366 East Graves Ave, Suite D
Orange City, FL 32763-5266
386-775-0990

- ☐ Bryce Laraway, MS, LMFT
- ☐ Lynda Ruf, EdS, LMFT, LMHC
- ☐ Sutton Shepherd, MA, LMHC
- ☐ Veronica Petkus, MS, LMHC

Dear Client:

Thank you for requesting services with me. I am committed to provision of the best possible services to individuals, couples, and families. I value my relationship with you, the opportunity to serve you and your family, and I strive to respect your dignity and self-determination. The model from which I work is health-oriented, emphasizes empowerment and collaboration, and affirms and supports diversity.

I would like to take this opportunity to inform you of several procedural aspects of my work:

Initial

Fees: My standard fees are $225 for the initial consultation and $150 per subsequent session. Usually sessions last between 45 and 50 minutes, unless other arrangements are made. Payment in full is required at the time of service. There is a $35.00 service charge for each returned check.

Confidentiality: Services provided to you, as well as the records maintained in my files are confidential. No information is provided to anyone without your written consent. ***All*** participants must give written consent in the event that one member of the client system requests copies of the records. You may have access to your records at any time you request them. If you desire a copy of your records, I will make a copy of them for you as soon as possible. Due to the costs involved with duplication, there will be a service charge of .25 per page. The limits of confidentiality are legally determined. I am required to violate confidentiality when child or elder abuse is reported. I am also required to violate confidentiality in the case of intention to harm self or others. For further information on privacy practices, please refer to my privacy statement.

Appointments: When you schedule an appointment, that time is reserved for you. In the event that you are not able to keep that appointment, I would appreciate knowing as soon as possible. If an appointment is missed, and notification is not received 24 hours in advance, I will charge you for that missed session.

Hours of Operation: My office hours are by appointment. I schedule my own appointments, so if I am unavailable at the time of your call, please leave a message with your name, contact phone number, and reason for the call, and I will contact you as soon as possible. I am not available on a 24-hour on-call basis.

Smoking: To protect you and those around you from second-hand smoke, please do not smoke inside the building.

Restrooms: There is one public restroom in the building. It is located in the center of the building,

I hope that the services I provide you will assist you in accomplishing the goals that brought you here. I am committed to treat you with respect and to value your participation in our work together. If, at any time, you have any questions, concerns, or comments about the therapy or my services, I would like to hear from you. Your feedback is very important to me.

If you have any questions or comments regarding this letter, I invite you to discuss them with me. By signing below, you are acknowledging that you have read and received a two-page informational letter; have the option of practice brochure and a privacy practices statement available on request; that you are voluntarily seeking services; and that you give your consent to receive services and participate in therapy with me. You are also acknowledging that should you cease attending sessions with me for 30 days without prior indication of reason, your case will be considered closed and that you are aware that you can reinitiate therapy with me at a later date by contacting me at (386) 775-0990.

____

Client signature   Date

____

Therapist signature   Date

over

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Consent for Purposes of Treatment, Payment, and Healthcare Operations

I, ____ , consent to the use or disclosure of my protected health information by my therapist for the purpose of diagnosing or providing treatment to me, obtaining payment of my health care bills, or to conduct mental health care operations and practices by my therapist. I understand that diagnosis or treatment of me by my therapist may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. My therapist is not required to agree to the restrictions that I may request. However, if my therapist agrees to a restriction that I request, the restriction will be documented and binding for her/him.

I have the right to revoke this consent, in writing, at any time, except to the extent that my therapist has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my therapist, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have read/received a Notice of Privacy Practices for my therapist and have had the opportunity to review them prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of mental health care operations of my therapist.

My therapist reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by verbal or written request.

______________________________	______________________________
Signature of Client or Personal Representative	Date
______________________________	______________________________
Printed Name of Client or Personal Representative	Description of Personal Representative's Authority

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