Welcome to Sage Heart Studio LLC ,

I am glad you have chosen my practice for your individual, marriage, or family therapy needs. I am an integrative therapist with a Masters in Marriage and Family Therapist under supervision toward licensure with Robb Palmer, Ph.D., D.Min, LMFT. I earned my Masters degree from Evangelical Seminary in Myerstown, PA and pursued further training to become a Certified Somatic Therapist. I am a Pennsylvania licensed massage therapist with additional certification in Trauma Touch Therapy™. I hold a certificate in spiritual direction from Oasis Ministries in Camp Hill, PA. I have worked as a spiritual director and contemplative retreat leader since 2011. I work primarily with clients who are 14 years and older on a variety of issues including life transitions, communication challenges, trauma resolution, spiritual and personal growth issues, and relationship conflict. I also offer education around these same issues for community groups, churches, and support groups.

In my practice, I desire to address your needs from a holistic perspective, meaning I want to involve your whole person (body, mind, spirit/soul) and the environment in which you live. In my psychotherapy practice I use acceptance and commitment therapy, contextual, and collaborative frameworks primarily, but also use current research and evidence based practice to inform goals and treatment options, drawing from a variety of therapy modalities. Acceptance and Commitment Therapy focuses on increasing psychological flexibility by helping clients be present, open up, and do what matters to them. Contextual therapy brings forward the importance of what happens between people when there is genuine meeting and takes each member of the family's side into consideration when dealing with presenting issues and strengths. Collaborative therapy values the two-way conversation between people, listening to the client, focusing on client strengths, and allowing space to explore possibilities while being genuinely present with the client.

If the environment of the office is not conducive to your treatment or you have concerns about your treatment, please let me know as soon as possible. I take your concerns seriously and would like to discuss how I can best support you on this journey. I can be contacted at (717) 449-0934. A message may be left on my confidential voice mail.

Sincerely,

Ramona A. Ndlovu, MFT, L.M.T. (MSG007885), CST, TTT™

Attachments:
Notice of Privacy Practices (HIPAA)
Acknowledgement of Receipt of Notice of Privacy Practices
Informed Consent and Service Agreement
New Client Questionnaire and Client Intake Form
Health History
ACE Questionnaire
Personal and Family History
Notifications
Worksheet(s) for Getting the Most Out of Your Counseling Experience
Credit Card Authorization

Notice of Privacy Practices (HIPAA)
Sage Heart Studio LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES
Privacy is a very important concern for all those who come to this office. It is also complicated because of the many federal and state laws and my professional ethics. Because the rules are so complicated some parts of this notice are very detailed and you probably will have to read them several times to understand them. If you have any questions I will be happy to help you understand my procedures and your rights.

A. Introduction - To my clients
This Notice will tell you how I handle your medical/ PHI (Personal or Protected Health) information. It tells how I use this information here in this office, how I share it with other professionals and organizations, and how you can see it. I want you to know all of this so that you can make the best decisions for yourself and your family. Because the laws of this state and the laws of federal government are very complicated and I don't want to make you read a lot that may not apply to you, I have removed a few small parts. If you have any questions or want to know more about anything in this Notice, please ask me for more explanations or more details.

B. What I mean by your medical information
Each time you visit me or any doctor's office, hospital, clinic, or any other of what are called "healthcare providers", information is collected about you and your physical and mental health. It may be information about your past, present or future health or conditions, or the tests and treatment you got from me or from others, or about payment for healthcare. The information I collect from you is called, in the law, **PHI**, which stands for **Protected Health Information**. This information goes into your medical or healthcare record or file at my office. In this office this PHI is likely to include these kinds of information:

- Your history- as a child, in school and at work, marriage and personal history.
- Reasons you came for treatment-your problems, complaints, symptoms, or needs.
- Assessment/Diagnoses-diagnoses are the medical terms for your problems or symptoms.
- A treatment plan- a list of the treatments and any other services that I think will be best to help you.
- Routine progress notes- Each time you come in I write down some things about how you are doing, what I notice about you, and what you tell me.
- Records I get from others who treated you or evaluated you.
- Psychological test scores, school records, and other reports.
- Information about medications you took or are taking.
- Legal matters
- Billing and insurance information
- And other records (such as Release forms, personality inventories, etc)

Again, this list is just to give you an idea. There may be other kinds of information that go into your healthcare record here. I use this information for many purposes. For example, I may use it:

- To plan your care and treatment.
- To decide how well my treatment is working for you.

- When I talk with other healthcare professionals who are also treating you, such as your family doctor or the professional who referred you to me.
- To show that you actually received the services from me which I billed to you or to your health insurance company (where applicable, as at this point I do NOT participate in third party reimbursement plans/insurance companies).
- To improve the way I do my job by measuring the results of my work.

When you understand what is in your record and what it is used for you can make better decisions about who, when, and why others should have this information. Although your health record is the physical property of the healthcare practitioner or facility that collected it, the information belongs to you. You can read it and if you want a copy of select portions thereof, I can make one for you (but may charge you for the costs of copying and mailing, if you want it mailed to you). In some very rare situations you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or believe that something important is missing you can ask me to amend (add information to) your record although in some rare situations I don't have to agree to do that. If you want, I can explain more about this.

C. Privacy and the laws
I am also required to tell you about privacy because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA law requires me to keep your Personal Healthcare Information (or PHI) private and to give you this notice of my legal duties and my privacy practices, which is called the Notice of Privacy Practices (or Notice or NPP). I will obey the rules of this notice as long as it is in effect, but if I change it the rules of the new NPP will apply to all the PHI I keep. If I change the NPP I will post the new Notice in my office where everyone can see or provide an updated copy to my clients.

D. How your protected health information can be used and shared
When your information is read by me or others in this office, and used by me to make decisions about your care, this is called, in the law, "use." If the information is shared with or sent to others outside this office, that is called, in the law, "disclosure." Except in some special circumstances, when I use your PHI here or disclose it to others I share only the minimum necessary PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, how it is used and to have a say in how it is disclosed (shared), and so I will tell you more about what I do with your information. I use and disclose PHI for several reasons. Mainly, I will use and disclose it for routine purposes as explained herein. For other uses I must tell you about them and have a written Authorization from unless the law lets or requires me to make the disclosure without your authorization. However, the law also says that there are some uses and disclosures that don't need your consent or authorization.

1. Uses and disclosures of PHI in healthcare *with your consent*
After you have read this Notice you will be asked to sign a separate Acknowledgement form to allow me to use and share your PHI. In almost all cases I intend to use your PHI here or share your PHI with other people or organizations to provide treatment to you, arrange for payment for my services, or some other business functions called health care operations. Together these routine purposes are called TPO or Treatment, Payment and health care Operations), and the Acknowledgement form allows me to use and disclose your PHI for TPO. Take a minute to re-read that last sentence until it is clear because it is very important. Next, I will tell you more about TPO (Treatment/payment/operations).

1a. For treatment, payment, or health care operations.
I need information about you and your condition to provide care to you. You have to agree to let me collect the information and to use it and share it to care for you properly. Therefore, you must sign the Acknowledgement form before I begin to treat you, because if you do not agree and consent I cannot treat you. When you come to see us, I may collect information about you and all of it may go into your healthcare records here. Generally, I may use or disclose your PHI for three

purposes: treatment, obtaining payment, and what are called healthcare operations. Let's see what these mean.

For treatment. I use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the benefits of my services.
I may share or disclose your PHI to others who provide treatment to you, such as with your personal physician. If you are being treated by a team I can share some of your PHI with them so that the services you receive will be working together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, so we all can decide what treatments work best for you and make up a Treatment Plan. I may refer you to other professionals or consultants for services I cannot provide. When I do this I need to tell them some things about you and your conditions. I will get back their findings and opinions and those will go into your records here. If you receive treatment in the future from other professionals I can also share your PHI with them. These are some examples so that you can see how I use and disclose your PHI for treatment.

For payment. I will/ may use your information to bill you, your insurance (where applicable, please note that I do not currently participate in third party reimbursement plans) or others so I can be paid for the treatments I provide to you. TPO allows me to contact your insurance company (where applicable) to check on exactly what your insurance covers. I may have to tell them about your diagnoses, what treatments you have received, and the changes I expect in your condition. I will need to tell them about when we met, your progress, and other similar things. This is especially true when using managed care insurance

For health care operations. There are a few other ways I may use or disclose your PHI for what are called health care operations. For example, I may use your PHI to see where I can make improvements in the care and services I provide. I may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If I do, your name and personal information will be removed from what I send.

1b. Other uses in healthcare
Appointment Reminders. I may use and disclose medical information to reschedule or remind you of appointments for treatment or other care. If you want me to call or write to you only at your home or your work or prefer some other way to reach you, I usually can arrange that. Just tell us. There is a place to note this on my Notices form.
Treatment Alternatives. I may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.
Other Benefits and Services. I may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
Business Associates. There are some jobs I hire other businesses to do for me. In the law, they are called my Business Associates. Examples might include a copy service I use to make copies of your health records and a billing service that figures out, prints, and mails my bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy they have agreed in their contract with me to safeguard your information.

2. Uses and disclosures that require your *Authorization*
If I want to use your information for any purpose besides the TPO or those I described above I need your permission on an Authorization form. I don't expect to need this very often. If you do authorize me to use or disclose your PHI, you can revoke (cancel) that permission, in writing, at any time. After your revocation is received I will not use or disclose your information for the purposes that I agreed to. Of course, I cannot take back any information I had already disclosed with your permission or that I had used in my office.

3. Uses and disclosures of PHI from mental health records that don't *require* a Consent or Authorization
The law lets me use and disclose some of your PHI without your consent or authorization in some cases. Here are examples of when I might have to share your information.

When required by law
There are some federal, state, or local laws, which require me to disclose PHI.
- I have to report if I suspect you might harm yourself or someone else;
- I have to report suspected child abuse or elder abuse;
- If you are involved in a lawsuit or legal proceeding and I receive a subpoena, discovery request, etc., I may have to release some of your PHI. I will only do so after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.
- I have to disclose some information to the government agencies, which check on me to see that I am obeying the privacy laws.

Please note this list is NOT exhaustive and there may be other situations which dictate the release of your records. I will do my best to discuss these with you should they arise.

For law enforcement purposes
I may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

For specific government functions
I may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment. I may disclose your PHI to Workers Compensation and Disability programs, to correctional facilities if you are an inmate, and for national security reasons.

To prevent a serious threat to your health or safety, or that of another. If I come to believe that there is a serious threat to your health or safety or that of another person or the public I can disclose some of your PHI. I will only do this to persons or organizations who can prevent or reduce the threat

4. Uses and disclosures where you to have an opportunity to object
I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose such as close friends or clergy. I will ask you about who you want me to tell what information about your condition or treatment. You can tell me what you want and I will honor your wishes as long as it is not against the law. If it is an emergency - so I cannot ask if you disagree - I can share information if I believe that it is what you would have wanted and if I believe it will help you if I do share it. If I do share information in an emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law.

5. An accounting of disclosures
When I disclose your PHI I may keep some records of whom I sent it to, when I sent it, and what I sent. You can get an accounting (a list) of many of these disclosures.

E. Your rights regarding your health information
1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment. I will try my best to do as you ask.
2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep my agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information I have about you such as your medical and billing records, but you must make your request in writing. I will respond within 30 days of receiving your written request. In certain situations, I may deny your request. If so, I will tell you, in writing, of the reasons for the denial and your right to have the denial reviewed. You can even get a copy of these records but I may charge you, no more than $1.00 per page. Instead of providing the health information you requested, I may provide you with a summary or explanation of the information as long as you agree to that and to the cost in advance.
4. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to me. You must tell me the reasons you want to make the changes. I will respond within 60 days of receiving your request. I may deny your request if the health information is a) correct and complete, b) not created by us, c) not allowed to be disclosed, or d) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your health information.
5. You have the right to a copy of this notice. If I change this NPP I will post the new version in my waiting area and you can always get a copy of the NPP from me, or from my website.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me and with the Secretary of the Department of Health and Human Services at 200 Independence Avenue SW, Washington, DC 20201. All complaints must be in writing. If you do file a complaint it may be best for us to discuss transferring you to another therapist to continue providing excellent service to/for you. Also, you may have other rights, which are granted to you by state laws, and these may be the same or different from the rights described above.

F. If you have questions or problems
If you need more information or have questions about the privacy practices described above please speak to me. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, contact me. You have the right to file a complaint with me and with the Secretary of the federal Department of Health and Human Services.

If you have any questions regarding this Notice or my health information privacy policies, please contact me at Sage Heart Studio LLC, 44 East Main Street, Annville, PA 17003.
The effective date of this notice is April 1, 2017.

Privacy Officer
Pursuant to HIPAA Regulations: Ramona Ndlovu is hereby designated as the Privacy Officer for this practice and such individual shall be responsible for developing and implementing this entity's health care privacy policies and procedures, including, but not limited to, receiving and handling patient requests for restrictions on uses and disclosures of protected health information ("PHI"); patient requests to inspect & receive a copy of their PHI; patient requests to receive accountings of disclosures; and, patient requests to amend their PHI.

Contact Person: Ramona Ndlovu is hereby designated as the Contact Person for this practice and such individual shall be responsible for receiving complaints from patients concerning possible violations of their privacy rights.

Notice of Privacy Practices (HIPAA) Acknowledgement
Sage Heart Studio LLC

Acknowledgement of Receipt of Notice of Privacy Practices

This form is an agreement between you, _____ and Sage Heart Studio LLC/Ramona Ndlovu, MAMFT. LMT (MSG007885), CST, TTT™ When I use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____ . When I examine, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business functions. By signing this form you are agreeing to let me use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and describes how I can use and share your information. Please read this before you sign this Consent form. In the future I may change how I use and share your information and so may change the Notice of Privacy Practices. If I do change it, you can get a copy from me. If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish. After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on, but I may already have used or shared some of your information and cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

__ Copy given to the client/parent/personal representative

ACKNOWLEDGEMENT RECEIPT NOTICE OF PRIVACY PRACTICES/HIPAA
Sage Heart Studio LLC

**********You May Refuse to Sign this Acknowledgement**********

I, _____, have received a copy of this office's Notice of Privacy Practices/HIPAA

Print Name_____

Signature _____

Date _____

_____Individual refused to sign

_____Communication barrier prohibited signing

_____Emergency situation prevented us from obtaining acknowledgement

INFORMED CONSENT AND SERVICE AGREEMENT
FOR MARRIAGE AND FAMILY THERAPY
Sage Heart Studio LLC

This document contains important information about therapy, my practice, and is an agreement between us about how we will proceed together in therapy. You are invited to ask any questions you may have before you sign, or at any point in the future. Please take the time to read these agreements thoroughly and understand what you are signing. Information about the Health Insurance Portability and Accountability Act (HIPPA) is found on the Privacy Agreement, which you are also required to sign in order to proceed in therapy with me. HIPPA describes the use and disclosure of your Personal Health Information (PHI).

Please read my "Welcome Letter" to understand more about the way I practice therapy.

A. You have the right to request clarification or ask questions about any techniques, procedures, and modalities used in therapy. If you would like me to, I will explain my methods and approach to therapy to you.

B. It is my intention to approach marriage and family therapy from a holistic perspective. For me this means I involve and address the whole person, including body, mind, and spirit/soul. This may involve the use of traditional psychotherapeutic techniques focusing on cognitions, emotions, and behaviors; literature, including sacred texts; prayer; an invitation to explore your relationship with God, as you understand God; and an invitation to explore your body's experience of life. If there is anything mentioned in this section that you are not open to having me invite you to address please list them here (print clearly please):

_____

_____

C. You have the right to safe, quality, appropriate care that is respectful of you as an individual, couple, or family without discrimination in regards to race, ethnicity, color, disability, gender, sexual orientation, age, religion, immigration status, or national origin.

D. If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to honor the request of minors in individual therapy, in regard to sharing of information with parents, but we may make some recommendations/suggestions of types of information that might be useful to share with your parents. If you are in agreement, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concerns. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will

discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

If I see a client under the age of 14 (the age of consent in PA) all custodial parents and/or legal guardians must sign a release form for treatment. Although the law may give parents the right to information regarding their minor child's treatment it is important for you to know that exercising this right may have negative consequences on the therapeutic process. Consider allowing confidentiality between the therapist and child for these purposes.

E. You have the right to conclude therapy at any time. At your request, I will provide a list of qualified professionals you may choose to work with instead.

F. If you choose to conclude therapy you have no moral, legal, or financial obligations other than those you have already incurred. I request that you contact me in writing if you decide to conclude therapy without prior mutual agreement to conclude therapy. You may use the address at the top of this form. I will make a note in your record of the date I received this notification.

G. You have the right to review your records and request modifications at any time. Please refer to the PRIVACY AGREEMENT.

H. Confidentiality is very important to the therapeutic process therefore, information revealed by any party in therapy will be held in complete confidence unless maintaining that confidence violates the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics, local, state, or federal law; or my professional ethics. However, this limit does not extend to supervision or consulting with another therapist who is trained and more experienced. Accept for these limits, I will not release your PHI without your prior written consent. Please note, that I view all members of the family attending sessions to be the client and as such will not release any information about family sessions without a signed release of information from each attending person and/or their representative, as in the case of children under the age of 14 years.

i. Within the family system I will not keep secrets.
ii. I will offer the use of an Interfamily Information sheet to facilitate the sharing of all information in a therapeutic way at the next session.
iii. Please be aware that if you share a secret with me I will take this to mean that you wish my help in finding a way to share this information in a therapeutic way with those in the family unit.
iv. Please be aware that if you are under 18 years old and are engaging in behaviors that I consider high risk for personal endangerment such as gang activity, self-harm, drug use beyond minor experimentation, or high risk sexual behaviors I will encourage you to share this with your parents. If you refuse, then I will share this information in your presence. Please initial here to indicate that you are in agreement _____.

I. You have the right to put limits on who your information is released to and how it is released. I will comply within the limits of the law, the AAMFT Code of Ethics, and my own professional and personal ethics.

J. You have the right to request that any part of your PHI be released to any entity you designate. If you request it, I will tell you if I believe releasing your PHI to that entity may be harmful to you in some way. You will be charged the fee for copying, excluding the first copy, and postage.

K. You have the right to know that there are situations in which I am required by law to disclose your PHI and/or information disclosed during therapy sessions without your written or verbal consent. In these situations I am not required to inform you of my disclosure. They are as follows: 1) If you threaten serious bodily harm or death to yourself; 2) If you threaten serious bodily harm or death to another person; 3) If I become aware of child abuse or neglect; 4) If I become aware of elder or incapacitated adult abuse, neglect, or exploitation; 5) If I receive a signed court order for documents relating to your treatment and/or diagnosis; 6) If you are in therapy due to an order of a court of law, then that court has a right to the records of your treatment; 7) If you seek payment of treatment fees through an insurance company, I will be required to disclose your confidential information to them; and 8) In the event another therapist has made an ethical violation in relation to your treatment.

L. It is important that you know I cannot guarantee that information disclosed to an insurance company will remain confidential. In some instances this can have a negative impact on your circumstances due to multiple staff having access to your records and a possible lack of confidentiality related to job applications, insurance eligibility, and other situations.

M. You acknowledge that if in the course of your work at Sage Heart Studio LLC you involve me in any and all legal/court related matters, you agree to compensate me at the rate of $200.00 per hour, paying me *in advance* for a minimum of three hours ($600.00) and within ten days for any additional hours. You realize you will be billed for hours including document preparation, travel expenses, meals, telephone time, parking and any and all legal counsel I seek regarding your case, etc. Furthermore, if you as a counselee file a complaint/legal suit against me, you understand that I am authorized to fully disclose any and all relevant information regarding you/our meetings together, in my defense and you, thereby, waive your right to confidentiality and/or privacy.

N. If I receive a court ordered subpoena for my records I will request that you contact the attorney and request the attorney to quash the subpoena.

O. I am currently pursuing licensure in Pennsylvania as a Marriage and Family Therapist. As such, I am in ongoing supervision with Robb Palmer, Ph.D., D. Min, LMFT. An important part of my supervision involves giving my supervisor the opportunity to observe my work with clients through video or audio for later

playback during supervision sessions. Please be aware that the profession of marriage and family therapy has very clear and strict ethical standards concerning the confidentiality and protection of privacy. Recordings are generally erased after one month or after being used in supervision, whichever is sooner.

I understand fully the information regarding audiovisual recording and its use and my initials here indicate my consent:
_____.

I understand that sometimes therapists find it helpful to consult other health care, ministry care and/or mental health professionals and I authorize Ramona to do so regarding my case. I realize that she will only do so making every effort to avoid revealing my identity. I also realize I may or may not be informed of these anonymous consultations.

P. I will typically use the first 4-5 sessions to gather information on what brings you in for therapy, your history, and to make an assessment. Sessions 5-6 will generally be used to create goals we all agree upon. At the end of this evaluation I will offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist or counselor you select. If you have questions about any procedures, we should discuss them whenever they arise. If your doubts persist, I would be happy to refer you to another mental health professional for a second opinion. I will do my very best to provide you with therapy that tailors activities and strategies to your individualized needs and issues or to your family's needs and issues. You are asked to "speak up" if you have any questions about what we are doing or what I am recommending so that we can talk further about the rationales and your concerns. You always have the right to say no to any of the homework or in-session suggestions I recommend to you and we can always talk about what is and what is not working for you in therapy between you, your family, and myself.

If you choose to proceed with therapy, sessions 6 through conclusion will include assessing progress, modifying goals, creating a plan for support after the conclusion of therapy, and concluding therapy. I will purpose to keep therapy as brief as possible while maintaining an appropriate standard of care to the best of my ability. Therefore, fewer than six sessions may be needed to resolve your presenting problem.

Q. Sober expectations: I must insist that you never come to sessions under the influence of any mood altering chemical unless you are on prescription medication managed by an appropriate physician or psychiatrist. If I feel that therapy is being sabotaged by your substance abuse in any way I will ask you to submit to a substance abuse evaluation at a licensed drug and alcohol facility in the area. Based on the results of that assessment you may be asked to refrain from all non-prescribed use of drugs and alcohol. If for some reason you are not successful in

abstaining I will work with you in referring you to the next level of care, which may be intensive outpatient therapy or inpatient substance abuse rehabilitation services at an agency that is licensed to provide those services.

R. You have the right to make an official complaint about the treatment services you have from me. These complaints can be made to the AAMFT, the Pennsylvania Department of Health and Human Services, and/or the Pennsylvania State Board of Social Workers, Marriage and Family Therapists and Professional Counselors.

S. I request that if you have concerns or complaints about the treatment services you are receiving from me that you first approach me by phone or in person. If we are unable to resolve our differences, then we will enter into mediation. We will use legal recourse as a last resort. Initial on the line if you agree to this _____.

Benefits and Risks of Therapy and Therapeutic Process:

Therapy is intended to be a healthy relationship between therapist and client for the general purpose of promoting increased health in the client's relationships including relating to self and others. When you enter into therapy, all those who make up the "client" (individual, couple, or family) will establish the goals of therapy with me. These goals will attempt to address the presenting issue(s) as communicated by those present. You may experience benefits such as improved ability to relate to others and cope with difficulties in any or all of your current relationships such as marriage, family, or job. In order for therapy to have the best outcome it will require hard work on your part and a willingness to work openly and honestly with the therapist and other members present for therapy. Please plan to work on homework assignments between therapy sessions. It is my belief that the stated goals we set together will be achievable. It is my intention to meet you where you are and assist you to gain greater health and wholeness with regards to the way you experience life through your relationships.

There are times when therapy, of necessity, needs to address painful and/or sensitive issues. Challenging and uncomfortable emotions, thoughts, or memories may arise. These can even disrupt the way you currently conduct your life. Some may choose a course of action that brings significant change to their lives such as separation, divorce, or other changes in the way you relate to others in your life. I ask that you would let me know when this is happening for you so that we can make plans to support you so that changes bring successful resolution to your presenting issue(s). Therapy is not an exact science and specific outcomes cannot be guaranteed.

I use specialized treatment services including Trauma Touch Therapy and Transformative Touch Therapy. In general, body based therapies over time can increase energy, reduce stress, tension and fatigue, increase body awareness, and options for responding to life's challenges. For each of these specialized services you may be required to do additional paperwork beyond this informed consent.

To Contact Me:

Please contact me by telephone. The phone number included below for scheduling appointments may be used to leave a message on my confidential voice mail. At times I may not be available by phone, such as when I am with another client. You may leave a message and I will return your call as soon as possible. Please allow 24 – 48 hours for non-emergency matters.

I offer outpatient therapy only, which does not include crisis intervention services. This does not mean my clients will not have crises. They do and I try to assist in any way I can. What it does mean, however, is that in a crisis there are much more qualified professionals that are available and set up to assist at a moment's notice. If you experience an emergency (you are not able to wait for a return call or if you feel that you are unable to keep yourself safe): 1) Go to your local Hospital Emergency Department; or 2) call 9-1-1 and ask to speak to a mental health worker on call; 3) Call your local Crisis Intervention number; or 4) Call your family physician.

In the event of any planned absences I will make every effort to inform you in advance.

Appointment, Fees, and Payment:

Appointments are made by phone (717) 449-0934, or in person for a time that is mutually convenient for all parties. Sessions are usually 50 minutes in length. I recommend that sessions be scheduled weekly early on in therapy in order to develop the therapeutic relationship between client and therapist; assess; set goals; and engage the therapy process. The time set for your appointment is reserved just for you and cannot extend beyond the scheduled time. If you arrive late we will work with the time remaining at the full fee.

If you need to cancel or reschedule your appointment, I request that you give me 24-hour notice. **If you cannot give 24-hour notice or you don't show/call to an appointment you may be charged the full session fee** for the missed session unless we both agree that it was for an emergency. This fee will be charged to your credit card on file or taken from the deposit you made at the beginning of therapy.

I will make every effort to be on time for your scheduled appointment. If I can I will go over the session time limit to make up for the time if the lateness was due to my schedule. If I am running late and cannot go over the scheduled time I will pro-rate the session for you. Please try to be on time as much as possible keeping in mind that I want to give you the best opportunity to deal with issues, any trauma resolution and then containment and closure for the week to come. If you come more than 15 minutes late to a session I may not be able to accomplish what you had in mind due to the shortened time frame.

I currently do not participate with any insurance companies. If you wish to submit a claim to your insurance carrier for reimbursement as an out-of-network provider, please inform me and I will provide you with a statement for that purpose. This usually requires you to allow me to disclose your mental health information to the insurance company.

Your signature below means that all parties participating in therapy understand that the fee for a 50-minute therapy session is $80. I do offer a sliding fee scale for those clients who are in need of it. Please ask if this may apply to you. **Payment is expected at the end of each session.** You, and not a third party, are responsible for this fee. You have agreed to a fee of $_____. You understand that if you fail to pay I have the right to discontinue meeting with you.

It is important for you to understand that the fee schedule on the above services may change at any time due to increased costs and inflation. I will give one-month notice of any fee increases to you.

It is also important for you to know that it is not necessary for you to give anything in the way of gifts. I only expect those fees that are due to me for the provision of services.

I do not provide electronic billing to any entity including individuals and agencies.

Consent to Psychotherapy and to pay fees accrued:

Your signature below means that you understand that the therapist has the right to seek legal recourse to recoup an unpaid balance. The therapist will only disclose biological information and the amount owed in order to ensure confidentiality in the process of recouping an unpaid balance. Your signature below also means that you have read this Agreement and the Privacy Agreement and you agree to their terms.

Client Signature	Printed Name	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If client is a minor child, the signature of the legal guardian(s) is required.

_____ _____ _____

Relationship to minor child _____.

_____ _____ _____

Relationship to minor child _____.

_____ _____ _____

Relationship to minor child _____.

Therapist: _____ Date: _____

The client or family members: _____ accepted a copy of this form (online) _____ rejected a copy of this form.