JENNIFER BLOOM, LCSW

Licensed Clinical Social Worker

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Therapist-Client Service Agreement & Informed Consent

OUTPATIENT SERVICES CONTRACT

Greetings and welcome to my practice. This document (the Agreement) contains information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. Please be assured you have the right to revoke this agreement in writing at any time.

THERAPEUTIC SERVICES

Marriage and Family Therapy or Mental Health Counseling may vary from therapist to therapist depending on the specific approach/theoretical orientation and personalities of the clinician and client, as well as the particular presenting issues. There are many different methods I may use to assist you in addressing problems. Effective therapy calls for a therapeutic alliance or “team effort” between therapist and client. In other words, both parties actively work together to confront challenging issues. Often times, this may require the client work on things we have discussed in session, and at home as well. I will not be providing
Therapy may have risks, as well as benefits. Therapy often involves discussing unpleasant aspects of life and may cause unpleasant feelings, such as sadness, guilt or anger. However, benefits often include improved relationships, specific solutions and significant improvement of sense of happiness and well-being. Unfortunately, there is no way to guarantee individual results.

Generally, sessions progress more effectively if you are able to talk as freely as you can about any relevant issues or problems you are experiencing. This may include thoughts, feelings, memories, perceptions, dreams.

WHAT YOU MAY EXPECT

A therapeutic hour is approximately 50-60 minutes long. Our initial session will consist of the completion of all required documentation (i.e. informed consent/agreements, fees, etc.), an evaluation of your needs and expectations regarding therapy. At this time, I would like to provide a better perspective on what working with me will be like. I understand and respect the importance of therapy and the commitment of time and resources it requires. Counseling is not a “one-size-fits-all”, I encourage you to feel empowered to choose the best counselor for you; one you feel comfortable with. Please

be aware of your rights as a client. Feel free to ask any questions you may have, including assistance if finding another therapist if necessary. This is your therapy.

Should you decide to continue with me, we would schedule hourly appointments on a week to week basis, or as needed. Generally, sessions are 50 minutes, but may run longer due the severity of the issue or progress gained in session (a “breakthrough" for example). Once an appointment is scheduled, via text, email, in person or by phone, you will be expected to pay for it, unless at least 24 hour notice is given. I am aware that there are sometimes circumstances beyond our control, in that case another appointment may be rescheduled without the cancelation fee.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. Barring emergencies, I do not answer the phone when I am in session out of respect for my client’s time and commitment to therapy. I encourage you to leave me a voice mail or email and I will be sure to respond as promptly as possible (usually same business day). When leaving emails it is best **NOT** to include in-depth or personal information due to protecting your privacy. I am open to receiving phone calls on the weekends and holidays for urgent situations or emergencies. Again, be sure to leave me a voice mail if you want me to call you back.
I may take time for vacation, but I will always discuss upcoming breaks in advance so that we can sufficiently prepare for the temporary interruption of services. I will also offer a referral for alternate counseling should it become necessary. ***If you are unable to reach me or cannot wait for a call back, please see list below for alternative numbers for assistance:***

The Alzheimer’s Association Helpline………………………………………………………………………… (800) 272-3900
The Wave Of Clearwater/ Women’s Mental Health Center……………………………………………(727) 437- 7789
Windmoor Healthcare……………………………………………………………………………………………..(727) 541- 2646
John Hopkins All Children’s Hospital……………………………………………………………………… (727) 898-7451
HCA Largo Indian Rocks Hospital…………………………………………………………………………… (727) 581-9474
Suicide Hotline…… 800-273-8255
Boley Centers……… (727) 821-4819
St. Anthony’s Behavioral Health Center……………………………………………………………………(727) 825-1501
Joseph’s Hospital – 24 Hour Psychiatric Crisis Line…………………………………………………(813) 872-9299
Largo Medical Center………………………………………………………………………………………………(727) 588-5200
Memorial Hospital of Tampa……………………………………………………………………………(813) 873-6400
Abuse Hotline…………………………………………………………………………………………(800)962-2873
Crisis Center of Tampa Bay……………………………………………………………………………(813)964-1964
2-1-1 Crisis Hotline (also on-line)
or ***911**

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization or consent form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on the other accompanying Acknowledgement Receipt provides consent for those activities as follows:
● I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. I will note all consultations in your Clinical Record.
There are some situations where I am permitted or mandated to disclose information ***without*** either your consent or authorization:

- ● If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide information to them.

- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

If a client files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parities, including the client's employer, the insurance carrier or an authorized qualified rehabilitation provider.

There are some situations in which I am ***legally*** obligated to take actions, which I believe are necessary to protect others from harm and I may have to reveal some information about a client's treatment. These situations include:

- If I know or have reason to suspect, that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited, the law requires I file a report with the central abuse hotline. Once such a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the client, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member and/or police or seeking hospitalization of the client.
- If you inform me that another licensed healthcare professional in the state of Florida has engaged in any form of sexual behavior with a client, I must report this to the appropriate licensing board in the state.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. In situations where specific advice is required, formal legal advice may be needed.

PERSONAL RECORDS

The law and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (other than a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health care professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee. I will not be providing you a diagnosis or a treatment plan since I am not taking insurance. If you haven't been to therapy before and your trying to figure out what your diagnosis may be, I can help you find other providers in the area to get in touch with.

CLIENT RIGHTS

HIPPA requires you are provided with a Notice of Privacy Practices for the use and disclosure of PHI for treatment, payment and health care operations. This notice, explains **HIPAA** and its application to your personal health information in greater detail. The law requires I obtain your signature acknowledging that I have provided you with this information. **HIPAA** provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in our records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am more than happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. Because privacy in therapy is often crucial to successful progress, particularly with teenagers, and parental involvement, is also essential to request an agreement with minors and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the client's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete, any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

INSURANCE REIMBURSEMENT

I am not any accepting insurance.

FEES

My policy is that fees need to be paid in the ***beginning*** of session. My fee is $150 for individual therapy, $175.00 for couples therapy and $185.00 for Brainspotting session. I accept cash or check at this time. As my company grows, I will be accepting credit card payments. If you're a veteran or student, discounted rates are an option.

Cancelation Policy

Life happens and sometimes you won't be able to make it to therapy. I will give you one free pass the first time you cancel. Moving forward, if you cancel less than 24 hours prior to your appointment, you will be charged a $50.00 fee. Remember that your appointment is your self-care time. By canceling last minute takes that time away for someone who may also need that time to see me. If you know that you need to cancel your appointment, I strongly recommend you contacting me a few days before your appointment.

NO-SHOW POLICY

You will be billed the full amount of session if you no-show an appointment. I strongly suggest that you let me know 24 hours in advance that you cannot make your appointment.

INFORMED CONSENT

I do hereby seek and voluntarily consent to take part in treatment with Jennifer Bloom, LCSW. I understand that in this treatment, we will be working on goals to lessen the problems and concerns that we identify and discuss. As time goes on, we will review our goals and additional goals may be defined. I understand that the development and regular review of these goals are in my best interest and I agree to play an active role in this process.

● I am aware that during the course of treatment, there is a risk that I may have uncomfortable or upsetting feelings. I also understand that my problems may temporarily worsen after beginning treatment and my relationships with others may be disrupted as a result of my attempt to make important changes in my life. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

● I am aware that I may stop my treatment at any time. Should I do so, I will only be responsible for the payment of services I have already received.

Your Signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

- I am aware that with being outside in nature includes other people walking by us. Your privacy is my focus and I will find private areas away at these locations, however, people may still walk in our direction.

- I will attend all of my scheduled appointments. No-Showing is not tolerated. If you do not inform me that you will not be at your session 24 hours in advance, you will be billed the full amount.

Name (printed): ____

Signature: ______________________________________ Date: ______________________

Guardian: _______________________________________ Date: ______________________

Name (printed): ____

Signature: ______________________________________ Date: ______________________

Guardian: _______________________________________ Date: ______________________

CLIENT INFORMATION

Client Name: ____________________________ Today's Date: ____/____/_____

Gender: □ Male, □ Female DOB: ________________

Email Address: ______________________________________

Credit Card Number:

Expiration Date _________________________________

Name on Card ______________________________________

CVV2 Number ____

OK to send you emails? ☐ Yes, ☐ No

Home Address: ____

____

Primary Phone: ________________________ OK to leave message/text? ☐ Yes, ☐ No

Emergency Contact: ____

Address: ____

Phone: ____

Relationship to Client: ____

Emergency Contact: ____

Address: ____

Phone: ____

Relationship to Client: ____