RafaelaBuena

THERAPY CONSENT, POLICIES & AGREEMENT

PART `I: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific problem or concern. Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce emotional distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater satisfaction with life. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they attend their therapy sessions with regularity as scheduled. Participation in the process with honesty and engagement is of utmost importance. Make no mistake about it, therapy is work and thus requires time, effort, and a commitment that belies any spurious quick-fix notions around mental health. Increasing your satisfaction with life is an ultimate goal of therapy and one that you should expect to feel as the process moves along; but be aware that there may be particularly charged sessions along the way where you may feel uncomfortable or challenged—all this means is that you are engaged in the necessary work, so trust in the process. Throughout the therapy process, we identify goals, review progress, and modify the plan of treatment as needed.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Discussing unpleasant events from the past as a means to resolving them and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

LENGTH OF THERAPY: The frequency of therapy sessions varies depending on your particular needs and desires, but we typically meet weekly or bi-weekly for 50 minute sessions. Initially, it is difficult to predict the duration of how many sessions will be needed, so we will collaboratively discuss from

Rafaela Buenaventura, LCSW
Florida License #17766

rafa@rafaelabuena.net
904-351-8697
Rafaelabuena.net

session to session what the next steps are and how often therapy sessions will occur. The patient reserves the right to request an increase or decrease to frequency at any time. The patient also reserves the right to end treatment at any time, but I request that you communicate this desire directly to me.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each scheduled appointment and agree to adhere to the following policy:

If you cannot keep the scheduled appointment, you MUST notify my office to cancel or reschedule the appointment within 24 hours of the scheduled appointment time. If you give less than 24 hours notice, you are responsible for payment of your half your regular fee. If you cancel or reschedule appointments excessively, we may re-evaluate your needs, desires, and motivations for treatment.

FEES: The fee for each 50-minute therapy session is $100.00 and payment is due in full at the end of every session. Acceptable forms of payment are: credit/debit card. In the event that a scheduled appointment time is missed or cancelled less than 24 hours, please refer to the "Appointments and Cancellations" policy above.

The clinician reserves the right to terminate the therapy relationship if more than three sessions are missed without proper notification.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged an hourly rate of $120.00 to include travel time, court time, preparing documents, etc.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, the cost is $10.00 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records.

PHONE CONTACTS AND EMERGENCIES: Office hours are from 8am to 7pm, Monday through Thursday. If you need to contact the clinician for any reason please call (904) 351 - 8697, leave a voicemail, and a return call will be made within 24 hours or as soon as possible. In case of an emergency or if you are in acute crisis, please call 911, the mobile crisis unit (904-632-0600) for 24/7 emergency assessment, or visit your nearest ER for stabilization. If either you or someone else is in danger of being harmed, dial 911 or the National

Suicide Prevention Lifeline at 1-800-273-8255.

PART II: CONFIDENTIALITY

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, *except* for the following limitations:

• Child Abuse - Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.

• Vulnerable Adult Abuse - Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.

• Self-Harm: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the patient's safety, which may include disclosure of confidential information.

• Harm to Others: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.

• 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. If I cannot get in touch with you by phone, I will send you written correspondence. 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 therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.

• Written Request: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes." If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.

• Fee Disputes: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake

form unless otherwise noted.

Electronic Communication: If you need to contact me outside of our sessions, please do so via phone or email.

Do not use e-mail for emergencies. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment. E-mail is not confidential. Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it.

PART III: REASONS I CHOOSE NOT TO ACCEPT INSURANCE

• Reduced Ability to Choose: Most health care plans today offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require pre-authorization before you can receive services. This means you must call the company and justify why you are seeking therapeutic services in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company's list. Reimbursement is reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.

• Pre-Authorization and Reduced Confidentiality: Insurance typically authorizes several therapy sessions at a time. When these sessions are finished, your therapist must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an abrupt end of the therapeutic relationship even if a crisis suddenly emerges. Your insurance company may require additional clinical information that is confidential in order to approve or justify continuation of services as "medically necessary." Confidentiality cannot be assured or guaranteed when an insurance company requires this disclosure of information. Even if the therapist justifies the need for ongoing services, your insurance company may decline services. Your insurance company dictates if treatment will or will not be covered, which in my view violates your right to self-determination. Note: Personal information might be added to national medical information data banks regarding treatment.

• Negative Impacts of a Psychiatric Diagnosis: Insurance companies require clinicians to give a mental health diagnosis (e.g. "Major Depressive Disorder" or "Obsessive-Compulsive Disorder") for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

RafaelaBuena

1. Denial of insurance when applying for disability/ life insurance due to a "pre-existing condition"
2. Company (mis)control of information when claims are processed 3. Loss of confidentiality due to the increased number of persons handling claims
4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to: applying for a job, financial aid, and/or concealed weapons permits
5. A psychiatric diagnosis can be brought into court (i.e. divorce court, family law, criminal)
6. It is also important to note that some psychiatric diagnoses are not eligible for reimbursement. This is often true for marriage/couples therapy, adjust- ment disorders or more long-term approaches like psychoanalysis.

Not working with insurance leads to enhanced quality of care and other advantages such as:

1. You are in control of your care, including choosing your therapist, duration of treatment, frequency of sessions, etc.

2. Increased privacy and confidentiality (except for limits of confidentiality outlined above)

3. Not having a mental health disorder diagnosis on your medical record

4. Consulting with me on non-psychiatric issues that are important to discuss but not billable by insurance such as learning how to cope with life changes, gaining more effective communication skills in your relationships, increasing personal insight, exploring ambivalence and developing healthy coping.

After reading my position on why I do not accept health insurance, you may still decide to use your health insurance. Although I choose not to participate in any insurance panels directly, I am willing to provide you with the necessary paperwork for partial reimbursement of services if your insurance accepts out-of-network benefits. Please speak to your insurance company directly for specific reimbursement conditions and limits. If do you elect to submit paperwork to your insurance for purposes of reimbursement, please be aware that a written diagnosis is a requirement for coverage, the risks of which I have detailed above.

EMERGENCY CONTACT: It is necessary that RAFAELABUENA, LLC has someone to contact on your behalf in the case of an emergency or due to a communication breakdown. Who would you like to list as your emergency contact?

_____
Full Name

Rafaela Buenaventura, LCSW
Florida License #17766

rafa@rafaelabuena.net
904-351-8697
Rafaelabuena.net

RafaelaBuena

_____
Relationship

_____
Phone Number(s)

Please check the appropriate box below if you agree and sign below:

□ I agree to allow RAFAELABUENA, LLC to contact my emergency contact and leave a telephone voice- mail on my behalf in the case of an emergency.

□ I agree to allow RAFAELABUENA, LLC to contact my emergency contact, but I do NOT authorize leaving a telephone voicemail on my behalf.

_____

Signature

_____

Date

PART IV: INFORMED CONSENT

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with Rafaela Buenaventura, LCSW. My signature below indicates that I am voluntarily giving my informed consent to receive psycho- therapy services and agree to abide by the agreement and policies listed in this consent. I authorize Rafaela Buenaventura, LCSW to provide psychotherapy services that are considered necessary and advisable.

2. If I elect to submit paperwork to my insurance company for out-of-network partial reimbursement, I authorize the release of treatment and diagnostic information (as described in Part III, above) by Rafaela Buenaventura, LCSW necessary to process bills of service to my insurance company. I acknowledge that I am financially responsible for full payment of services whether or not covered by insurance. I understand, in the event that unpaid fees, Rafaela Buenaventura, LCSW of RAFAELABUENA, LLC may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney, the costs of which will be billed to the client.

Your signature below signifies that you have received a copy of the "Therapy Agreement, Policies and Consent" *for your records and that you agree to all terms therein.*

Printed name

_____

Signature

_____

Date of birth

_____

Date

Rafaela Buenaventura, LCSW
Florida License #17766

rafa@rafaelabuena.net
904-351-8697
Rafaelabuena.net