accept requests to connect or communicate with current or former clients on social media. Any requests to connect or communicate through social media platforms will not receive a response. This policy is to protect your confidentiality and preserve the integrity of our therapeutic relationship.
- **Email Communication:** Please do not use email for emergencies or for therapy purposes. If you need to be seen, please call to schedule an appointment. Do not use email to communicate sensitive medical or mental health information. **Email communication cannot be guaranteed to be confidential**. Email may become a part of your medical record. A timely response through email communication cannot be guaranteed. Please call the office if a timely response is needed.
- **Texting:** Texting or the use of any messaging services is not permitted for communication with current or former clients or family members. The office line (941-564-3018) does not have access to send or receive text messages.
- **Sessions Outside the Office:** Rarely during the course of therapy, I may recommend that we meet in an alternate location (i.e. client's home, in public, school, etc) for very specific clinical purposes. Should you agree to meet outside of my office, I cannot guarantee your confidentiality due to physical surroundings.

PART 2: THERAPY BENEFITS/RISKS AND EXPECTATIONS

BENEFITS/OUTCOMES: Participating in therapy can result in numerous benefits, including improving intrapersonal and interpersonal relationships and reducing emotional symptoms, resolving the concerns that led you to therapy. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific concern(s). A major benefit that may be gained from participating in therapy includes a reduction in distress and a better ability to handle or cope with personal, relational, family, work, and other problems as well as stress. Another possible benefit may be a greater understanding of personal and relational goals and values; this may lead to greater happiness as an individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving initial concerns brought to therapy. I will do my best to assess progress on a regular basis and solicit your feedback regarding the therapeutic process to provide you with the most effective therapeutic services. I make no guarantees as to the ultimate outcome of therapy.

EXPECTATIONS: Work outside of the counseling sessions is an essential aspect of change. I may assign tasks between sessions related to your goals. My commitment is to work as efficiently as possible and, at the same time, therapy may move more slowly than you anticipated. We will collaborate to identify your therapeutic goals, periodically review your progress toward them, and modify our treatment plan as needed.

RISKS: In working to achieve these potential benefits, the therapeutic process requires that actions be taken to achieve the results you desire. Sometimes in taking these actions you may experience discomfort. Therapeutically resolving unpleasant events and relationship patterns may arouse intense, unexpected feelings. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work together for a desirable outcome; however, there is a possibility that the goals of therapy will not be met.

SECTION 3: APPOINTMENTS

SCHEDULING: With your permission, my scheduling system (TherapyPortal) will provide automated email reminders prior to your appointments. Leaving me a voicemail at 941-564-3018 is another option for scheduling needs or questions. Additionally, emailing me is the most efficient method for schedule changes.

LENGTH OF SESSIONS: Sessions are 55-minutes in length and are typically weekly or biweekly, depending on clinical need. It may be difficult to accurately predict how many sessions will be needed to achieve treatment goals; however this will be an on-going collaborative discussion between client and therapist.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment you scheduled. If you need to cancel or reschedule your appointment, 24-hours notice is required to avoid charge. The fee for a missed session (cancel with less than 24-hour notice or no-show) is the full session rate of $125. Your card on file will be charged for the appointment on the day of the missed appointment. **Please note, that I may discontinue services if more than 2 sessions are missed *without proper notification*.**

Periodically, I will be out of the office. I will attempt to give you reasonable notice whenever possible. If I am unable to contact you directly due to circumstances out of my control, I will have a colleague contact you to cancel or reschedule an appointment.

INSURANCE: I am not an in-network provider for insurance companies. I am considered an "out-of-network provider" for most insurance companies. I do not accept insurance benefits as payments for service. I also do not submit claims or contact insurance companies for clients. You are encouraged to determine your plan's out-of-network benefits and which of our services may be eligible for reimbursement. At your request, you will be provided with a "superbill" (i.e. receipt) which includes the necessary documentation for your claim submission.

FEE SCHEDULE AND FEE AGREEMENT:

1. **Timing of Payment:** Payment in full is due at the beginning of the session. All costs for services outside of session will be billed to your account at the time the service is provided.
2. **Methods of Payment:** Payments are accepted in the form of exact cash (change cannot be provided), check (insufficient-fund fee of $25) or credit/debit/HSA card.
3. **Initial Intake Fee**: The fee for the first appointment is $150. At the initial intake appointment, we will review policies and procedures, complete paperwork, discuss the therapeutic process, begin to obtain psychosocial history and initial assessment, and perhaps begin to formalize the treatment plan. Individualized therapy will begin at subsequent sessions following the completion of the intake/assessment process.
4. **Therapy Sessions:** All follow-up sessions after the initial intake appointment are $125.
5. **Extended Sessions:** Periodically, sessions extended beyond the 55-minute allocated time. Sessions extending beyond 55-minutes will be charged $30 per additional 15 minutes. By signing below, I understand that such situations cannot always be predicted or scheduled (i.e. crisis situations), and I am still responsible for the fees charged from the extended time/treatment provided.
6. **Cancellations and/or Missed Appointments:** You are responsible for attending each appointment you scheduled. Notification by email or voicemail is required, with at least 24 hour notice prior to session, in order to avoid charge. Sessions missed or canceled with less than 24 hours prior notice will result in a charge of the full-session rate of $125 for the originally scheduled session.
7. **Court Appearances:** The cost for any time spent for court appearances, deposition costs, preparation, and related expenses will be charged at the rate of $200 per hour plus direct expenses incurred.
8. **School and other off-site therapy:** Such services are **only** offered during specific clinical circumstances and are offered at an hourly rate of $125, plus the time and cost of travel.
9. **Account Balances:** It is the policy of Megan Earles, LCSW, LLC that accounts must be paid in full and balances will not be carried between sessions. Appointment scheduling will not be allowed if there is a balance on your account. Upon payment in-full of account balances, appointment scheduling may resume.
10. **Collections:** If accounts are not paid in-full, Megan Earles, LCSW, LLC reserves the right to take appropriate collection action to obtain payment. This includes taking legal action to collect amounts due. Should this happen, the minimal amount of information necessary will be released for collection activity. By signing this agreement, you consent to this policy and authorize such release of needed confidential information.
11. **Medical Records:** Medical records are released, with your written permission, at a rate of $0.50 per page. Please allow at least 2 weeks to prepare your records.
12. **Other fees:** Fees of $30 per 15-minute interval are charged for phone calls, email correspondence, writing assessments or letters, and collaborating with professionals (with your permission) for continuity of care.
13. **Fees are subject to change.**

PART 4: CONFIDENTIALITY

Therapy communications are confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations which do NOT require your consent to report to appropriate authorities:

- **Child Abuse and/or Neglect:** As a mandated reporter, I am required by law to report suspected or disclosed child abuse and/or neglect. This includes, but is not limited to, verbal, physical, emotional, sexual abuse, and neglect of emotional, medical, physical needs, and domestic violence or drug abuse in the presence of a child. (Florida Statute 39.201)
- **Vulnerable Adult Abuse, Neglect or Exploitation:** I am required by law to report suspected or disclosed abuse and/or neglect of an elderly or disabled adult. This includes, but is not limited to, verbal, physical, emotional, sexual abuse, exploitation, and neglect of emotional, medical, physical needs. (Florida statute 415.1034)

PART 4: CONFIDENTIALITY Continued

- **Harm to Self:** I am required by law to report if I suspect, learn of, or you report intent to, planning of, or attempt of seriously harming or killing yourself. I am required to take steps to protect your safety which may include the disclosure of confidential information and steps being taken to ensure your safety (Florida statute 491.0147 & Chapter 394).
- **Harm to Others:** I am required by law to report suspected or reported intent to harm another person (Florida statute 491.0147). If bodily harm or death of another person is suspected or threatened, I am required by law to report this to the appropriate authority to ensure the safety of others.
- **Court Orders & Legal Issued Subpoenas:** If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone and send you written correspondence (if I cannot get in touch with you by phone). If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Court Ordered Therapy:** If you are in therapy ordered by the court, and the court requests records or documentation of your participation in services, I will discuss the information/documentation that will be disclosed on your behalf prior to sending information to the court. At this time, I am not a court-approved provider.
- **Written Request:** Except for the above exceptions, your specific written request is required to disclose information regarding your psychotherapy to a third party.). If therapy sessions involve more than one person, ALL participants over the age of 18 MUST consent to release of requested information prior to information being released.
- **Medical Record Request:** Psychotherapy notes are notes that a mental health professional takes during a private counseling session or a group, joint, or family counseling session. Per HIPAA, clients do not have the right to access my psychotherapy notes. They are kept separate from the medical and billing records. In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("psychotherapy/process notes"), I reserve the right to provide to you or the authorized third party an assessment and/or treatment summary in lieu of copies of the actual records, unless the third party is a treating psychotherapist (Florida Statute 456.057 & HIPAA Privacy Rule).
- **Fee Disputes:** In the case of a credit card dispute, I reserve the right to provide the needed and adequate documentation (i.e. your signature on the "Therapy Agreements and Consent") that covers the cancellation policy to your Bank or Credit Card Company should you dispute a charge that you are financially responsible for. If your account has a balance, a statement bill will be sent to the home address on the intake form, unless written request is provided otherwise.
- **Couples/Family Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. Before beginning treatment with couples, I will request authorization to facilitate communication and disclose information between parties. Open communication is imperative to achieve goals in the treatment of families and couples. I will not keep "secrets" as doing so would jeopardize the integrity therapeutic process and therapeutic relationships. I reserve the right to discontinue therapy if either party requests that I keep a "secret" in confidence. Should this happen, I will provide referrals to other therapists.
- **Dual Relationships & Public:** Our therapeutic relationship is strictly professional. In order to preserve the integrity of this relationship and for treatment to be most effective, it is imperative that we do not have any relationship outside the therapeutic relationship. Due to the unique nature of the therapeutic relationship, it is vital that strict boundaries are maintained and other relationships (such as business relationships, friendships, social relationships) with each other are avoided. If we have contact in a public setting, I will not acknowledge you in any way that would jeopardize your confidentiality, nor will I initiate making contact with you. Should you choose to acknowledge me, I may not be able to protect your confidentiality.
- **Clinical Consultation:** As a solo private practitioner, I periodically engage in case consultation with trusted colleagues. When consulting with colleagues, I will provide only pertinent clinical information, however do not provide identifying information regarding clients. The purpose of engaging in case consultation, when deemed necessary, is ultimately to provide the best, most thorough, clinical care possible.

PART 5: EMERGENCY CONTACT

It is necessary that **Megan Earles, LCSW, LLC** has someone to contact on your behalf in case of emergencies.

In case of an emergency, please contact the following person(s):

_____

Full Name, Relationship, Phone

I agree to allow Megan Earles, LCSW, LLC to contact the aforementioned emergency contact on my behalf in the case of emergency, as determined by Megan Earles, LCSW. I authorize the release of necessary information to the aforementioned person. I understand that the minimal amount of information necessary, as determined by Megan Earles, LCSW, will be disclosed.

_____

Signature/Date

PART 6: CONSENT TO TREATMENT

I have read and understand the information contained in the consent and therapy agreement. I have discussed any questions that I have regarding this information with **Megan Earles, LCSW**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Megan Earles, LCSW** to provide counseling services that are considered necessary and advisable. I acknowledge that Megan Earles, LCSW or I reserve the right to discontinue treatment at any time.

_____ _____

Client Name (Print) **Date of Birth**

_____ _____

Client Signature **Date**

_____

_____ _____

Printed Name of Parent/Legal Guardian (if required) Relationship

_____ _____

Signed Name of Parent/Legal Guardian (if required) Date

Only complete this page for minor children or dependent adult clients

CONSENT FOR TREATMENT OF A MINOR CHILD (or DEPENDENT ADULT)

STATEMENT OF RESPONSIBILITY AND GRANT OF PERMISSION FOR THERAPY

I, _____, certify that I am the:
(Printed Name of Parent/Legal Guardian)

(Check one): ☐ Parent of ☐ Legal Guardian of

(Name of minor child or dependent adult) (Date of Birth)

CHECK ONLY ONE:

☐ **I certify that I have complete legal authority to consent to treatment of the child/dependent adult. No other person's consent is required.**

OR

☐ **Another person's consent to treatment is also required in addition to my own. I understand that person must also sign this form prior to the commencement of treatment.**

I authorize Megan Earles, LCSW, LLC to conduct therapy with this minor child or dependent adult.

I accept responsibility for the timely payment of all fees due to Megan Earles, LCSW, LLC for services provided to this minor child or dependent adult.

I understand and agree with all the terms and conditions in this agreement.

Signature: _____ Date: _____

Second consenting person's signature (if required):

Signature: _____ Date: _____