# *Circle of Life Counseling, LLC*

## Dorith Prutchi, MSS, LCSW- Licensed Clinical Social Worker

## Office Policies and Professional Services Agreement

Please take the time to read this document. It contains descriptions of the **Informed Consent, Confidentiality Policies, Office Policies and Procedures, and Client Rights and Responsibilities of Circle of Life Counseling, LLC ("Practice")**. My Financial Policies are in a separate policy which has been provided to you. You are required to sign an acknowledgement that you received and were given a chance to read this to show that you understand and agree to these policies and your rights regarding them for yourself or as the legally responsible representative for the client. Please ask your therapist if you have any questions before you sign this contract.

## Informed Consent

**Purpose, Risks, and Consent to Treatment**: I/We hereby authorize and request that Dorith Prutchi, MSS, LCSW carry out mental health examinations, treatments, and/or diagnostic procedures which now or during the course of my care are advisable. I/We understand that the purpose, risks and benefits of these procedures, as well as any alternative treatments, will be explained to me and be subject to my agreement before treatment commences. I/We understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within the scope of the provider's license, certification, and training. If the patient is under 18 or unable to consent to treatment, I attest that I am authorized to initiate consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

**Process of Evaluation and Treatment:** You will be evaluated based on the information that you and/or your guardian/authorized representative provide. You and your therapist will agree upon a Treatment Plan based on this information, along with the therapist's assessment of the symptoms and problems presented. Therapy is a unique experience for each person and the results depend greatly on the collaboration between the therapist and the client or clients. You may be asked for your feedback and views on your therapy, its progress, and other aspects of your treatment. Your honesty and openness with your therapist will help determine which approach(es) are the best course of treatment for you. Try to think of the relationship as a partnership focused on you!

There is no guarantee that psychotherapy will yield positive or intended results. Please be aware that therapy can sometimes be difficult or even painful but the goal is always to help you to feel better and to live a healthier life. The benefits of therapy may include a reduction in stress, improved interpersonal relationships, and solutions to specific problems. During the course of treatment you may experience uncomfortable feelings while discussing unpleasant aspects of your life. These feelings may include sadness, guilt, anger, frustration, loneliness, helplessness, and insomnia. During the course of treatment, your therapist may use various psychological approaches/treatments based on her assessment of what will best treat your problems. These therapeutic approaches may include cognitive behavioral, behavioral, family systems, psychodynamic, developmental, psycho-educational or EMDR (Eye Movement Desensitization and Reprocessing) therapy.

**Referrals Termination:** Therapy usually ends when the therapist determines, after discussion with the client, that the treatment goals have been reached, or if you or your therapist believes that your treatment is not effective in helping you reach your therapeutic goals. Sometimes life changes bring out further issues to address. At any time during treatment, it may be determined that your specific needs require you to be referred to another healthcare provider. You also have the right to terminate therapy at any

time. In such cases, your therapist will assist with referring you to other professionals for the continuation of services or for alternative sources of assistance. Upon your request and written authorization, your therapist will assist you in communicating with the treatment provider of your choice. A copy of your record, or a summary of the record, will be provided to your new treatment provider, within 30 days of our receipt of a written authorization from you or your authorized representative. Allowable copying costs will be charged.

**Dual Relationships:** A dual relationship occurs when a therapist relates to a client in more than one relationship, whether professional, social or business, either before the therapeutic relationship begins or during the therapeutic relationship. Psychotherapy never involves any sexual contact, relationships that are exploitive in nature or relationships that impair a therapist’s objectivity, clinical judgment or therapeutic effectiveness. However, not all dual relationships are unavoidable or unethical. Your therapeutic relationship will never be acknowledged within a dual relationship without your written consent. Many clients choose a specific therapist because they know of him/her and that therapist’s stance on a specific topic. However, your therapist will not take advantage of any professional relationship or exploit a client to further the therapist’s or client’s personal, religious, political or business interests. Your therapist will discuss with you any identified or potential complexities, difficulties or conflicts that exist or develop due to dual relationships during the course of treatment. It is impossible to know ahead of time or to anticipate these relationships and their effects on treatment. Please communicate any potential dual relationships, or ones that develop during the course of treatment, with your therapist and they will carefully be discussed with you. Dual relationships will be discontinued if you or your therapist feels that it is interfering with your treatment.

**Family/Couples Therapy:** When the therapist provides services to two or more people who have a relationship with each other (e.g., couples, family members, or separated or divorced parents), the therapist will identify to all parties the individual who is the client and the nature of the therapist's obligations to the individuals receiving services. If the therapist anticipates a conflict of interest among the individuals receiving services, or anticipates having to perform potentially conflicting roles, she will notify the parties as to the therapist's role and take action to minimize any conflict of interest.

In cases of family/couples therapy, all members of the family or couple must be present at each session unless the therapist requests otherwise. If this is not possible at any point in time, the session will have to be cancelled and a cancellation fee may apply. During the course of treatment, your therapist may meet with one or more family members without other family members present. These sessions should be viewed as confidential between the therapist and those present in the session. By signing this contract, I agree that the therapist may use her judgment as to what information will be shared with family members who are not present. The therapist will not be deceptive with individual family members, as this is counterproductive to treatment. The therapist will seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. The therapist cannot guarantee that all participants will honor such agreements and you agree that the therapist will not be held liable or responsible for any information shared with family members receiving services and a member's disclosure of such information. Each member of the family/couple receiving services must read and sign our Policies and Professional Services Agreement. In circumstances where more than one person in a family is receiving services, each family member involved in that treatment who is at least 14 years of age or older must authorize a disclosure of the record related to those services or the therapist will not be allowed to disclose any information received from any family member.

## Office Policies and Procedures

**Limitation on Disclosures:** Due to the nature of psychotherapy with regard to the therapeutic process and confidential nature of the work, disclosure of the client's protected health information by the therapist in any legal proceeding (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), will be limited to only such disclosure or testimony that is authorized or required by law or by court order

**Professional Records:** The laws and standards of your therapist's profession require that she prepare and maintain treatment records. You are entitled to receive a copy of your record, or a summary of your record, from your therapist. However, your therapist may withhold from the client or authorized representative certain information contained in the client record if, in the reasonable exercise of her professional judgment, she believes release of the information would adversely affect the client's health or welfare. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we will be happy to review them with you so that we can discuss the contents. You will be charged an appropriate fee, as allowed by law, for any professional time we spend in reviewing records with you. In addition, I will charge for our allowable costs in providing copies of the records. The record or the summary shall be accompanied with an explanation of the reasons for withholding any information.

**After Hours and Emergency Procedures:** If you need to contact me between sessions, please call 856-448-2439 and leave a message. I will do MY best to return all phone calls as quickly as possible.

**However, in the event of an emergency,** please call 911 or go to your nearest Crisis Center or hospital Emergency Room. You may also consider calling the 24-hour "NJ Suicide Prevention Helpline" at 855-

654-6735 for immediate information and resources. If you need to cancel a session, you may call or text ME 856-448-2439. Texting is unencrypted and should not be used for any purpose other than cancellation and rescheduling of appointments. Text messages should not include more information than necessary to cancel (and reschedule) an appointment. See our Financial Policy regarding our cancellation policy and cancellation fees.

**Mediation and Arbitration; Collections:** To the extent allowed by law, all disputes arising out of this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the therapist and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful within thirty (30) days of commencing mediation, any resolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Gloucester County, NJ in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the forgoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, or if you are delinquent under a payment plan, the therapist can forego mediation and arbitration and use all legal and equitable means (court, collections agency, etc.) to obtain payment, including payment of interest charges allowed by law and other reasonable costs of collection, including reasonable attorneys' fees. The prevailing party in arbitration or court proceedings shall be entitled to recover reasonable attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

## Client Rights and Responsibilities

**Clients have the right to:**

1. Be treated with dignity and respect.

2. Fair treatment; regardless of race, religion, gender, ethnicity, age, disability, or source of payment.

3. Have treatment and other client information kept private in accordance with law and therapeutic benefit

4. Easily access timely care.

5. A clear explanation of their condition and to know about their treatment choices, regardless of cost or coverage by insurance.

6. Share in developing their treatment plan.

7. Information in a language they can understand.

8. Ask their therapist about the therapist's work history and training.

9. Freely file a complaint and/or learn how to do so.

10. Know of their rights and responsibilities in the treatment process.

11. Have therapist decisions about their care made without regard to financial incentives.

**Clients have the responsibility to:**

1. Treat their therapist with dignity and respect.

2. Give their therapist information they need to deliver appropriate services.

3. Ask questions about their care. This is to help them understand their care.

4. Follow their treatment plan. The plan of care is to be agreed upon by the client and therapist.

5. Tell their therapist about all medication changes.

6. Keep their appointments and understand our policy regarding missed appointments. Clients should call or text the therapist as soon they know they need to cancel a visit.

7. Let their therapist know when the treatment plan isn't working for them.

8. Let their therapist know about problems with paying fees.

**NO CELL PHONE ALLOWED DURING SESSION**

# <u>Consent to Treatment</u>

By signing below, I acknowledge that I have had the opportunity to read the above Office Policies and Professional Services Agreement, have my questions answered, and fully understand and agree to such Policies and Professional Services Agreement. I also consent to receiving mental health services from Dorith Prutchi, MSS, LCSW, or consent on behalf of the client, for whom I am responsible.

Client Name: ______________________________________ DOB: ____________________

_________________________________________________________________________________
Client Signature Date

_________________________________________________________________________________
Authorized Representative Signature, if applicable:
Date

Authorized Representative's Name: _________________________________________________
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_________________________________________________________________________________
Dorith Prutchi, MSS, LCSW Date