Melissa Hofstetter, PhD, MDiv
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PsyPact Interjurisdictional Telehealth Provider #4880

CLIENT TREATMENT AGREEMENT

ABOUT DR. HOFSTETTER: Melissa Hofstetter, PhD, MDiv is a licensed clinical psychologist in the states of California (Lic.No.PSY25696) and Arizona (#4125). She occasionally provides interjurisdictional telehealth (PsyPact APIT #4880) Dr. Hofstetter's psychology practice provides psychotherapy services for late adolescents, adults, couples, families, and groups in an outpatient private practice setting. Her psychology practice also includes psychological assessment.

Dr. Hofstetter's practice is completely independent and not affiliated with the private practices of other practitioners in the office suite (who are not Dr. Hofstetter's employees or supervised clinicians).

SUPERVISED CLINICIANS: As a part of Dr. Hofstetter's practice, professional services may be provided by unlicensed, supervised clinicians working under Dr. Hofstetter's license. These individuals are graduate students in a clinical psychology program and are closely supervised by Dr. Hofstetter.

Supervised Clinician:_____ **Phone:**_____

You are encouraged to discuss any concerns or issues you may have regarding your assessment or treatment with your clinician. If you feel that your comments or concerns need further discussion, you are invited to contact Dr. Hofstetter at 626-437-3866.

VOLUNTARITY: Psychotherapy is voluntary and the client is free to terminate psychotherapy any time.

CONFIDENTIALITY: Information disclosed during assessment and treatment is considered confidential and will not be revealed to anyone without your written permission, except where disclosure is permitted by law and deemed to be in the best interests of the client. The following are the legally permissible exceptions to confidentiality:

1) when there is reasonable suspicion of child, elder or dependent adult abuse or neglect;
2) when the client presents a serious danger of violence to others or the property of others;
3) when the client presents a serious danger to harm him/herself;
4) pursuant to a lawfully issued subpoena.
5) with client written informed consent.

Note: If/when we communicate via wireless phone (and/or Internet), privacy problems may occur due to the nature of technology capable of capturing broadcast conversations and transmissions. Dr. Hofstetter and supervised clinicians may use wireless phones (i.e., cell phones) for your care.

Minors: When minors (under 18 years of age) are assessed or treated, the parent or guardian holds the legal privilege regarding release of information (ask about any exceptions that may apply to you).

CANCELLATIONS: At least 24 hours advanced notice of cancellations is required for scheduled appointments. Your full session fee will be charged for missed appointments not cancelled 24 hours in advance. **INITIAL THIS HERE ____**.

COMMUNICATION: Dr. Hofstetter and supervised clinician generally communicate with therapy clients by text message/email only to make scheduling arrangements. Please refrain from communicating matters of a personal, sensitive, or clinical nature in text/email. Dr. Hofstetter has encrypted email, but cannot fully guarantee your confidentiality when communicating by text or email. To permit such communication with Dr. Hofstetter, please sign the email/text consent form. You may call Dr. Hofstetter directly at 626-437-3866 (or your clinician's number) listed above. Please allow 48 hours for Dr. Hofstetter to return messages to you by phone or email.

EMERGENCIES: Dr. Hofstetter and her supervised clinicians do not carry a pager and are not available for emergency services. If you are at risk of harming yourself or someone else, or if you are having severe symptoms, please call 911, or for mental health emergencies 988, or go to your nearest emergency room. If you are participating in a social service program, please contact your service provider in that program for emergency assistance. If you would like to contact your clinician between sessions, please use the contact information listed above.

EMERGENCY CONTACT FOR CLIENT: If there is an emergency while you are a therapy client, or if Dr. Hofstetter or your supervised clinician become concerned for your personal safety, your clinician or Dr. Hofstetter may be required by law and by the rules of the profession to contact someone close to you—perhaps a relative, spouse, or close friend. Clinicians may also be required to contact this person, or the authorities, or any potential victims, if they become concerned about your harming someone else. Please write the information of your contact person in the space provided:

Name: _____ Address: _____

Phone: _____ Relationship to you:_____

PAYMENT FOR SERVICES:

PSYCHOTHERAPY Your session fee will be $240 per 45-min session, unless another fee has been pre-arranged in writing with your clinician. Fees are to be paid to the clinician at the time of the appointment, unless other arrangements have been made with your therapist. Charges may be assessed and pro-rated based at the discretion of the therapist for additional services (e.g. court appearances, court reports or other third party reports, phone therapy sessions and/or long distance phone call expenses, etc.).

If you become involved in legal proceedings that require Dr. Hofstetter's participation, you will be expected to pay for her professional time even if Dr. Hofstetter is called to testify by another party involving you. Because of the complexity of legal involvement, Dr. Hofstetter charges **$1500.00** per hour for preparation for and attendance at any legal proceeding including but not limited to legal records review, depositions, and testimony. Note that unlicensed supervised clinicians are unable to provide expert testimony, as they are not licensed professionals.

ADDITIONAL BILLING-RELATED INFORMATION/POLICIES:

a. Client accounts may not accrue an unpaid balance. Dr. Hofstetter reserves the right to submit past due accounts to a collection agency or pursue matters in a small claims court.
b. Before accepting payment on a client's account by someone other than the client, the client must give written consent to her/his clinician. The clinician will place this consent in the client's file. Third party payment from an organization and cases involving Minors are exceptions to this.
c. In order to safeguard the confidentiality of a client, proof of identity may be requested if someone approaches to ask for client related information. This enables appropriate verification prior to the release of client-related information.
d. Clients will be charged a $10 service charge for each non-sufficient fund (NSF) check. If a client has 2 NSF checks in his/her account history, payments for sessions may need to be paid by cash or money order following the receipt of the second NSF check.

INSURANCE OR OTHER CONTRACTUAL REIMBURSEMENT: Services are provided and charged directly to the client, not to the insurance or contracted organization. All clients must pay their fees directly to the clinician as indicated above and are fully responsible for obtaining reimbursement from their insurance or contracted organization. Monthly insurance statements may be provided, only upon advanced request, which may be submitted by the client to the insurance carrier. It is possible that you may not be reimbursed by your insurance company for Dr. Hofstetter's services. Some clients may not wish to use their insurance, as a mental health diagnosis will become part of your permanent medical record once submitted. Please discuss a desire to seek reimbursement from your insurance carrier with Dr. Hofstetter ahead of time. Dr. Hofstetter is not a Medicare-participating provider at this time. If you are a Medicare beneficiary, let Dr. Hofstetter know and she will refer you to a participating provider. Note that services provided by a unlicensed supervised clinician are often NOT reimbursed by insurance.

RECORDS: Your records are confidentially maintained in storage with Dr. Hofstetter upon your termination of services. I will store your files for the amount of time required by your state, or otherwise in accordance with state law. Conjoint therapy records cannot be released without written authorization from all parties.

OUR AGREEMENT

Clients, please review these statements, and sign below if these statements are true for you:

I have received and reviewed the Information for Client's brochure that provides detail about psychological services provided by Dr. Hofstetter. **INITIAL HERE**_____

I have received and reviewed the Notice of Privacy Practices that provides detail about how your personal health information may be used and shared. **INITIAL HERE**_____

My signature below indicates that I have read and discussed this agreement. I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

I have read, or have had read to me, the issues and points in this form. I have had my questions, if any, fully answered. I agree to act according to the points covered in this form. I hereby agree to enter into therapy with this therapist (or to have the client enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here.

Signature of client (or person acting for client) _____**Date** _____

Printed name _____

Relationship to client:

__ Self __ Parent __ Legal guardian __ Health care custodial parent of a minor (less than 14 years of age)

__ Other person authorized to act on behalf of the client

Clinician:

I, the clinician/therapist, have met with this client (and/or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this form. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment.

Clinician Signature _____ **Date** _____

___Copy accepted by client ___Copy kept by therapist

Approved by Supervisor: _____Date _____

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