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Disclosure Statement and Treatment Agreement Form

Welcome to Achieve Family Therapy, PLLC. You are taking a courageous step towards moving in a new direction, especially if this is your first experience with therapy. This form is designed to inform you of what to expect while receiving treatment and you are invited to ask any additional questions at your initial visit.

CONSENT FOR SERVICES

_______	(PLEASE INTIAL)	I have received and understand the Notice of Privacy Policy regarding my privacy rights per federal HIPAA laws.
_______	(PLEASE INITIAL)	I have received and understand the Clients Rights and Responsibilities
_______	(PLEASE INITIAL)	I consent for services based on the terms outlined in this document. I commit to keep my therapist up to date about my condition and any changes in feelings, thoughts and behaviors. If I have concerns, I will openly and honestly express these concerns so they will not block the therapeutic process. I understand that goals will be formulated with my therapist and that these goals may change as therapy progresses. I understand that reaching the agreed upon therapeutic goal(s) is not guaranteed and that psychotherapy has varying levels of effectiveness for different individuals.

Risks and Benefits: I understand that therapy involves both risks and benefits. Initially, my symptoms may feel more intense as I learn to sit with the emotions rather than utilize previous coping strategies like avoidance, numbing or suppressing of feelings, thoughts and actions. I understand that I will be the primary catalyst for change which means investing time, money and emotional work which at times may be frustrating, discouraging or aggravating. Once engaged in the process, there are also rewards and benefits that may include solutions to presenting problems,

improved relationships, increased sense of security and abilities to communicate clearly my basic attachment needs. I understand that with therapy there are no guarantees of what I and or my family or minor child will achieve. I also understand I may work with an Intern or Associate who is under supervision. If asked to videotape sessions, I will sign an additional form and know that I can revoke this at any time. The video taped material will only be used for the clinical benefit you outlined on this form.

Alternatives: I understand that I may be referred to other providers in the course of my treatment that may include, but not limited to, a medical provider for medication management, group therapy, or treatments not offered at Achieve Family Therapy. This may include therapists who specialize specifically in a diagnosis requiring more specialized care. I may be referred to a higher level of care if outpatient therapy is no longer a good fit. I understand that I am able to discuss these options at any time and am free to ask questions.

Couple and/or Family Psychotherapy: I understand that couple and family therapy is unique in that there is more than one individual being treated in the room. Due to this, I agree to the additional terms outlined below.

- I understand that the "couple" or "family" becomes the client and that the therapist acts in the best interest of the client and not just an individual.
- Information discussed is for therapeutic purposes and is not intended for legal purposes and by signing this agreement I understand that I am agreeing to not subpoena information to be used later in legal proceedings.
- Phone calls, texts or emails between sessions will be used for scheduling appointments. If it is necessary to communicate information all members will be copied and included unless it is specific to safety issues.
- If one member decides that they want information from session shared with a referral source, I understand that a release of information must be signed by all parties present.
- I agree to sign a "No Secrets Policy" form and understand that this is to help facilitate the treatment of the couple or family and eliminate the need for unnecessary termination.
- At times, a couple or family may choose to change their goal and split up. At this point, the therapist will decide, based on his/her clinical judgment, if therapy will proceed. I understand that some family members or individuals may be referred to a different provider to avoid any potential conflict of interest.

Group Psychotherapy: I understand that I need to have an initial assessment before participating in group therapy. In this session, goals will be determined and the therapist will assess if group therapy is a good fit for your needs. I also understand that I will be agreeing to follow the rules of group. This includes, but is not limited to agreeing to hold what is said in group confidential and to not disclose any identifying factors of individuals present. I will not photograph or record other members. If I am uncomfortable I can choose to decline participating or leave at any time. If I am triggered by group or other group members, I agree to discuss this with my therapist or the group facilitator. I agree to be respectful in group by allowing others time to contribute, by using

respectful language and by showing acceptance of other's ideas and opinions. Though all group members agree to follow these rules, I understand that my confidentiality cannot be guaranteed by Achieve Family Therapy.

Custody Evaluations: Typically custody evaluations are performed by a Psychologist who specializes in making recommendations to the court about parenting time distribution that is in the best interest of the minor child. Achieve Family Therapy does not conduct custody evaluations and therefore does not make recommendations associated with these decisions.

PROFESSIONAL BOUNDARIES

The relationship that a client has with their therapist is unique. It is a professional relationship and not a friendship. This relationship allows the best possible circumstances for safety, growth and development. For this reason, you agree and understand that therapists do not friend clients on social media. Also, if you are to encounter your therapist in public, they will not approach you. This is to protect your right to confidentiality. If you choose to acknowledge the therapist, they may speak with you. I understand that I will not be allowed to meet with the therapist socially after the termination of therapy. This is due to ethical boundaries that prevent my therapist from having dual relationships with me and/or my family members or from having a personal relationship with me following the termination of our work together in therapy. I also understand that no form of sexual relationships is appropriate and that any violations need to be reported.

TERMINATION OF SERVICES

I understand that I can terminate therapeutic services at any time. When doing so I agree to notify my provider and schedule a final session. This is for my benefit. If a conflict of interest arises, my therapist will make an appropriate referral.

If your therapist leaves Achieve Family therapy, you will be given appropriate referrals. These referrals may include providers at Achieve Family Therapy and information about providers outside Achieve Family therapy who work with your presenting issue.

ELECTRONIC HEALTH RECORDS DISCLOSURE

Achieve Family Therapy keeps and stores records for each client in a record-keeping system using paper and computer files. Achieve Family Therapy uses security measures to protect this information. Paper files are kept in a locked file cabinet. On computers, we employ firewalls, antivirus software, and passwords to protect the computer from unauthorized use. The building and office unit are locked and the building is equipped with an alarm system. USB storage devices are kept in a lock box or safe with pass code or are encrypted and require a secure access code. Achieve Family Therapy uses Availity or Office Ally as a claim clearing house to store, process, and transmit claims to 3rd party payers. In addition, Achieve Family Therapy uses Microsoft Home and Office, Google Calendar and email services. Documents are stored on a computer owned by Achieve Family Therapy or by staff members. Achieve Family Therapy uses an electronic health record called TheraNest which is HIPAA compliant.

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GOOD FAITH ESTIMATE

Under Section 2799B-6 of the Public Health Service Act (PHSA), health care providers and health care facilities are required to inform individuals who are not enrolled in an insurance plan or coverage or a Federal health care program, or not seeking to file a claim with their insurance plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" (GFE) of expected charges.

Note: The PHSA and the GFE does not apply currently to any clients who are using insurance benefits, including Out of Network Benefits (i.e., seeking reimbursement from your insurance company).

COMMUNICATIONS POLICY

I understand that most questions and concerns should be addressed with the therapist during my session. If you need to ask questions not related to therapy, you may leave a message in the voicemail box at 801-890-5151. Therapists try to get back to you within 48 hours. Our therapists are part time and may not receive messages for a few days. In the case of an emergency, you need to contact 911 or the closest emergency room.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I understand that if I choose to communicate by email, text message or telephone that these methods are not considered a confidential form of communication. I understand that there are reasonable chances that a third party may be able to eavesdrop or intercept these messages. It is possible that people in your environment may have access to your phone, computer or texts. If you communicate at work, an employer may have access to this information. Other third parties who monitor internet traffic may be able to see your message.

I consent to allow Achieve Family Therapy to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

_____ Information related to the scheduling of meetings or other appointments

_____ Information related to billing and payment

_____ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment

_____ My health record, in part or in whole, or summaries of material from my health record

_____ Other information. Describe: ____

_______ (Initial here) I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

ACCESS TO MEDICAL RECORDS

By law you have a right to review your Protected Health Information that is kept in your clinical record. For the most part, this means you may review your assessment and treatment plan if you request this in writing. Reading this material may be upsetting and it is recommended that you review this with your therapist present or another trained professional. The clinical notes are designed for the therapist's use and are not generally considered a part of your health record.

CONFIDENTIALITY

What you share with me in the therapy is confidential. There are some exceptions to this which include:

- Some of your information will be shared for billing/payment purposes with another covered entity
- Situations where you report being a danger to yourself or others
- Abuse to a child, elderly or other protected class
- A court order to share the information
- If you choose to bring a court case against me or Achieve Family Therapy, you choose to have your information reviewed by the court
- You choose to share the information with another party and sign a release

Your case may be discussed with Supervisors or other peer counselors in a consultation setting to ensure quality service consistent with professional standards. In this situation, your personal identity and information revealing your identity will be kept confidential.

EMERGENCY PROCEDURE

In the event of a life-threatening emergency, call 911. If I have another crisis that can not wait, I am aware I can call the UNI Crisis Line at 801-587-3000. There is a suicide crisis line available 24/7 at 801-261-1442.

My signature on this AGREEMENT FOR PSYCHOTHERAPY SERVICIES/INFORMED CONSENT means I have reviewed, understand, and consent to everything above and indicates my consent to participate in therapy at Achieve Family Therapy, PLLC.

Client Signature: ______________________________ Date: __________________

Client Signature: ______________________________ Date: __________________

Parent/Guardian Signature: ______________________ Date: __________________

Parent/Guardian Signature: ______________________ Date: __________________

Provider Signature: ____________________________ Date: __________________

Provider Signature: ____________________________ Date: __________________

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Clients Rights & Responsibilities

At Achieve Family Therapy, our goal is to provide a safe, secure environment in which our clients can access their inner capabilities and achieve emotional health. Our clients have the following rights and responsibilities regardless of race, color, culture, language, ethnicity, religion, sex, sexual orientation, gender identity or expression, socioeconomic status, age, national origin, physical or mental disability, and / or veteran status:

It is your responsibility to:

- Give correct and complete information about your health, history and previous therapeutic experiences.
- Ask questions when you do not understand information or instructions.
- Inform your therapist if you do not intend to or cannot follow the treatment plan.
- Take accountability for consequences that may occur if you decide to refuse treatment or instructions.
- Cooperate with your therapist.
- Respect the rights and property of other clients or tenants in the facility.
- Tell your therapist of any medications you are taking.
- Report any changes in your health status to your therapist.
- Come to sessions sober. You will be free and clear of any substance that might hinder your ability to access therapy. You will not be treated if inebriated. Also if inebriated, you will be asked to obtain alternate transportation.

You have the right to:

- Respect in a caring and safe environment
- Have your beliefs and preferences respected
- Personal privacy and confidentiality of your health information
- Quality Care
- Proper evaluation and treatment
- Be free from abuse.
- Be part of creating and reviewing your treatment plan
- Have your concerns heard and resolved when possible. If you have concerns about your care, contact your therapist first. If you are not able to resolve the issue contact the owner at (801) 890-5151. If you feel there has been negligence in your care, you may also file a complaint with the Department of Public Licensing at http://www.dopl.utah.gov/ or by calling (801) 530-6628 or Toll-Free: (866) 275-3675.
- Be informed of recommended treatments, options, risks and benefits.
- Information about the costs of your care and payment methods.
- Review and receive a copy of your medical record, subject to state law.
- Make Decisions
- Be involved with your care through discussions with your therapist.
- Be informed of benefits and risks of your treatment options and agree to or refuse a course of action.
- Seek an alternate therapist or ask for a second opinion. You have a right to terminate therapy at any time. Please communicate your intentions beforehand.

Please sign that you have read and understand the patient rights and responsibilities and that you agree to comply.

Signature ______________________________________ Date: ___________________________

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