NEW LEAF
COUNSELING OF THE RIVER VALLEY

Informed Consent and Therapeutic Contract

with Bryant Prieto, MS, LPC-TA, NCC, ACCTS, EMDR-CT

PART I: THE THERAPY PROCESS

Participating in therapy can result in a number of benefits, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in your experiencing discomfort. Change often will be easy and swift, but it can also be slow and somewhat frustrating. Remembering unpleasant events and resolving them through therapy can bring on strong feelings which have to be dealt with. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended.

As part of my therapeutic process, I use several techniques including Emotionally Focused Therapy (EFT) and Eye Movement Desensitization and Reprocessing (EMDR) Therapy. My theoretical perspective is a combination of Family Systems Therapy, Structural Family Therapy, Cognitive Behavioral Therapy, and Attachment Theory being the major theoretical perspectives.

PART II: CLIENT'S RIGHTS

You have the right to a confidential relationship with me. Within certain legal limits (see #3 below), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission.

1. You will have the right to know your records at any time and I have the right to provide you with the complete records or summary of their content.

2. If you ask me, I can release any part of your records on file with me to any person you specify. I will tell you when you make your request whether or not I think releasing this information to that agency or person might be harmful to you at any time.

3. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:

    a. If you reveal information to me about active child abuse or neglect, elder abuse, or dependent physical abuse, I must make a report to protective services. When a perpetrator of child abuse is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors, I must also report that information.

b. If you seriously threaten harm or death to another person, I am required to warn the intended victim ad notify the appropriate law enforcement agencies.

c. If you are in therapy or being tested due to an order of a court or lawyer, the results of the treatment or tests ordered must be revealed to that court or lawyer.

d. If a court of law issued a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.

e. If you are in a lawsuit where emotional harm is being claimed, the opposing side may subpoena your records.

4. You have the right to ask questions about any of the procedures used in the course of your therapy. If you ask, I will explain my customary approach and methods with you.

5. You have the right to choose NOT to receive therapy from me. If you choose this, I will provide you with names of other qualified professionals whose services you might prefer.

6. You have the right to terminate therapy with me at any time without any financial, legal or moral obligations other than those you've already incurred. I have the right to terminate therapy under the following conditions.

    a. When I believe that therapy is no longer beneficial to you

    b. When I believe that you will be better served by another professional, whom I will recommend. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent from you, I will provide that professional with essential information she or he requires.

    c. When you have not paid for the last two sessions, unless special arrangements have been made with me.

    d. When you have failed to show up for your last two therapy sessions without a 24-hour notice.

If any of these situations apply, I will send you a certified letter to your address of record to inform you of my decision, and I will give you the names of several therapists for your future counseling needs.

As life can bring unexpected circumstances, should I be unavailable to continue your therapy, provisions will have been made beforehand, and you will be contacted by my trusted colleague, Dr. Monty Atchley, to discuss what would be best for you at that time.

NEWLEAF
COUNSELING OF THE RIVER VALLEY

Informed Consent, Fee Schedule, and Therapeutic Contract

with Bryant Prieto, MS, LPC-TA, NCC, ACCTS, EMDR-CT

Client's Printed Legal Name: _____

Legal Guardian Printed Name (if client is a minor): _____

Relationship to the Client (if not the client): _____

Phone Number: _____

PART III: FEES AND LENGTH OF THERAPY

I, or legal guardian of the client, agree to enter therapy with Bryant O. Prieto, MS, LPC-TA, NCC, ACCTS, EMDR-CT for as needed 50-minute sessions during the next year consent.

I (or my current health insurance provider) agree to pay the standard fee of $257.00 for each completed Individual/Family Session (prorated for longer sessions), or $290.00 for a Diagnostic Evaluation, or as agreed upon between the provider and the health insurance provider in the fee schedule. I will make payment in cash, debit or credit card at the time of the therapy appointment, unless we have made other arrangements and said arrangement has been documented in my chart. I agree that I am financially responsible if my insurance company denies any payment on any claim made on my behalf for myself, or my dependent's, treatment. I understand that I can leave therapy at any time and that I have no financial (except what has accrued), legal, or moral obligation to complete therapy services in this contract. I am contracting only to pay for completed therapy sessions, sessions I miss without providing 24-hour notice, no-shows, and telephone time as delineated further down in this contract.

_____
INITIAL

Court Related Fees: Mental Health Therapists do not normally make court appearances. If court ordered (subpoenaed), the therapist is legally bound to comply with the court order. However, the charge of $3,500.00 per day for any court related activities will be charged to the client/attorney requesting the court order, regardless of whether or not the therapist actually testifies or not. This includes any court order (subpoena) from opposing counsel/attorney, seeing as this particular situation is contingent on the client signing a release of information legally authorizing the opposing counsel direct access to their case including, but not limited to: release of diagnostic evaluation, progress notes, demographic information, as well as the possibility of the therapist having to testify concerning information pertaining to the client's mental health record and/or clinical observations. By signing such a release of information, the client is assuming financial responsibility in the case of an opposing counsel/attorney requiring the therapist to testify as to their mental health record. This includes an additional cost for travel to and from court. The therapist will block their schedules for a minimum of four (4) hours, unless otherwise notified ahead of time to block out more time, whether the therapist actually testifies or not. The entire fee must be paid prior to the therapist leaving the office for the court date. In addition, a fee of $500.00 an hour will be charged for having to testify at

a deposition, as well as an additional charge for travel expenses to and from the deposition. Since there is no way to determine the length of time a deposition will take a minimum of two (2) hours will be blocked off on the therapist's schedule and will be charged before the therapist leaves for the deposition. Any additional time will be charged immediately after the deposition, unless prior arrangements have been made between the client and the therapist and have been formally documented in the client's chart. The therapist will not be on-call for court testimony or depositions without receiving retainer for the time scheduled to be on-call at the rates mentioned above. We do not apply scholarship assistance to time spent making court appearances. We reserve the right to file a complaint with the Arkansas Bar Association for non-payment if necessary.

_____
INITIAL

If the therapist prepares correspondence or documentation for you during a therapy session, the normal fee will be applied for the session. However, a $220.00 per hour prorated fee will be charged for all correspondence prepared outside of clinical sessions. If the therapist must prepare a letter for immigration purposes a set fee of $600.00 will be charged for said letter or documentation. You will be charged $20.00 for copying and forwarding records if correspondence is not necessary. I understand that these fees are for services that my insurance plan does not cover and would hence be my responsibility to pay for.

_____
INITIAL

Telephone Time: After 5 minutes of telephone time, you will be charged a prorated fee at your regular fee of $217.00 per hour for the time incurred. Therapists do not normally speak to attorney's over the phone, but if a situation requires for this type of communication to occur a prorated fee of $185.00 per hour will be charged to you, and you will be held responsible for this fee.

Client's Signature: _____ Date: _____

Parent or Guardian Signature of minor child: _____

Staff Signature: _____

PART IV: CONSENT FOR TREATMENT

I authorize Bryant O. Prieto, MS, LPC-TA, NCC, ACCTS, EMDR-CT to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of my treatment as a client.

I understand that the purpose of any procedure will be explained and be subject to my agreement.

I acknowledge that no guarantees have been made to regarding the results of this treatments.

I understand that within the scope of this treatment there is no intent to cause detrimental effects to the individual.

I understand that I may withdraw consent for treatment at any time.

The consent is effective for one year from the day of my approval.

I have read and fully understand this Consent for Treatment form.

Client's Signature: _____ Date: _____

Parent or Guardian Signature of minor child: _____

Staff Signature: _____

PART V: OFFICE COMMUNICATIONS

I agree to and understand that any information that I send/receive to/from NewLeaf Counseling via text messaging, email, or other means such as Facebook Messenger is not secure per the requirements of the Health Information Portability and Accountability Act of 1996 and that any data sent thereby could be compromised.

Client's Signature: _____ Date: _____

Parent or Guardian Signature of minor child: _____

Staff Signature: _____

PART VI: OFFICE POLICIES

Payment for Service: You are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify me if any problems arises regarding your ability to make timely payment.

Initials: _____

Cancellation and No-Show Policy: Clients will be billed $50.00 dollars for any **therapy, counseling, or testing sessions** that they cancel with less than 24 hours' notice, as well as if they fail to show up for any scheduled appointment. It is required that clients leave a card on file in order to maintain up-to-date with account balance, and to keep from having to send monthly bills, unless other arrangements are made, in writing, between client and therapist. Cancellation/No-Show fee will be billed to the credit card we have on file for a client or billed to the address you've provided if card on file does not work.

Appointments made the same day will be charged the cancellation policy if a client does not show up.

This fee is charged without exception unless waived by the Therapist.

To cancel an appointment (including over a weekend) you may:

1) Call 479-709-2369 and leave a message
2) Email contact@newleafbh.com and write "Cancel Appointment" in the email subject line.

If you decide you need to cancel a Monday appointment, you need to contact us and leave a message by the appropriate time on the Sunday before.

Concerning our No Show policy, missing or no showing *any* two (2) scheduled therapy appointments within a three month period of time will be an automatic discharged from services with New Leaf Counseling. If a client misses or no shows any three (3) scheduled therapy sessions within the span of six (6) months they will be an automatically discharged from services with New Leaf Counseling.

If you are discharged for any reason, you have the right to request that the decision be reconsidered by the therapist. Clients are fully aware of the fact that when they schedule an appointment, they are booking an hour slot for themselves that other clients are not able to have. When you late cancel or no show an appointment this is an hour slot that was not billed. The fee charged is primarily only to cover the overhead for being able to run the business. In the case of reconsidering an automatic discharge, the client may be offered being forgiven one (1) of the No Shows of they are willing to pay the full rate (minus $50 fee already paid) for the last No Show appointment.

We do everything in our power to avoid a financial burden for our clients, which is why, if you are unable to make your appointment "in-person" due to transportation issues, etc. you may call, text, or email our office at your soonest convenience (prior to your appointment time) to request to be switched to a Telehealth service in order to avoid a No Show/Cancellation fee.

Phone/Text: (479) 709-2369
Email: contact@newleafbh.com

While we hate to have a cancellation/no show policy, it is important to ensure that our therapist's limited availability does not get wasted.

Initials: _____

Telephone Time: After 5 minutes of telephone time, you will be charged a prorated fee at your regular fee of $257.00 per hour for the time incurred. Therapists do not normally speak to attorney's over the phone, but if a situation requires for this type of communication to occur a prorated fee of $200.00 per hour will be charged to you, and you will be held responsible for this fee

Initials: _____

Sessions Greater Than 50 Minutes: Sessions that go beyond 50 minutes will be prorated to the nearest quarter hour, unless you have made prior arrangements with me.

Initials: _____

Emergency Procedure: An emergency is an unexpected event that requires immediate attention and can be threat to your health. If an emergency situation arises, please state that when you leave your message and I will return your call a soon as possible. If I have not called you back within 60 minutes, the emergency persists, or the emergency requires it, please call your primary care physician or admit yourself to a hospital for observation. Please refer to the following services in case of after-hours crisis:

Crisis or Emergency Line: 1-800-542-1031

Initials: _____

PART VII: NOTICE OF PRIVACY PRACTICES:

This notice describes how health information about you may be used and disclosed, and how you may obtain to this information.

PLEASE REVIEW IT CAREFULLY.
The privacy of your health information is important to us.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. These requirements are a part of the Health Information Portability and Accountability Act of 1996 (also known as HIPAA). We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our Notice of Privacy Practices at any time, including any revisions of the Notice of Privacy Practices. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed below.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For Example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your healthcare information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclose permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Initials: _____

I have read, and by signing below, express understanding and agreement of the Office Policies enlisted above.

Client's Signature: _____ Date: _____

Parent or Guardian Signature of minor child: _____

Staff Signature: _____

CREDIT/DEBIT CARD TO LEAVE ON FILE

Patient Name: _____

Card Type: _____

Card Number: _____

Expiration date: _____

Zip Code: _____

3-digit code: _____

I hereby authorize NewLeaf Counseling of the River Valley, Inc to keep this card on file, and may use this card to pay for services that are not paid for in-person, or for services *not* covered by my insurance provider, unless I specifically request that another card be utilized.

Client Signature: _____

Date/Time: _____

Parent/Guardian Signature: _____

Date/Time: _____

Staff Signature: _____

Date/Time: _____