ANDREW PRICE THERAPY, LLC
INFORMED CONSENT, TREATMENT DISCLOSURE & CONTRACT FOR SERVICES

This information is required by the Board of Professional Counselors and Therapists which regulates all licensed therapists and certified counselors and therapists. The Board of Professional Counselors and Therapists is located at 4201 Patterson Ave, Baltimore, Maryland, 21215-2299; 410-764-4732, Fax: 410-358-1610.

PURPOSE OF TREATMENT: The purpose of treatment is to support you, the client, in personal growth, development, and the accomplishment of identified goals. Some of these may be long term goals such as improving the quality of your life, learning to live with mindfulness, and self-actualization. Others may be more immediate goals such as reducing anxiety/depression symptoms, developing healthy relationships, changing behavior, or decreasing/ending drug use. Whatever the goals for therapy, they will be set by the client according to what they want to work on in treatment. The therapist makes suggestions on how to reach goals, but you decide where you want to go.

GENERAL PROCEDURES USED IN TREATMENT: I utilize a variety of therapeutic modalities including, but not limited to, traditional talk therapy, cognitive behavioral techniques, family systems and couples therapy, experiential processes, and mindfulness techniques.

BENEFITS, LIMITATIONS, AND RISKS: As with any treatment, there are benefits, limitations, and risks. **Benefits** include enhanced awareness and emotional understanding of yourself; improvement in your relationships with others; reduction in presenting symptoms; greater ability to cope with stress; improved functioning in social, vocational, educational, and/or relational areas; strengthened self-cohesion and overall sense of well-being. **Risks** may include temporary disturbance of emotional and functional aspects of your life; no experience of change; feeling worse before feeling better; an increase in such feelings as grief, sadness, and anger; feeling better but having increased conflicts with others as you approach situations differently. **Limitations** may include my therapeutic skills and training, along with your capabilities, motivation, and potential. The client has a right to question and/or refuse any therapeutic interventions, suggestions or directives at any time.

CONFIDENTIALITY: The information you give me during session is strictly confidential. It will not be divulged to anyone unless you have given me written permission, with the following exceptions. Should any of these exceptions arise, I will attempt to inform you before taking any required action on my part:

- I have reasonable cause to believe that you are an imminent threat and may cause harm to another person or the property of another person. In such cases, I am required to inform that

person or persons of your intentions. I must also notify the police and ask them to protect any potential victims.

- I have reasonable cause to believe that you are in such a mental or emotional state that you are in imminent danger of harming yourself. I will share my concerns with you and we will take steps to ensure your safety. If your safety cannot be assured, I will call the police to assist.
- I suspect or have evidence that there is abuse to a child (under 18) or a dependent or disabled adult. Abuse can be classified as physical injury, sexual assault, cruel punishment or neglect. In such cases, I am required by Maryland State law to contact Child Protective Services or Adult Protective services. Generally, I will discuss my concerns with you and encourage you to make the call with me. You may decline to make the call, but I will have to.
- You inform me of another licensed medical or mental health provider's behavior that indicates sexual contact has occurred with a patient/client or suggests provider impairment due to medical or cognitive deficits and/or substance abuse. I am required to report this behavior to the Maryland State board that has granted a license to that individual.
- If I am ordered or subpoenaed by a court of law to disclose information or to defend myself in any lawsuit filed by a client.
- For the invoicing and payment of claims filed for insurance purposes (if applicable).
- My services were sought or obtained to enable or aid anyone to commit or plan a crime.

In order to provide you with the best possible treatment experience, I participate in supervision and consultation with other professionals. Unless I obtain your written authorization, you will never be identified by name and steps are taken to anonymize your information during such consultation. Please respect the confidentiality of others seen or met in the therapy office and waiting area.

TREATMENT DECISIONS: You are in charge of your own therapeutic process. I am working in your interests. You determine your goals and my role is to help you reach them. We both agree that your goals can be changed at any time.

APPOINTMENTS: Appointments are generally 45 minutes in length and scheduled on a weekly basis, although some clients may choose to meet more or less often. The time we schedule is held for you and you alone. When a client fails to cancel appointments in a timely manner, s/he prevents other clients from receiving much needed treatment. **As such, you will be charged for your full**

session fee if you cancel with less than 48 hours notice or do not appear for your session. Insurance will not pay for missed-session fees. I will make every attempt to reschedule you for the same week and if able to do so, I may waive the missed-session fee. I reserve the right to waive the missed-session fee in certain circumstances. If you are late to session, it does not alter the session fee or session ending time. If I am late to session, any missed time will be made up to you.

FEES AND PAYMENT: All payments are due at the time of treatment is provided. I cannot allow clients to carry balances forward. By signing this consent you agree to pay for all services rendered.

$150 for a 45 minute individual session

$250 for a 90 minute individual session

$180 for a 45-60 minute couple or family session

$280 for a 90-120 minute couple or family session

Fees for video sessions are in line with those listed above. Fees for mobile and at-home sessions are determined on a case-by-case basis, given client composition, location, and travel time. Mobile and at-home fees will be listed and contracted for in a separate addendum to this consent.

I prefer payment by credit card and utilize a secure credit card processor for client payments. I will process payments at the completion of each session using the credit card information you provide me on an accompanying form. It will be destroyed once your information is entered in their system. If you prefer, you may register for access through my client portal and enter the information yourself.

In certain cases, I will accept a personal check or cash if credit-card arrangements are not feasible. There will be a $50.00 fee for any returned checks.

Outstanding payments of 60 days or more will be charged a $25.00 late fee for each unpaid session.

I reserve the right to utilize an attorney or collection agency to secure unpaid debts.

If my fees change in the future you will be notified in writing at least 30 days prior to any change.

In certain cases, I am available to participate in meetings and can complete summary-of-service letters or forms upon your request. Fees for these services are prorated to an hourly rate of $150. I do not complete court reports, custody recommendations, disability applications, psychological and/or academic testing. If you require these, please let me know and I can refer you to a specialist.

INSURANCE: I am an out-of-network provider and do not complete or submit claims to your insurance company. If you plan to use insurance, it is important that you call your provider before

we first meet. Their representative can confirm your mental health benefits and authorization to use an out-of-network provider for therapy. **Clients who use insurance are required to pay my full fee at the time of service and can seek reimbursement from their insurance**. You are responsible for filing claims with your provider. If your insurance company authorizes reimbursement for out-of-network treatment, they will reimburse you directly. I will provide you with a monthly invoice that contains the information insurance companies usually require for reimbursement. My clients are usually successful in receiving reimbursement. I do not accept third party payments from insurance companies, health savings accounts, workman's compensation, attorneys, or disability services. You are expected to make all payments.

COMMUNICATION AND TECHNOLOGY: Contact outside of scheduled session times is available on a limited basis as my schedule allows. I make the greatest attempt to return all messages within 24 hours. If a message is left on a Friday, it may be returned by end of day Monday. No charges will be assessed for brief occasional phone calls. However, if there are frequent telephone calls lasting more than 15 minutes, you will be billed proportionately at the in-person session rate.

We may agree to use text and/or email periodically to make appointments and send general information. They should not be utilized for clinical purposes and you are advised not to include content from your therapy sessions. You acknowledge that these are not guaranteed confidential modes of communication and release me from any liability and/or risk to your confidentiality when you choose to text and email me. For more private communication, call me and leave a voice message or schedule a session to talk in the office.

EMERGENCIES: Although I will be as supportive as possible in times of crisis, the nature of this practice is that of outpatient services. This assumes that all clients are self-responsible and not in need of day-to-day supervision. I cannot assume responsibility for your daily functioning like a hospital or inpatient facility can. By signing this document you agree that if you feel that you are in crisis or having an life threatening emergency you will dial 911, contact the Montgomery County Crisis Center at 240-777-4000, or go to your local hospital. In the event of such an emergency, please contact me once you have been stabilized so we can consult on your treatment together. As a part of your self-care and healthy functioning, I encourage you to develop and utilize a support system outside of therapy that you can rely on in the event of such emergencies.

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RECORD KEEPING: Throughout your therapy, I will keep records of your therapy sessions, treatment plan with goals for your therapy, as well as our communications. I am required to keep these records by Maryland State law. They also ensure a direction to your sessions and continuity in service. They are stored on a HIPAA compliant, encrypted electronic medical record system. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should you wish to have your records released, you will be required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer.

CLIENT-THERAPIST RELATIONSHIP: While sessions may involve discussing psychologically and emotionally intimate material, the therapist-client relationship is unique in that it is exclusively professional. Contact is limited to paid therapy sessions and administrative and scheduling communications. In other words, it is not appropriate for a client and a counselor to spend time or communicate together outside of sessions. If we encounter one another outside of therapy, I will not acknowledge you unless you have greeted me first and I will most likely keep our interaction to a minimum. I will not accept or respond to friend/follow requests on social media and other platforms. The purpose of these boundaries is to ensure that you and I are clear in our roles for your therapy process and that your confidentiality is maintained. Additionally, if there is ever a time when you believe that you have been treated unfairly or disrespectfully please talk with me about it. I want to openly address together any issues that might get in the way of your therapy. This includes administrative and financial issues as well.

TERMINATION: You can revoke your consent for treatment and terminate therapy at any time. If you do not revoke your consent, it will automatically expire one year later from the date indicated on the consent form. If we decide that you might be better served by another therapist, specialist, or treatment that I do not provide, I will assist you in finding appropriate referrals. Ending therapeutic relationships can be challenging. Therefore, it is important we try to terminate intentionally in order to consolidate your growth and achieve closure. The appropriate length of the termination process depends on the length and intensity of the treatment. If I determine that psychotherapy is not being used effectively or if you are in default on payment, I may terminate treatment. I will not terminate the therapeutic relationship without attempting to discuss with you the basis for termination. For legal, ethical, and clinical reasons, should you fail to schedule or attend session for three consecutive weeks

or you no longer respond to my efforts to schedule, I must consider the professional relationship discontinued and your file will become inactive.

Please feel free to talk with me about any questions you might have about this consent. I look forward to our work together.

CREDENTIALS: I am a Licensed Graduate Marriage and Family Therapist in the State of Maryland, license number LGM650. I earned a Masters of Science degree in Couple and Family Therapy from The University of Maryland, College Park.

CONTACT INFORMATION: Andrew Price, LGMFT. 8555 16th Street Suite 202, Silver Spring, MD 20910. Tel: 240-745-5998

I have read and agree to this entire Informed Consent, Treatment Disclosure, and Contract for Services, consisting of six pages. By signing below, I agree to enter therapy with Andrew Price, LGMFT. I understand I may end therapy at any time I choose. I consent and agree to the above assumption of therapeutic risks, limitations, and confidentiality policies. I understand their meaning and ramifications. I have read and understand my responsibilities as a client and my therapist's responsibilities to me.

_____ _____
Client (or Parent) Signature **Date**

_____
Client Name

_____ _____
Andrew Price, MS, LGMFT **Date**