

# ANNIE TEMPLE, LCSW



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## Treatment Agreement

Welcome to my practice. This document includes important information about my professional practice and business operations; in addition, it contains information about how I will manage your Protected Health Information (PHI) as mandated under HIPAA (Health Insurance Portability and Accountability Act). As with any relationship, it is important to outline the boundaries, limitations, and expectations at the outset. Please read through this document and feel free to ask any questions you may have. Once this document is signed, it will represent an agreement between us.

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Confidentiality & Privacy Policy

The law protects the relationship between a client and a psychotherapist, and information cannot be disclosed without written permission.

Exceptions include:

- Suspected child abuse or dependent adult or elder abuse, for which I am required by law to report to the appropriate authorities immediately. This includes physical, mental, and sexual abuse, as well as neglect.
- There is a duty to warn (“Tarasoff”) an identifiable victim of serious threats of physical violence made by the patient or patient’s family members. (CA Civil Code 43.92 (a))
- There is a reasonable suspicion that you are a danger to yourself or others.

Other instances may include subpoena or court order as well as information needed to bill insurance companies (when applicable). Please note that you will be informed of any disclosure beforehand and that in the case of disclosure, I will make every effort to provide the least amount of information necessary to abide by the law.

Sign below to confirm that you have reviewed and understand the confidentiality and privacy policy.

→ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Professional Record Keeping

At this time, I utilize protected electronic and paper records, which will be secured under three locks at any given time, in accordance with HIPAA guidelines. Records may include forms completed, dates of sessions, types of services provided, diagnosis/differential diagnosis, symptoms, treatment plans/goals, and progress in therapy. Per California law, records will be kept at a minimum of 7 years post treatment termination date or 7 years after a client’s 18th birthday.

You have a legal right to review your records and may make a written request to review records at any given time. As is standard practice, I will provide a summary statement of your record unless there is a specific reason the entire record must be produced. Upon such a request, I will provide your record or summary statement of your record within 14 days. Please note that I will treat any information provided by third parties as part of your records and protect them as such. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. In the event that you do review the full records, I recommend that they are reviewed in my presence so that we can discuss the contents. Finally, as per NASW Code of Ethics, if there is compelling evidence that providing records would cause serious misunderstanding or harm, I will make an effort to interpret records and/or withhold potentially harmful portions of records.

### **Session Times, Fees and Payment**

Intake sessions are 60 minutes and subsequent sessions will be 50 minutes in duration. The cost per session is \$130 and is due at the time of service via cash, check or credit card. If utilizing insurance benefits, copayment is due at the time of service. I will make every effort to bill insurance companies that I am contracted with; however, if insurance fails to pay, clients are responsible for the full fee.

A limited number of reduced fee cases are offered on a sliding scale basis. Special arrangements can be made for on-site visits, extended sessions, or special accommodations. Fees associated with these services will be discussed in advance. Please note that I reserve the right to periodically adjust the fee. You will be notified no less than 30 days in advance of any fee adjustment.

### **Court Involvement and Subpoenas**

I strongly prefer not to get involved in legal matters pertaining to clients. I ask that my clients refrain from involving me in legal matters including issuing subpoenas. It is my desire and ethical obligation to preserve the confidentiality and trust that is established in the counseling relationship. Having me and/or my records subpoenaed often damages this relationship. It is in your best interest to know that conducting expert witness testimony is not my area of expertise. I can refer you to another professional who can provide this service if needed. I will not attend court or deliver my records unless a valid subpoena is issued. If you cause a subpoena to be issued for me or my records, you will be responsible for all charges involved. If you or your child become involved in legal proceedings that require my participation from another party, you will be responsible for all charges. Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I will bill the party responsible for my participation at the rate of \$390 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs. Please note you may be responsible to pay my fees for participating in legal matters even if you did not cause my involvement.

### **Child Custody Legal Involvement**

I strongly desire to remain uninvolved in any court or custody-related proceedings. By signing this consent, you are acknowledging that this is not an area of expertise for me and that compelling me to participate in such proceedings likely will be detrimental to my relationships with you/your child/your

family. You agree that in any child custody/visitation proceedings, neither parent will seek to subpoena treatment records or ask me to testify in court, whether by person or by affidavit, or to provide letters or documentation expressing their opinion about parental fitness or custody/visitation arrangements. Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness at or otherwise perform work related to any legal matter, I will bill all time (time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs) at a rate of \$390 per hour, and you will be responsible for these fees even if we are called to testify by another party.

Acknowledgment: I understand that Annie Temple's fee for work related to **any legal matter** is \$390 per hour and additional time is billed at a prorated rate. \_\_\_\_\_ initial(s)

### **Communication and Social Media Policy**

Please contact me via phone (530) 419-5551 or email annietemplepsychotherapy@gmail.com if you need to get in touch with me. I will return calls within 24 hours unless you indicate that it is urgent. I only accept text messages for scheduling/rescheduling, cancellations, or other brief messages. In general, all other communication will take place during scheduled therapy sessions. If there are urgent therapeutic issues that require a phone session, these will be billed at the regular rate of \$130/session. In the case of a crisis or psychiatric emergency, it is important that you call 911 or go to your nearest hospital emergency department.

Please note that I do not accept friend requests on social media (e.g., Facebook, Instagram, Twitter) from current or previous clients in order to preserve the boundaries of the therapeutic relationship and to ensure that your confidentiality is maintained.

### **Risk Disclosure**

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, for therapy to be effective, active participation is necessary during the treatment process. During treatment, you will be asked to try new ways of thinking and behaving in order to achieve your treatment goals. Additionally, you may be asked personal questions in order for the clinician to better understand your needs. You are encouraged to engage in this process and voice your goals for therapy. However, these improvements cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Uncomfortable feelings and thoughts may arise throughout therapy and are a normal part of the process. If at any point you believe therapy is harmful, I recommend you speak with me in order to process what is happening during therapy and determine whether continuing therapy would benefit you.

## **Insurance**

Please note that insurance companies usually require the therapist to identify a clinical diagnosis. Sometimes I must provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). Whatever information is disclosed to your insurance company will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

## **Cancellation Policy**

Scheduling an appointment involves the reservation of time specifically for you. Once an appointment hour is scheduled, you will be expected to pay the standard fee for it unless you provide 48 hours advance notice of cancellation with exception of health emergencies. If you are late for a session, I am not required to extend the appointment to make up for lost time, and if you have not called ahead, I may not wait more than 25 minutes.

Acknowledgment: I understand that I must cancel sessions 48 hours in advance, or I will be billed for the scheduled hours (\$130). \_\_\_\_\_ initial(s)

Sign below to confirm that you have reviewed and understand the cancellation policy.

→ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Consent to Treatment**

I consent to receive therapy services with Annie Temple, LCSW. I understand that while I expect benefits from this treatment, I fully understand and accept that many factors are outside of our control and such benefits cannot be guaranteed. I have the right to refuse treatment at any time and the right to be informed about the risks of stopping therapy. I understand that I have the right to ask any questions about my care and am encouraged to take an active role in my treatment.

Sign below to confirm that you have reviewed the treatment agreement and understand the risk disclosure.

→ Signature: \_\_\_\_\_ Date: \_\_\_\_\_