Transitional Anger Management Services, LLC
Counselor/Client Agreement

Welcome. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operation. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which you are given with this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before your treatment here. We can discuss any questions you have about the procedures during session. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

The Counseling Process: Therapy is a cooperative learning process through which you will grow into taking enhanced control over your life and becoming more self-motivated and empowered. This process requires a commitment for you to explore the problems that brought you to counseling. At times, therapy may stir up feelings of discomfort and a realization that a loss or previously unresolved issue may contribute to your current situation. Therapy can also result in humor and fun, relief, new insights and behavior change. The greater the investment you make in therapy by expressing your feelings and opinions about the process, the more successful this endeavor will be for you. Sometimes outside "homework" is helpful such as reading, journal writing, exercising, or simply taking better care of yourself. It is not advised for clients to leave therapy prematurely once he/she receives some relief from initial concern. Consult with the therapist prior to ending sessions. Recordings are not permitted.

Confidentiality: Under the code of ethics for American Counseling Association, Protected Health Information, particularly information shared in the therapy session, is strictly confidential and will not be disclosed without your written authorization except in these situations:

1) When there is clear and immediate danger to you, other individuals, or society, we are required to intervene. If we believe you pose a life threatening risk to yourself or to others, we may need to notify responsible individuals for your protection. In this case, we may call your emergency contact person, a friend or relative, or

summon the police to take you to a hospital for psychiatric evaluation or observation.

2) Child abuse reporting laws in the State of Tennessee require counselors to report suspected cases of child abuse to the Department of Human Services. Child abuse and neglect may include physical, emotional or sexual abuse of children or the abandonment of children.
3) If we know that an elderly or disabled adult has been abused , neglected, exploited, or been sexually or emotionally abused, the law requires that we file a report with the appropriate governmental agency, usually the Department of Human Services. Once such a report is filed, we may be required to provide additional information.
4) If you are involved in a court proceeding and a request is made for information concerning your
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6) diagnosis and treatment, we will not disclose information without your (or your legal representative's) written authorization, a subpoena or court order.
7) In order to receive payment from insurance companies, DHS or other agencies, we may be asked to release details about your treatment with us. When disclosing information we will make reasonable efforts to limit the information to the minimum necessary to accomplish the

intended purpose of the disclosure. If your account becomes delinquent, we may release minimal information to a collection agency in order to obtain payment.

1) At times, we may consult with other mental health professionals if we feel it is needed to offer the best possible service for you. During a consultation we make every effort to avoid revealing the identity of the client.
2) You should be aware that we employ administrative staff and utilize interns as a business practice. It may be necessary to share information with them related to scheduling, billing, bookkeeping and quality assurance. All of our staff or interns are bound by the same rules of confidentiality and have been given training about protecting your privacy.
3) Clients under 18 years of age who are not emancipated should be aware that the law may allow parents to examine their treatment records unless we decide that such access is likely to be harmful to the child, or we agree otherwise. The therapeutic relationship with children is to be respected. Children need to know that they can trust their therapist and feel safe and secure in their therapy session. Because privacy in therapy is often crucial to successful progress particularly with teenagers, it is often our policy to request an agreement from the parents that they consent to give up their access to their child's records. If they agree, we will provide them with general information of the child's treatment, and attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when complete. Any other communication will require the child's authorization unless we feel that the child is in danger or is a danger to someone else, in which case we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he or she might have.

4) If a government agency is requesting information for health oversight activities, we are required to provide it for them.
5) If a client files a worker's compensation claim, we may disclose information relevant to that claim to the client's employer or insurer.
6) We reserve the right to use the information you reveal to us to evaluate our services and conduct research. Anonymity will be maintained.
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8) **Appointments:** Appointments are usually scheduled on the hour and last fifty minutes. Therapy is a time sensitive activity and your appointment is reserved specifically for you. If you must cancel an appointment or reschedule, please call 24 hours before the appointment time. Cancellations with less than 24 hours notice will be charged your regular fee. If you fail to show up for your scheduled appointment without notifying us ahead of time, you will be held responsible for the full fee of the missed appointment.
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10) **Length and Termination of Therapy Sessions**: Sessions are 45-50 minutes. The number of therapy sessions may vary depending on the type and severity of problems. Your therapist will take into account individual factors and discuss a time frame that meets your needs. Because of the importance of the therapeutic relationship between client and therapist, we encourage you to talk to your therapist if you are considering leaving therapy. The therapy process involves a growth experience. Therefore, terminating the relationship is part of that growth experience.
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13) **Fee and Payment**: Fees are based on individual and group services. Individual Anger Management $40 (35 mins), Group Anger Management $30/20, Couples Anger Management $70, Individual Therapy $70, ASD Therapy $65, Couples Therapy $90, Child/Teen Individual Therapy $50, Child/Teen Anger Management $30, and Hypnotherapy $75. Payment due at time of service. We accept payment by credit card/cash/check. If you have concerns regarding your payment, this may be discussed with your therapist prior to the appointment. **Additional time in sessions are per 10 minutes, $15.** I consent to 3% fee for credit/debit payment.
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15) **Business Hours**: Our business hours are generally from 8:30 am to 5:00 pm Monday through Friday, and occasional Saturdays. However, hours may vary according to therapist availability and emergencies. We have voicemail available to you anytime. If you leave a message after hours or on weekends, it will likely be the next business day before we are able to return your call. However, if you feel that you need immediate assistance after-hours, you should contact the Crisis Center at 901-274-7477 or 911, contact your primary care physician or go to the nearest emergency room.
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17) **Procedures Regarding Legal Proceedings**: Any attorneys requiring confidential information on clients will be charged to the client for the information released,

the time required to compile the information and any materials or postage necessary. The client will also be billed for all court costs incurred. This will include preparation time, actual court appearance, and travel time. (A minimum of three hours will be billed for the court appearance and travel time.) The fee involved for these services will be $95.00 per hour. The sliding fee scale does not apply when Legal Proceedings are involved. Fees are due at the time of appearance. For clients who are/have been married and/or parents who have both been clients of this provider are not entitled to therapy information on the other party without permission from said client. Release of information in couples therapy is only granted with both parties consent.

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19) **Patient Rights**: HIPAA provides you with new or expanded rights with regard to your Clinical Record and disclosure of Protected Health Information. These include requesting that we amend your record; requesting restrictions on what information from your Protected Health Information that you have neither consented to nor authorized, determining the location to which protected disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a copy of this Agreement and the Notice of Policies and Practices to Protect the Privacy of Your Health Information form. IF YOU HAVE ANY QUESTIONS ABOUT THIS AGREEMENT, PLEASE ASK YOUR THERAPIST. YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client or Legal Guardian Printed Name, Date:

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Client or Legal Guardian Signature, Date:

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Therapist Signature Date: _____

Teresa S. Hall-Franklin, Ed.S, Licensed Professional Counselor, National Certified Counselor, Certified Anger Management Facilitator
5100 Poplar Avenue, Ste. 2700
Memphis, TN 38137
901-608-1000
www.gotangermanagement.com