AGREEMENT FOR SERVICE/ INFORMED CONSENT

This agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Constance G. Hall, Licensed Marriage and Family Therapist, MFT 40416 (operating under the business name Connie Hall Therapy) and is intended to provide Client with important information regarding the practices, policies, and procedures of Connie Hall (herein Therapist), and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Any questions or concerns regarding the contents of this agreement should be discussed with the Therapist prior to agreeing to it.

Risks and Benefits of Therapy

Participating in therapy may result in a number of benefits to the Client, including, but not limited to reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self- confidence. Such benefits may also require substantial effort on the part of Client, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts, and behaviors. There is no guarantee that therapy will yield any or all the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge the perceptions and assumptions of the Client and offer different perspectives. The issues presented by Client may result in unintended outcomes, including changes in personal relationships.

During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth may be easy and swift at times but may also be slow and frustrating. Client should address any concerns he/she has regarding progress with Therapist.

Confidentiality

The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except when permitted by law. Exceptions to confidentiality include, but are not limited to reporting child, elder, and dependent adult abuse; when a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another.

Psychotherapist-Client Privilege

The information disclosed by Client, as well as any records created, is subject to the psychotherapist- client privilege. The psychotherapist-client privilege results from the special relationship formed between the Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the Client is the holder of the privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a

court of law, Therapist will assert the psychotherapist-client privilege on Client's behalf until instructed in writing to do otherwise by a person with the authority to waive the privilege on Client's behalf. Client should be aware that they might be waiving the psychotherapist-client privilege if they make their mental or emotional state an issue in a legal proceeding.

Appropriateness for sessions

Patient is expected to be present and ready for sessions. Sessions where patient is under the influence of drugs or alcohol may be cancelled at the full cost of the session.

Fee and Fee Arrangements

The usual and customary fee for service is $250 per 60-minute session. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjust at least three weeks in advance of the effective date of the new fee. Therapist works on a sliding scale for uninsured clients and slides to one half the full fee, or $125.

Insurance

Therapist accepts the following insurance providers: Blue Shield of California, Cigna, Aetna, United Healthcare, Optum, Health Net. Therapist bills insurance providers on Client's behalf; Client is responsible for Copay only.

Cancellation Policy

Client is responsible for payment of the agreed upon fee for any missed sessions. Client is also responsible for payment of the agreed upon fee for any sessions for which Client failed to give Therapist at least 24 hours' notice of cancellation. Cancellation notice may be sent via text or email. Therapist will take into consideration illnesses by the Client as a matter of possible exception to this policy. Abuse of this exception may result in the exception being revoked on a case-by-case basis.

Therapist Availability

Therapist's voice mail is confidential, and Client may leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day) but cannot guarantee that calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. If Client is feeling unsafe or requires immediate medical or psychiatric assistance, Client should call 911 or go to the nearest emergency room. Therapist will not respond to any text messages that are not within the context of scheduling appointments or phone calls. Any more personal communication should be sent via email or voicemail; text messaging is insecure.

Termination of Therapy

Therapist reserves the right to terminate therapy at their discretion. Reasons for termination include, but are not limited to, failure to comply with treatment recommendations, conflicts of

interest, failure to participate in therapy, Client needs are outside the Therapist's scope of practice or competence, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at their discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Client participate in a termination session to review progress and make recommendations for after care treatment and identify potential vulnerability factors that may necessitate for Client to return to therapy. This session is intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done.

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Acknowledgement

By agreeing to treatment, Client acknowledges that they have reviewed and fully understand the terms and conditions of this agreement. Client has discussed such terms and conditions with Therapist and has had any questions with regard to its terms and conditions answered to Representatives satisfaction. Representative agrees to abide by the terms and conditions of this agreement and consent to participate in psychotherapy with Therapist.

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that Therapist provider may wish for me to engage in a telehealth session.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a session will not be the same as a direct client/health care provider visit because I will not be in the same room as my provider.
3. I understand that a telehealth session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth session/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions about this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
6. I understand that my therapist is legally required to confirm my name and address at the beginning of every telehealth session.
7. I understand that my therapist will evaluate my appropriateness for participating in telehealth during each session. If it is determined that I am not suitable for the session, I understand that I am responsible for any fees that may result from a late cancelled session.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Printed Name

Signature Date