Client Information and Consent

Welcome and thank you for considering Minerva Center for Psychology PLLC ("Company", "us") for your mental health needs. This document contains important information about our professional services and business policies.

Mental Health Services

The undersigned professional is a licensed healthcare professional. The mental health professional is engaged in private practice providing mental health care services to clients through the Company or via licensed agents of the Company. As an agent of the Company, your mental health professional provides all mental health services through the Company and not personally.

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The mental health professional, using their knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches for change to occur.

Appointments

Appointments are made by email ckangel@mac.com during the normal business hours listed at www.minervacenterforpsychology.com or visiting https://www.minervacenterforpsychology.com/appointment and using our EHR system for which you will receive instructions on how to access. Please email or log in to your EHR portal to cancel or reschedule at least 24 hours in advance, or you may be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. If you are late, you will be charged for the full amount of the appointment and there will be no pro-rating of the fee. If the mental health professional has to cancel the appointment, you will be entitled to a refund.

Number of Visits

The number of sessions needed depends on many factors and will be discussed by the mental health professional. Your initial session will involve an evaluation of your needs and depending on your circumstances further evaluative sessions may be required. At the end of the evaluation process the assigned mental health professional will be able to provide you with some first impressions of what mental health services may include and a treatment plan to follow if both you and mental health professional agree to work together. You should evaluate this information along with your own opinions of whether you feel comfortable working with the mental health professional. Mental health services involve a large commitment of time, money, and energy, so you should be very careful about the mental health professional you select. If you have questions

about procedures feel free to discuss them with the mental health professional at any time. If you have doubts your mental health professional will be happy to help you set up a meeting with another mental health professional for a second opinion.

Length of Visits

The initial intake and evaluative session is normally scheduled for fifty (50) minutes and may run longer depending on the testing or assessments a client is asked to complete. Further evaluative sessions may be scheduled as needed for the mental health professional to accurately assess your needs. Once the evaluation process is completed sessions are 45-50 minutes in length.

Relationship

Your relationship with the mental health professional is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the mental health professional not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The mental health professional cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you.

If the mental health professional encounters you in a public setting, in order not to reveal your identity the mental health professional will not acknowledge your presence unless addressed by you first.

Gifts, bartering, and trading services are not appropriate and should not be shared between you and the mental health professional.

Payment for Services

The fees for our services are listed below (or attached on a fee schedule):

1 hour Diagnostic Assessment (90791) - $250

60 minute session (90837) - $200

45 minute session (90834) - $175

30 minute session (90832) - $150

Testing Administration (96136) - $150

Testing Administration (96137) - $150

Test Interpretation (96130) - $275

Test Interpretation (96131) - $250

3 hour Training - $800

2 Day Seminar - $3500

These fees are subject to change upon thirty (30) days' prior notice to you. If you are unable to pay, or are not willing to pay, the higher fee after receipt of notice, services may be terminated, and you may be given referrals to other competent providers. The undersigned mental health professional will look to you for full payment of your account, and you will be responsible for payment of all charges.

Although it is the goal of the undersigned mental health professional to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or the mental health professional's testimony are requested by you or required by law, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged by the mental health professional at the time of the request or service of the subpoena (current rate is $350/hour) for the time involved in traveling to and from the testimony location, reviewing records and preparing to testify, waiting at the location, and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the mental health professional. The mental health professional may require a deposit for anticipated court appearances and preparation. You will not be entitled to a pro-rated refund.

Duty to Warn

In the event that the undersigned mental health professional reasonably believes that you are a danger, physically or emotionally, to yourself or another person, by signing this information and consent form below, you specifically consent for the mental health professional to warn the person in danger and to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel.

This information is to be provided at your request for use by said persons only to prevent harm to yourself or another person. This authorization shall expire upon the termination of your mental health services with the undersigned mental health professional.

You acknowledge that you have the right to revoke this authorization in writing at any time to the extent the undersigned mental health professional has not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned mental health professional that you have received and reviewed.

You acknowledge that you have been advised by the undersigned mental health professional of the potential of the redisclosure of your protected health information by the authorized recipients and that it may not be protected from unauthorized disclosures as required by the federal Privacy Rule.

You further acknowledge that the treatment provided to you by the undersigned mental health professional was not conditioned on you providing this authorization.

Mandated Reporting

Under certain state law, persons in designated professional occupations are mandated to report suspected child abuse or neglect or maltreatment of vulnerable adults. Persons who work with children and families are in a position to help protect children from harm. These persons may be required by law to report, if they know or have a reason to believe that a child or vulnerable adult is being abused or neglected. As a mandated reporter, the mental health professional may be required to break confidentiality and report certain information to the appropriate authorities.

Risks of Mental Health Services and Assumption of Risk

You may learn things about yourself that you do not like. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from mental health services. Specifically, one risk of marital mental health services is the possibility of exercising the divorce or separation option. There are no guarantees in mental health services and the mental health professional does not make any guarantees with this agreement. You assume the risk of mental health services by signing this form. The mental health professional is not liable for any adverse reactions to mental health services. The mental health professional may take any reasonable action necessary during mental health services when there is a dangerous circumstance, as determined by the mental health professional.

After-Hours Emergencies

Please know that your mental health professional and Company do not provide twenty-four (24) hour crisis or emergency mental health services. Should you experience an emergency necessitating immediate mental health attention, immediately call 911 or if you are able to safely transport yourself, go to the nearest hospital emergency room for assistance.

Contacting Your Mental health professional

Your mental health professional is often not immediately available by telephone or in person. Email or the electronic portal are the best way to communicate with the mental health professional.

There is no guarantee of a response time or a response at all. If you are difficult to reach, please inform your mental health professional of times when you will be available. In most circumstances, the appropriate time to discuss any topic outside of rescheduling is at the next session.

E-Mail

The undersigned mental health professional and Company may use and respond to email only to arrange or modify appointments. Please do not send emails related to your treatment or mental health services as electronic communications are not completely secure and confidential. Any mental health services related questions or issues will not be addressed by the mental health professional in any electronic communication but will be dealt with during your next appointment. Any electronic transmissions of information by you are retained in the logs of your service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should know that any e-mails, online communications and specifically the website www.minervacenterforpsychology.com are not secure and you assume the risks of the insecure transmission.

Social Media

Your mental health professional does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the mental health professional and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to surreptitiously gain access to the mental health professional's personal site(s) will be cause for termination of the mental health services.

Mental health professional's Incapacity or Death

You acknowledge that, in the event the undersigned mental health professional becomes incapacitated or dies, it will become necessary for another mental health professional to take possession of your file and records for administrative purposes, but not necessarily to become your mental health professional. By signing this information and consent form below, you give consent to allowing another licensed mental health professional selected by the undersigned mental health professional to take possession of your file and records and provide you with copies upon request, or to deliver them to a mental health professional of your choice and also to provide you with simple notifications of updates of the Company transition. The Company will select a successor mental health professional within a reasonable time and will notify the appointed licensed mental health professional.

Colleague Consultation

In keeping with standards of practice, your mental health professional may consult with other mental health professionals regarding care and management of cases. The purpose of this consultation is to ensure quality of care. Your mental health professional will maintain complete confidentiality and protect your identity by not using real names or any identifying information.

Audio and Video Recordings

You acknowledge and, by signing this information and consent form below, agree that neither you nor the undersigned mental health professional will record any part of your sessions unless you and the mental health professional mutually agree in writing that the session may be recorded. You further acknowledge that the undersigned mental health professional objects to you recording any portion of your sessions without the mental health professional's written consent. You expressly agree that audio and video recordings used for security purposes are not part of mental health services, and are therefore not protected by confidentiality or any other provisions under this agreement.

Termination of Relationship

The undersigned mental health professional may set boundaries including forms of client interactions and communication including ceasing to provide services to you for good cause, including without limitation: your refusal to comply with treatment recommendations, the undersigned mental health professional or staff is uncomfortable working with you, or your failure to timely pay fees or deposits in accordance with this Agreement, subject to the professional responsibility requirements to which the undersigned mental health professional is subject. It is further understood and agreed that upon such termination of services of the undersigned mental health professional, any of your deposits remaining in the undersigned mental health professional's account shall be applied to any balance remaining owing to the undersigned mental health professional for fees and/or expenses and any surplus then remaining shall be refunded to you.

Conflicts of Interest

Mental health professionals avoid conflicts of interest in treating minors or adults involved in custody or visitation actions by NOT performing evaluations for custody, residence, or visitation of the minor. Mental health professionals who treat minors may provide the court or mental health professional performing the evaluation with information about the minor from the mental health professional’s perspective as a treating mental health professional, so long as the mental health professional obtains appropriate consents to release information.

Pre-Licensed Mental health practitioner

The Company may make use of a pre-licensed mental health professionals, which are individuals in the mental health field working toward their professional licensure in mental health services under an approved tract allowed by law. This means that the practitioner does not have a license.

The practitioner is authorized to provide services while under supervision of a licensed professional. You understand this engagement and you consent to it by signing this Agreement. You have had the opportunity to ask questions about the engagement. You may continue to ask questions or voice concerns at any time. You may request to not have a pre-licensed mental health professional, but this may mean that services are unable to be rendered at the Company.

Legal

This Agreement shall be construed in accordance with, and governed by, the laws of the State of Incorporation of the Company as applied to contracts that are executed and performed entirely in State of Incorporation of the Company. The exclusive venue for any court proceeding based on or arising out of this Agreement shall be the county of the business address of the Company. The parties agree to attempt to resolve any dispute, claim or controversy arising out of or relating to this Agreement by arbitration, which shall be conducted under the then current arbitration procedures of the American Arbitration Association any other procedure upon which the parties may agree. The parties further agree that their respective good faith participation in arbitration is a condition precedent to pursuing any other available legal or equitable remedy, including litigation, arbitration or other dispute resolution procedures. If any legal action or any arbitration or other proceeding is brought for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, the successful or prevailing party or parties shall be entitled to recover reasonable attorneys' fees and other costs incurred in that action or proceeding, in addition to any other relief to which it or they may be entitled.

Consent to Mental Health Services

I, voluntarily, agree to receive (or agree for my child to receive) Mental Health assessment, care, treatment, or services, and authorize the Company to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care (or my child's care), treatment, or services, and that I may stop such care, treatment, or services that I receive (or my child receives) through Company at any time.

By signing this Client Information and Consent form, I, the undersigned client (or parent/guardian), acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

I acknowledge that I received a copy of this signed information and consent form from my mental health professional on the date listed below.

Client/Parent/Guardian 1 Signature: _____
Date: _____

Parent/Guardian 2 Signature: _____
Date: _____

(Only necessary if client is a minor and parents are separated)

My signature indicates that I am the legal parent or guardian of the above named minor and that I am allowing my child to be treated at the Company in the event of an accident, injury, illness, or other medical condition. I understand that I am responsible for all costs incurred and that an insurance ready bill will be provided for me to submit to my insurance company. I recognize that I have the right to revoke this consent and that this consent is not needed when the above named individual reaches the age of consent or applicable law in my State and meets any of the conditions identified above.

Client/Parent/Guardian 1 Signature: _____
Date: _____

Parent/Guardian 2 Signature: _____
Date: _____

(If client is a minor and parents are separated)

Parental Waiver of Right to Child's Records [Optional]

I hereby waive my right as parent/guardian to obtain information from and copies of any records from Company pertaining to the assessment, evaluation, and treatment of the my child. I

understand that Company may refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child's mental health evaluation and treatment, if disclosure in the opinion of the child's mental health professional would negatively impact the child or the child's evaluation and treatment. I hereby release Company and its agents from any and all liability for good-faith refusal to disclose the child's information or records.

Parent 1/Guardian Signature: _____

Date: _____

Parent2/Guardian Signature: _____

Date : _____