EVOLVE

COUNSELING ✤ WELLNESS

Dorian Race, D.C., M.S.

1550 Lake Baldwin Lane, Suite B ♦Orlando, FL 32814 ♦407.616.5948 ♦evolvecounselingorlando.com

CLIENT-THERAPIST PROFESSIONAL AGREEMENT/ INFORMED CONSENT FORM

Welcome to my practice! I look forward to our work together as you seek to make positive, healthy changes in your life. Taking this first step toward new personal growth, like any new situation, can be both exciting and anxiety-provoking, in part because you do not know what to expect. I want to make your experience with me as comfortable and productive as possible. Therefore, in an effort to provide you with important information about our work together, and to promote a trusting and well-informed therapy relationship, I have constructed this document, which outlines crucial elements of the therapy experience as well as information about my professional services and business policies. Please read it carefully and make note of any questions you might have so that we can discuss them together before initialing and signing the sections below. This document will represent our professional agreement with one another, so by initialing and signing below, you are agreeing to the terms of this Professional Agreement and Informed Consent Form ("Agreement").

ABOUT ME

I have a Master's of Science degree from University of Central Florida in Clinical Psychology. I am a Registered Intern with the Florida State Department of Health, Division of Medical Quality Assurance, which allows me to practice under supervision until the internship period has ended. My licensure number is IMH12406. I am working under the supervision of Keri Nola, a Licensed Mental Health Counselor, MH9466. If you have any questions about my background or experience, please do not hesitate to ask.

PSYCHOLOGICAL SERVICES

Our first contact will consist of a free 15-minute phone consultation during which you and I will make an initial determination about whether or not we believe my services are a good fit for you. If we decide to proceed from there, the following 1-2 sessions will be considered an initial assessment period, which may include one or more of the following: an evaluation of existing current distress, a discussion of the factors that are contributing to your current concerns, and a complete psychological history. At any time during these contacts, and no later than the end of the second session, I will discuss with you whether or not I believe that you could benefit from my services, or if other services/care providers would be best suited to meet your needs. If we both determine that you could potentially benefit from my services, I will offer you some initial impressions of what our work together would include and recommend a treatment plan. You should evaluate this information along with your own opinions of whether you feel comfortable working with me to decide if you wish to continue the recommended course of treatment.

Throughout our work together, I will offer a variety of professional therapeutic techniques that will likely include facilitation of self-awareness, encouragement of new insights, experimentation with new behaviors, and new ways of looking at yourself and your life circumstances. Change usually involves letting go of things that are familiar in order to make room for new possibilities to emerge. Also, changes that you make in one area of your life (e.g. your interpersonal style) may induce changes in other areas (e.g. your relationships with others). All in all, there are no guarantees of what you will experience, the results you will achieve, or how you will feel during and after working together.

I believe the single most important factor in the success of therapy is the relationship between the client and the therapist. If at any point during the course of therapy it is determined by either the therapist or the client that other treatment alternatives are a better fit, I will provide you with referrals for alternative treatment services. Also, I may determine that supplemental treatment recommendations (e.g. psychotropic medications, reduction or cessation of drug/alcohol use, 12-step programs, a medical evaluation, etc.) would strongly support or be required for your continued use of my services. In some situations, my willingness to provide services will be dependent upon your participation in these additional treatment recommendations.

** Client's Initials* __________

INFORMED CONSENT

Psychotherapy is not easily described in general statements. It is an active and cooperative effort involving both the client and the therapist. Psychotherapy has both benefits and risks, and it is important that you are aware of the risks. For instance, therapy may result in reduction in feelings of distress, increased coping skills, solutions to specific problems, positive behavioral changes, more satisfying relationships, etc. At the same time, since therapy often involves discussing aspects of your life that you are currently struggling with, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and/or helplessness in the process.

Dorian Race, D.C., M.S.
1550 Lake Baldwin Lane, Suite B ♦Orlando, FL 32814 ♦407.616.5948 ♦evolvecounselingorlando.com

By initialing and signing below, you agree that you voluntarily request and consent to therapy, and you understand and have been informed of the potential risk and you are voluntarily and knowingly assuming these risks. You have had an opportunity to ask questions and you agree to the all aspects of the therapy and agree to assume all risks to cover the entire course treatment and for any future condition(s) for which you may seek treatment.

** Client's Initials* __________

APPOINTMENTS

An appointment (or session) is scheduled for 50 minutes duration. **Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation**. If you know in advance that you will have a time conflict with a scheduled appointment, please let me know as soon as possible, and I will try to find another time to reschedule the appointment. In the event that you do not cancel an appointment 24 hours in advance, you will be charged in full for the appointment. This amount will be due at the time of your next scheduled appointment. If you arrive late for your appointment, the session will still end on time, and no additional time will be added to the end of the scheduled appointment. Should you arrive late to the start of your scheduled appointment, you will still need to pay the full fee for the full appointment, even though you will only be seen for a portion of the session as you will have forfeited the time you missed due to being late. It is difficult for me to continue working with clients who exhibit irregular attendance and/or lack of contact regarding missed appointments as it prevents me from scheduling other appointments in those time slots; therefore, I may terminate your therapy if, in my discretion, I determine that you develop a pattern of canceling late and/or not showing for appointments.

** Client's Initials* __________

PROFESSIONAL FEES AND PAYMENT

As mentioned previously, I will provide a free 15-minute phone consultation to anyone who is interested in learning more about my services and to provide an initial determination about whether or not my services are appropriate for you. Thereafter, my fee for each 50-minute individual counseling session is $80.00, and appointments are often scheduled on a weekly or bi-weekly basis. Please be aware that I do revisit my fee structure bi-annually, and reserve the right to modify my rate accordingly at any time. As my client, you will be given 4 weeks-notice of any fee increase in writing before the modified rate would be used. In addition to appointments, you consent to this same rate ($80.00 for 50 minutes) applying to any other professional services you or others request related to our therapy ("Professional Services"), such as telephone conversations (with you or other persons you request and consent for me to consult with regarding your case), attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

My fee for group counseling varies depending on the type of group and the length of the group sessions. A separate informed consent form will be provided for participation in all group counseling.

My fee for any court-ordered time is $250/hour with a 3 hour minimum to be paid in advance.

All charges are payable by cash, check, or credit/debit. You will be expected to pay for each session at the end of each appointment. For any other Professional Services provided by me, I will send you an invoice that is due and payable within 30 days. At this time, I am not a member of any managed care/insurance provider panels or plans. However, you will be provided with a receipt for payment for your financial records and for your use if you decide to independently file an insurance claim. Please be aware that if you choose to use your own insurance, I am required to provide a diagnosis which may or may not be reimbursable depending upon your policy.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, you agree in advance that I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, you will be billed additional charges to cover the cost of time and expenses incurred by me in obtaining payment, including legal fees, and these costs to me will be included in the claim. In the case of collections, typically the information that is released is the client's name, the nature of services provided, and the amount due. I hope I would not need to resort to collections, but should that be the case, you are consenting to the release of this and any other relevant information should collections become necessary.

CONFIDENTIALITY AND DISCLOSURE

You consent to the use and disclosure of your identifiable health information for the purposes related to your therapy. You understand that you have the right to request restrictions as to how your identifiable health information is used or disclosed to others. Your identifiable health information includes health information as well as your demographic information that is collected from us and/or created or received by us, another health care provider, a health plan, your employer or a health care clearinghouse. This identifiable health information relates to your past, present or future physical or mental health or condition and identifies you, or there is reasonable basis to believe the information may identify you.

You understand that you have the right to:

- Request a copy of your health records
- Request a correction of information that you deem incorrect in your health records
- Request that your health information not be shared with certain individuals
- Request that your health information not be used for certain purposes (e.g., research)
- Request us to send a copies of your health records to whomever you wish
- Be informed as to who has read your records (for reasons other than treatment or payment)
- Specify how and where we may contact you
- Receive a paper copy of a full *Notice of Privacy Practices* upon request

In general, the privacy of all communications between a patient and a pre-licensed mental health counselor is protected by law, and I can only release information about our work to others with your written permission. But there are some situations in which I may be legally obligated to reveal some information about a client, even without your consent. You understand that your confidential patient health information will not be disclosed anyone else without your written consent prior to access or disclosure, except in the situations outlined below or as allowable under HIPPA (the Health Insurance Portability and Accountability Act), including:

- If in my professional judgment I believe a client lacks the capacity or refuses to care for himself/herself and such lack of self-care presents substantial threat to his/her well-being or the well-being of others.
- If a client threatens serious bodily harm or death to himself/herself.
- If a client threatens serious bodily harm or death to another.
- If the abuse, neglect, or exploitation of a child, elder adult, or dependent adult is suspected. Examples include: violence toward a minor, a minor witnessing violence or being in the presence of violence, drug use in the presence of a minor or while caring for a minor, financial exploitation of an elder adult, etc. This also includes incidents of past abuse, including those mentioned above, in any minor is still present in the home and/or the alleged perpetrator of abuse is currently in a caretaker capacity with any minor(s).
- If a client is involved in a legal proceeding and a judge issues a court order for my testimony.
- If a client pursues civil or criminal legal action against me or if a client makes a complaint to a Professional Board about me.
- If release of information is otherwise required by law (e.g. reporting of medical errors, due to a court order or subpoena, requested under the Patriot Act).

In addition, you should be aware of the following limits to confidentiality and you consent to disclosure under these circumstances:

- I may find it helpful or required to consult with other medical or mental health care professionals for the purpose of gaining professional supervision, support, education, and exchange of ideas. During such consultations, I make every effort to avoid revealing the identity of clients. The consultant in these instances will be a medical or mental health care professional who is therefore also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important.
- Information that you allow me to exchange with other professionals or information that you might choose to provide via email, fax, or cordless phones cannot be guaranteed confidential.
- Although rare and unexpected, it is possible that confidential information stored on my computer and protected by passwords and accessible legally only by me could be accessed illegally by others.

Dorian Race, D.C., M.S.
1550 Lake Baldwin Lane, Suite B ♦Orlando, FL 32814 ♦407.616.5948 ♦evolvecounselingorlando.com

Client's Initials ___________

CONTACTING ME

Should you need to reach me between appointments, you may reach me at (407)616-5948. Either calling or texting is acceptable in regards to scheduling, rescheduling or cancelling an appointment. Due to the nature of my work, it is important that I clarify that I am often unavailable to take calls or return calls immediately. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return that day or by the next business day, with the exception of weekends, vacations, and holidays when I will return your call at my earliest convenience when I am back in the office. I do not check voicemail after 6pm or on weekends or holidays. In all cases of emergency, call 911 or Lifeline of Central Florida (407-425-2624) immediately or go to the nearest hospital emergency room. You agree that it will not be sufficient to leave a voicemail for me in the case of an emergency as I may not receive it immediately, and you agree that you have been specifically instructed to immediately call 911 or Lifeline of Central Florida (407-425-2624) for help. Should I be unavailable for an extended time over a holiday or vacation I will discuss this with you ahead of time, and if you are interested, I may provide you with the name of a colleague to contact, if necessary.

If you need to consult with me via phone between your scheduled appointments, please leave a voicemail and I will contact you to arrange a time for us to speak. Please note that my regular rates do apply to any time spent discussing issues via phone, and I will send you an invoice for such time that is due and payable within 30 days.

* *Client's Initials* ___________

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records or a summary of your treatment upon request. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Because these are professional records, they can be misinterpreted by those who are not medically trained. You will be charged my standard hourly fee and invoiced for any professional time spent in responding to, preparing, and/or reviewing your clinical records requests.

* *Client's Initials* ___________

NO DUAL RELATIONSHIPS

Although our sessions may cover topics that are highly personal to you, it is important that you be clear that we have a professional relationship rather than a social one. Our contact will be limited to the sessions you arrange with me. Therapy never involves inappropriate, sexual or any other dual relationship that could impair my objectivity or clinical judgment. Please be aware that if we happen to see one another in a public setting, I will not acknowledge you unless and until you approach me and/or choose to speak with me. If we do communicate, I will not reveal that we have a therapeutic relationship in the presence of others, and the nature of our communication will not be revealed to any other person.

* *Client's Initials* ___________

NO CONTACT ON SOCIAL NETWORKING WEBSITES

I do not accept friend requests from current or former clients on social networking sites, such as Facebook. My concern is that any communication via such sites is likely to compromise your privacy and confidentiality as my client. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites. You agree and understand and respect this boundary.

* *Client's Initials* ___________

Dorian Race, D.C., M.S.
1550 Lake Baldwin Lane, Suite B ♦Orlando, FL 32814 ♦407.616.5948 ♦evolvecounselingorlando.com

MINORS AND PARENTS (if applicable)

Clients under the age of 18 and their parents should be aware that the law may provide parents with the right to examine their child's treatment records. I understand that as a parent, you are concerned about your child and therefore may want to know the content of your child's conversations with me. However, a child will often progress further in treatment if they know that the details of our conversations are kept private and not shared with his/her parents. Since privacy in psychotherapy is often helpful to successful progress, especially with teenagers, it is my policy to require that parents agree to give up access to their child's records. If the parents agree, I will provide them with general information about our work together, unless I feel there is a high risk that the minor will seriously harm himself/herself or someone else. In this case, I will notify the parents of my concern, but before giving parents any information, I will discuss the matter with the minor, if possible, and do my best to handle any objections he/she may have with what I plan to discuss with the parents. You as a child and your parents signify that you agree to this policy by initialing below.

** Client's Initials* __________ *Parent's Initials* __________

TERMINATION OF TREATMENT

The length of your treatment and the timing of the eventual termination of your treatment depend upon the specifics of your treatment plan and your rate of progress. It is a good idea for us together to determine the timing of your termination of treatment. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You have the right to discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either you or I may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral to another therapist, revising your treatment plan, or terminating your therapy altogether.

** Client's Initials* __________

SIGNATURES

Your initials throughout this document and your signature below indicate that you have read this Agreement, and have had the opportunity to ask questions and address your concerns before signing. Your signature also indicates that you understand and provide your informed consent to the issues related to the risks and benefits of psychotherapy, confidentiality, professional records, length of psychotherapy, fees and payment, emergency procedures and all other responsibilities and terms in this Agreement.

Your signature below also indicates that you have received and reviewed my *Notice of Privacy Practices.*

If you have questions or complaints regarding my psychotherapy practice, you may contact my supervisor, Keri Nola, at 407-242-9400 or the Florida Department of Health, Division of Medical Quality Assurance at 850-245-4339.

Client Printed Name: ______________________________

Client Signature: ______________________________ Date: ______________________

Parent/Guardian Printed Name: ______________________________
(if applicable)

Parent/Guardian Signature: ______________________________ Date: ______________________
(if applicable)

Therapist Name: Dorian Race, M.S., D.C.____________

Therapist Signature: ______________________________ Date: ______________________