PSYCHOTHERAPY AGREEMENT

EXPECTATIONS: Counseling can be helpful in a variety of ways, including to assist you with the psychological adjustments that can be associated with childhood traumas, the transition to adulthood (*including in the areas of education, employment and relationships with others*), intimate relationships, child-rearing, parenting, divorce, co-parenting, aging, care-giving, illness, disability, addiction and loss. It can be helpful in alleviating the symptoms of depression and anxiety, and help you develop additional coping and problem solving skills or strategies. It can be used on a short-term basis to address specific needs and concerns, or on an on-going basis, to pursue more comprehensive self-awareness, personal development, change and well-being. Typically, counseling occurs weekly, at the same time each week.

MY GOALS: As your counselor, I am committed to providing you with exemplary care. As part of that care, I will strive to:

- ✓ Listen to you attentively
- ✓ Communicate with you honestly
- ✓ Respect your right to engage in therapy at your own pace
- ✓ Seek to understand you and your life and world from your own perspective
- ✓ Provide you with therapeutic guidance, insight and reflections responsive to your particular needs, circumstance and goals
- ✓ Invite you to share your thoughts and feelings with me, including regarding the process of therapy and how it affects you, and whether you are receiving what you want and need
- ✓ Regard you as a whole and complex person, inherently valuable and with many qualities and attributes beyond the difficulties, symptoms or vulnerabilities you may be experiencing
- ✓ Respect your right to direct and govern your own life, including to decide when you wish to discontinue the process of psychotherapy
- ✓ Help you recognize and draw upon your natural capacities and strengths to attain or sustain the well-being you desire
- ✓ Encourage you to seek alternative or adjunctive assistance if necessary to meet your needs
- ✓ Offer you psycho-educational information that may be helpful in broadening your awareness of those needs, situation, circumstance or experience we discuss
- ✓ Retain a focus on you and your needs in our sessions

SESSIONS: Sessions are generally 50 minutes in length and occur either once or twice a week, unless we have agreed in advance to an alternative duration or schedule. I may recommend sessions of 1.5 hours for couples and families or in other special circumstances.

FEE: You have agreed to pay the following amount_____ per session. Unless other arrangements are made, your payment will be due at the beginning of each meeting. Payment can be made by cash, check, or credit. A fee of $30 will be charged for any checks that are returned unpaid. I can provide you with a monthly statement outlining the payments you have made for your sessions. You can use the statement for tax purposes or for reimbursement if you have a Health Savings Account (HSA).

CANCELLATION: If you need to reschedule or cancel an appointment, please *provide at least a full 24-hour's notice by calling my private voice mail.* A full session fee will be charged for any session that is missed or cancelled without the requested notice.

CONFIDENTIALITY: With the exception of certain specific exceptions described in this agreement, the information that you share in therapy is confidential and will not be discussed or released to anyone without your written permission and consent, unless required by law. I cannot and will not tell anyone else what you have shared with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will only do so in the event of an emergency or for the purposes of consultation. I will always act to protect your privacy even if you authorize me to release information to another party. You may direct me to share information with whomever you choose, and can also revoke that permission at any time. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA).

If you elect to communicate with me by email, I am willing to respond briefly by return email, but please be aware that email and other electronic media are not completely confidential. I do not use an encrypting program on email at this time.

The following are legal exceptions to your right to confidentiality:

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or tell me about someone else who is abusing a child or vulnerable adult, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.

3. If I believe that you are in imminent danger of harming yourself, I am legally permitted to call the police or our county's mobile crisis response team. I am not obligated to do this, and would pursue other options with you before-hand if possible. If you cannot take steps to guarantee your safety, I will call 911 to conduct a welfare check or call the local crisis team.

4. If you are being seen as part of a couple or family, you will be asked to review and sign a special agreement which outlines exceptions to confidentiality as it relates to your partner/family member.

AVAILABILITY: If you need or want to speak with me in between sessions for reasons concerning scheduling or other urgent or timely matters, please call my private voice mail number and I will return your call as soon as possible, generally within 24 hours. Please be clear in your message regarding whether or not you wish to speak with me immediately.

EMERGENCY: I do not have 24-hour emergency or "on call" coverage. If you believe you will need a therapist with 24-hour coverage I will be happy to provide you with a referral to an agency. If you are experiencing an emergency, and I am not available to assist you in acquiring the appropriate services, please go to your nearest emergency room or call 911. When I am out of town for an extended period of time, I will give you the name of a colleague you can contact in case of an urgent need.

INSURANCE: If you are enrolled in an insurance program that provides reimbursement for out-of-network psychotherapy, I can provide you with a monthly service and fee statement if requested. I cannot bill your insurance carrier directly.

DIAGNOSIS: If you are submitting bills to your insurance carrier for reimbursement, I am normally required to provide them with a diagnostic code. If I provide you with a diagnostic code, I will discuss it with you in advance.

RECORD-KEEPING: I keep brief records of each session noting the dates we meet, the topics we cover, progress reports from the client's perspective, interventions and impressions from the therapist and next steps.

DISCONTINUATION: You can discontinue psychotherapy at any time. If possible, I recommend reserving a minimum of two to three weeks for a closure process, so you can leave with a sense of completion. If for some reason, I have determined I cannot or am not assisting you effectively, I will refer you to other providers.

CLIENT CONSENT TO PSYCHOTHERAPY: I have read and considered this agreement carefully. I have clarified any questions I have, and understand all that is specified in this agreement.

I understand that I will be receiving psychotherapy from the following therapist:

Name: RaShun A. Stewart

I understand that this therapist is a: Licensed Professional Counselor

License Number:

I have read this Psychotherapy Agreement, and agree to its terms, by signing below.

Client's signature: Date:_____