Therapist and Client Service Agreement

Welcome to Nai'a Aloha, LLC. It is my intention to provide you with the best service possible and I look forward to getting to know you!

Privacy/Confidentiality

Please be assured that your care will not be discussed with anyone unless you authorize me to do so in writing or unless you are a danger to yourself or others (i.e. suicidal, homicidal, abusing a child or elder or suspicions of child abuse if the client is a child). In these cases, I am required by law to disclose certain information to keep you or others safe and get you the additional help you may need. _____ (**Initial**)

You understand that your confidentiality is also not protected under the law if there is any threat or suspicion of harm against me, my property or family members by you or anyone involved with your case. ___ (**Initial)**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your personal health information used for the purposes of treatment, payment and health care operations. This law protects your right to access parts of your medical records, not including my psychotherapy notes which I am not required to release. _____ (**Initial)**

If you authorize me in writing to discuss your case with another professional, the consent will state what information is to be shared, with whom, for what purpose and includes an expiration date of the consent. You may revoke your consent at any time verbally or in writing. Please know that although I would release only that information which I think is most necessary, I have no control over any information once it leaves my office._____ (**Initial**)

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order *signed by a judge*. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I am required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I may be required to file a report of the patient's injury or treatment. _____ (**Initial)**

If such situations arise, 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.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed. ____ (**Initial)**

If you choose to communicate with me via email or texting, you acknowledge that you understand that any regular email is most likely not HIPAA compliant and, even if encrypted, cannot guarantee confidentiality. You agree to accept responsibility for this risk if you choose to provide sensitive information or ask for a response for anything other than appointment scheduling. You also understand that any communication including email or texts can become part of your medical record. _____ (**Initial)**

Any recording of sessions in any form without prior written permission of all parties involved is strictly prohibited. All cell phones and electronic devices will be turned off or not be present during sessions unless discussed with me beforehand. _____ (**Initial**)

Minors and Parents

Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I decide that such access is likely to injure the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide parents only with general information about the progress of the child's treatment, provide suggestions for what the parents can do to assist their child at home, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents and relevant authorities as required by law of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. _____ (**Initial)**

Benefits and Risks

Psychotherapy can have benefits and risks. Since we will be discussing personal issues and difficult aspects of your life you may experience feelings such as sadness, guilt, anger, frustration, loneliness and helplessness, among others. This is perfectly normal and I would encourage you to bring it up to me in our sessions and we can deal with it together. It is also normal to experience some feelings of resistance to the therapy process or to suggestions that are offered. We can also explore these feelings together. Let me know what is happening for you before you consider giving up on therapy, if you experience difficult emotions or feel it is too difficult to come to therapy.

Therapy can provide many benefits including better relationships, solutions to specific problems, and significant reductions in feelings of distress. Often people develop increased self esteem, and improved problem solving and coping skills. There are no guarantees of what you will experience. Change doesn't always happen as quickly as we would like, but you will get out of it as much as you put into it. YOU make the change happen.___ (**Initial**)

Case Closure and Discharge

You understand that if you do not schedule an appointment within a three week period you will be considered to be discharged from care and my case will be closed. You understand you can call to ask that my case be re-opened, assuming there is space available. _____ (**Initial**)

Payment Policies

Payment/co-payment is due at the time of the session. You understand and agree that all charges for all services rendered are your responsibility regardless of insurance coverage. You agree to be responsible for all payments of denied claims. There is a $25 fee for returned checks. Unpaid bills older than 30 days will have a 10% or $10 late charge added for every **week** it is late and/or be sent to collections. If I must bill you for copays, there will be an additional fee of $5 per bill._____ (**Initial**)

In urgent situations or if you are feeling significant distress DURING REGULAR BUSINESS HOURS, I offer phone consultations if I am available. Phone consultations beyond 10 minutes will be charged your regular therapy rate and cannot be billed to insurance __ (**Initial**)

Unless we agree ahead of time about payment for time spent reading and/or responding to emails or texts, as well as phone calls, I am unlikely to respond to texts or emails with clinical information or treatment suggestions because it takes up a great deal of time, is not reimbursable from insurance companies in general and confidentiality cannot be assured. If a client repeatedly sends emails, voice mails or texts with clinical content, the client will be billed for the time I must spend on these activities unless I ask for the information, i.e. a quick update about your child before his/her session. _____ (**Initial)**

Sessions last between 45-60 minutes. Since I usually have patients scheduled after you, arriving on time is important. If you are going to be late, please call to let me know. If you are over 10 minutes late, I cannot bill your insurance for a full session and you will have to pay for the lost part of the session. If we have to reschedule, you will have to pay for the entire session and there will be a charge for the missed session. Please wait until your appointment time before coming into the therapy office. ____(**Initial**)

Online sessions are provided through HIPAA compliant videochat systems. Clients are responsible for making sure their system as well as internet provider have the proper connections and speed for the session to take

place. It is not the responsibility of Jeanne Teleia, Nai'a Aloha, LLC to provide additional time or technical assistance to make sure the session takes place. If sessions are delayed, interrupted or terminated because of computer problems, the client is still responsible for paying for the session or part of the session that cannot be billed to insurance. _____ (**Initial**).

When you make an appointment, you are reserving and purchasing a time slot. **I require a *minimum* of 24 hours notice DURING REGULAR BUSINESS HOURS (Monday through Friday) to change or cancel an appointment. You must CALL or TEXT me to notify me if you are cancelling, especially if it is over a weekend. DO NOT RELY on EMAIL, especially if it is over a weekend or after regular business hours as I will not get it in time and you will be responsible for the cost of the missed session. _____ (Initial)**

Unless covered by Quest, if there is a late cancellation or no show you are required to pay **the full amount paid by insurance**. You understand that insurance cannot be billed for no shows or late cancellations. You understand that until you have cleared any late cancellation/no show fees, you may not be able to be scheduled for another appointment. You understand that even though Quest does not allow me to collect for missed appointments, if it becomes a pattern (i.e. more than two occasions in a short time), it will be necessary to refer you to another mental health provider or clinic. ____ (**Initial)**

If I must leave the island for vacation or emergency, another therapist will offer coverage care. I will do my best to give you plenty of notice. _____(**Initial**)

Treatment Focus and Limitations

I do not provide treatment services for the purpose of court evaluations, testimony, evidence or other court related matters and do not wish to become involved in any cases where court or high legal conflict between parties exist. You understand that if you violate the intention of this agreement by attempting to involve me in court or other legal proceedings, it is my policy to terminate treatment immediately and will consider myself a hostile witness to any legal proceedings.

If you do engage in legal proceedings and require my participation, you will be expected to pay for all of my professional time, including time for preparation, time spent waiting at proceedings, time for travel to and from any proceedings, copying documents, and all related transportation costs, even if I am called to testify by another party. A retainer equivalent to at least ten hours of my work will be required before I begin work related to any legal proceedings. My hourly fee for these matters will be debited from this retainer, and as the balance of the retainer approaches zero, another similar installment will be due if I am requested to continue work related to your proceedings. Note that no services provided by Jeanne Teleia, MFT, CSAC are applicable or appropriate as evidence for testimony in contests of legal or any other nature including arbitration. One example of this is that the evaluations performed are specific to treatment, and are therefore not applicable for predictive purposes, assignment of responsibility, or other purposes not pertaining to treatment. _____ (**Initial)**

Evaluations, Testing, Assessments, Professional Opinions, Communications with Third Parties

I do not perform evaluations, testing, assessments, or similar tasks except for the purposes of treatment planning. Therefore, my opinions are formed and executed with only therapeutic purposes in mind and thus are not applicable to other uses or circumstances. I do not typically comply with requests, including those made by my clients, to communicate with third parties about your mental health status. This includes but is not limited to employers, attorneys, and/or government agencies. _____ (**Initial)**

Contact information

I can be contacted in an emergency at 808-224-5008 **during regular business hours (Monday through Friday)**. If I am unavailable or it is after regular business hours, and/or you are suicidal, you are required to call the 24 hour Crisis Line at 1-800-753-6879 or 911. ___ (**Initial**)

By signing below, you understand the policies of Jeanne Teleia, MFT, CSAC and Nai'a Aloha Play and Family psychotherapy and agree to comply with them. You agree that you have had an opportunity to discuss all aspects of treatment fully, have had my questions answered and understand the treatment process. ____(**Initial**)

Name of Client/Parent/Guardian: _____

Date: _____

Signature of Client/Parent/Guardian Party: _____