Couples Counseling Contract

Thank you for choosing to see Anne Evans-Cazier, LCSW. I look forward to working with you. This agreement is to clarify the business aspects of our relationship, and to help our therapeutic relationship to go smoothly. Please print this contract, supply the following information, read and sign it, and bring it to your first session with me. We will make time for any questions you have.

Partner 1:

Last Name ________________________ First Name ___________________________ Initial
Date of Birth ___________________ Age ______ Gender ________ Marital Status: _________________
Home Address : Street _______________________________City _______ State___ Zip ___________
Phone(s) ____ Email __________________________
Preferred method of contact: (circle one): phone voice message text email
How did you find the clinic? ____
In case of emergency, the name, address and telephone number of a person I may contact:
____

Relevant medical conditions (history, current condition, changes in condition)
____
____
____
Medications: Are you currently taking any psychotropic medications? (circle one) Yes No
Please list along with any other medications (dosage, dates of initial prescriptions, name of prescribing doctor) ____
____
____
Allergies/adverse reactions to treatment ____
____
____
Primary Care Physician Name ______________________________ Phone __________________________
Address____

Have you ever received therapy before? (circle one) Yes No
Therapist's Name ____________________ Address ____
Phone ___________ Was it helpful? ____
Are you currently seeing a psychiatrist? (circle one) Yes No
Psychiatrist's Name ___________________ Phone ____
Address ____

Couples Counseling Contract (cont.)

Partner 2:

Last Name ________________________ First Name ___________________________ Initial _____________
Date of Birth ____________________ Age _______ Gender ________ Marital Status: __________________
Home Address : Street ________________________________City ________ State___ Zip ____________
Phone(s) ____ Email __________________________
Preferred method of contact: (circle one): phone voice message text email
How did you find the clinic? ____
In case of emergency, the name, address and telephone number of a person I may contact:
____

Relevant medical conditions (history, current condition, changes in condition)
____
____
____
Medications: Are you currently taking any psychotropic medications? (circle one) Yes No
Please list along with any other medications (dosage, dates of initial prescriptions, name of prescribing doctor) ____
____
____
Allergies/adverse reactions to treatment ____
____
____

Primary Care Physician Name ______________________________ Phone __________________________
Address____

Have you ever received therapy before? (circle one) Yes No
Therapist's Name ____________________ Address ____
Phone ___________ Was it helpful? ____

Are you currently seeing a psychiatrist? (circle one) Yes No
Psychiatrist's Name ___________________ Phone ____
Address ____

Important policy information for both partners:

IF YOU NEED TO CONTACT ME

I can be reached for routine matters during business hours by phone, voice mail or text at 801-419-3312. Do not leave emergency messages on this line.

If you or a family member have an emotional or behavioral crisis call the *University of Utah Neuropsychiatric Institute at 801-583-2500,* or call *911*, or go to the nearest emergency room. I will make every effort to return your call promptly, with the exception of weekends, holidays and during the night time. You may also contact me via email at *anne@ResilientLifeCenter.com* to communicate about scheduling issues only. Therapy happens in my office, during our scheduled time, not by text and email. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact for continuing treatment.

TELEHEALTH:

Telehealth involves the use of the telephone, mobile devices, or interactive video conferencing, and is recognized by the UT state DOH. VSee is the HIPPA complaint video conferencing platform that I use. I am not able to use FaceTime, Skype, or other social media platforms. Telehealth is available for clients who privately pay and for clients whose insurance covers this service. If your insurance does not cover this service, it is possible to privately pay on an as-needed basis. In-person appointments are more ideal for certain treatments and there may be times where the intensity of your symptoms or needs may require we meet in the same physical space. I am happy to discuss a plan that addresses your individual needs.

ELECTRONIC COMMUNICATION:

As electronic modes of communication in social and professional situations is now so common the following information is provided to clarify my specific practices. Ethical and lawful communication that protects your privacy is my goal. If you have any questions, please feel free to discuss this with me.

Email and Text Communications

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages should be limited to things like setting and changing appointments, billing matters, and other related issues.

FEES AND BILLING

Clients are expected to pay the fee, agreed before therapy has begun upon, at the end of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments.

The full session fee will be charged for late cancellations and no shows. To avoid a late charge please cancel your appointment 24 hours in advance. Please do not come to the office if you are sick, even if it less than 24 hours in advance, please call and let me know you will not be coming in to avoid a no show fee of the full session charge.

Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. If agreed upon, I will provide you with a copy of your receipt, which you can then submit to your insurance company for reimbursement if you so choose. You should be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems which are dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If you have difficulties with your insurance company and/or with payment, please talk with me about it as soon as possible.

If your account is overdue and there is no written agreement on a payment plan, your signature below means that I can use legal or other means (courts, collection agencies, etc.) to obtain payment and that you agree to pay all attorney fees, court costs, filing fees, including charges or commissions, up to 50%, that may be assessed to me by a collection agency retained to pursue this matter, with or without suit. You further agree to pay interest at the rate of 1 ½% per month (18% per year).

Fees are reviewed and typically increased once a year.

CONFIDENTIALITY

I will make every effort to keep the information your share with me confidential. I will ask you to sign a release of information form before I discuss your treatment or send my records about you to anyone else.

At times I find it helpful to consult with other health and mental health professionals about my cases. During consultations, I make every effort to avoid revealing the identity of my clients. The consulted professionals are also legally bound to keep the information confidential. Unless you request otherwise in writing, I will not tell you about these consultations unless I feel that it is important to our work together. Unless you specifically request otherwise, your signature on this Agreement provides consent for this.

Electronic communication can be accessed by unauthorized people, compromising privacy. E-mails are particularly vulnerable to unauthorized access. Faxes can be sent mistakenly to the wrong address. Some phone systems are vulnerable. Please do not use e-mail, faxes or texts in emergency situations. I make every effort to safeguard your confidentiality, but as an extra precaution, do not text or email me anything you do not want a third party to see.

Your confidentiality/privacy is protected by state law and the rules of my profession with a few specific exceptions, which are detailed in the accompanying Notice of Policies and Practices to Protect the Privacy of Your Health Information.

LIMITS OF CONFIDENTIALITY YOU SHOULD KNOW ARE:

1. If you are sent to me by a court or an employer for evaluation or treatment, the court or employer expects a report from me. You have a right to tell me only what you are comfortable with telling.

2. If you are involved in a lawsuit and you tell the court that you are seeing me, I may then be ordered to show the court my records. Please consult your lawyer with these issues.

3. If you make a serious threat to harm yourself or another person, the law requires me to protect you or that other person.

4. If I believe a child or dependent adult has been or will be abused or neglected I am legally required to report this to authorities. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

5. If you choose to submit a claim to your insurance company, they will frequently ask for more information on symptoms, diagnoses, and my treatment methods. This will become part of your permanent medical record.

NO SECRETS POLICY

When you enter counseling as a couple, the couple is considered to be one unit. This means that my allegiance is to the couple "unit" and not to either partner as individuals. I find this is particularly important in creating a space where both partners can feel safe. Therefore, I adhere to a "No Secrets" policy, which means that I will not hold secrets for either partner. This policy is intended to allow me to continue to treat the couple by preventing, to the extent possible, a conflict of interest arising in which an individual's interests may not be consistent with the interests of the unit being treated. On occasion during the counseling process, individual partners may be seen for an individual counseling session. In this case, the individual session is still considered to be part of the couple's counseling relationship. Information disclosed during individual sessions may be relevant or even essential to the proper treatment of the couple. If an individual chooses to share such information with me, I will offer the individual every opportunity to disclose the relevant information and will provide guidance in this process. If the individual refuses to disclose this information within the couple's session, I may determine that it is necessary to discontinue the counseling relationship with the couple. This policy is intended to maintain the integrity of the couples counseling relationship.

MEDIATION AND ARBITRATION

If a dispute arises out of or relates to this Agreement, the breach thereof, or the treatment or therapy that is the subject of this Agreement, and if the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered in Utah, by the American Arbitration Association under its Commercial Mediation Procedures before resorting to arbitration. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

LIMITATION OF LIABILITY

The parties agree that in the event that any dispute arises from the provision of services pursuant to this Agreement, including but not limited to claims of malpractice, negligence, breach of contract, or any other legal theory, if the client prevails the client shall be entitled to recover no more than $50,000.00 or the total amount of fees paid, whichever amount is greater. It is the parties' intention to fix an amount that is reason-

able in the event a dispute arises, with mutual acknowledgement that establishing the actual monetary value of damages in such an action would be inherently subjective and uncertain, and that Evans Counseling's willingness to provide the services set forth in this Agreement depends on this agreed limitation to Evans Counseling's potential liability arising from providing the services. This clause is to be construed in accordance with Utah law on limitation of liability.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (clients) nor your attorneys, nor anyone else acting on your behalf will call on me, Anne Evans-Cazier, to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

YOUR SIGNATURE BELOW IS CONSENT FOR TREATMENT AND INDICATES THAT YOU HAVE READ AND AGREE TO THE TERMS OF THIS AGREEMENT AND ACKNOWLEDGES THAT YOU HAVE RECEIVED A COPY OF EVANS COUNSELING'S NOTICE OF PRIVACY PRACTICES AND UNDERSTAND THAT IF YOU HAVE ANY QUESTIONS REGARDING THE NOTICE OR YOUR PRIVACY RIGHTS, YOU CAN CONTACT ANNE EVANS-CAZIER AT THE ABOVE ADDRESS.

Client Name ____

Signature (Client)____ **Date**______________

Client Name ____

Signature (Client)____ **Date**______________

Signature (Therapist)____ **Date** ______________

Anne Evans-Cazier, LCSW Evans Counseling, LLC | Resilient Life Center
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