Live! LLC
4004 Carlisle Blvd. Suite C-1
Albuquerque, NM 87107
Phone: 505 717-7227

INFORMED CONSENT – INDIVIDUAL THERAPY AGREEMENT
Adult Client

Client Name: _____

This agreement is intended to provide you with important information regarding the practices, policies and procedures of **Live, LLC** and to clarify the terms of the professional therapeutic relationship between your therapist Any questions or concerns regarding the contents of this Agreement should be discussed prior to signing it. Please read the entire document carefully and ask any questions before signing the document. Please initial each section below to indicate that you have read and understood that section.

Professional Services: **Live, LLC** provides individual and group, child and family counseling and psychotherapy to individuals, children, adolescents, and parents. Sessions are usually held weekly but may be frequent depending on your needs. You and your therapist will identify your needs and concerns. Together you will complete assessments, develop goals and plans for your treatment. If at any time you have questions or concerns about any aspect of your therapy, please talk about them with your therapist. _____ Initials

Therapist Background and Qualifications: Live, LLC Child and Family Counseling Services is an agency that provides a variety of credentialed counselors. We offer play therapy, and counseling services by Master Social Workers, Licensed Clinical Counselors, Licensed Mental Health Counselors, and Licensed Professional Art Therapists. Our practitioners maintain their ethical practice in compliance with their individual licensing boards and all federal and state requirements. Feel free to ask your therapists questions about their background, experience and professional orientation. _____ Initials

Confidentiality: Contents of all therapy sessions are considered confidential. The client's verbal information, written notes, or client artwork cannot be shared with another party without the written consent of the client or the client's legal guardian. This information is considered Protected Health Information (PHI) and is protected by federal and state disclosure regulations (HIPAA) of the Health Insurance Portability and Accountability Act which are detailed in the Live Notice of Privacy Practices, a separate document. However, confidentiality cannot be maintained in the following situations.

- Suspected child abuse (including neglect and emotional abuse)
- Suspected abuse of the elderly
- Suspected sexual exploitation/abuse
- If the client communicates threat of serious harm to self or others
- If a third party communicates that a client is threatening harm to self or others
- When information is required by law or ordered by the court
- When filing of a complaint with a licensing board where the Board compels disclosure according to its lawful authority.

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Notice of Privacy Practices: This agency maintains HIPAA compliance. Please indicate here that you have received and signed the Notice of Privacy Practices. This document further explains how your personal, financial and medical information will be used by this practice.
_____ Initials

Professional Consultation: There are times when your therapist may need to consult with colleagues or a specialist about your ongoing therapy which ensures that your services are being provided at the highest therapeutic level. During such consultations no personal identifying information is shared and other professionals are required by professional ethics to keep any information confidential. _____ Initials

Release of Information: Upon your written request and signature on our Authorization to Disclose and Release of Protected Health Information (PHI), your therapist may release information to any persons/agencies that you specify to the limits you specify. _____Initials

Custodial, Visitation or other Legal Proceedings: We agree not to involve Live LLC in any custody, visitation disputes or other legal proceedings including court related proceedings.
_____Initials

Records and Record Keeping: in accordance with all ethical and legal standards, Live, LLC. maintains all personal, clinical and financial records in a confidential electronic health record (EHR). This EHR is maintain compliant with HIPAA and is restricted by individual agency role. These records are secure and are not readily available for those who do not need them.
_____Initials

Fees and Fees Agreement: ***You and your therapist will discuss the details of your financial arrangements during initial phone calls and at the first therapy session.*** The full fee is $120 per 50-minute session. Therapy is also available for those without insurance who cannot afford the full fee. Adjusted fees are based on family income and family size. _____Initials

Payments & Co-Payments: Payment/Co-payment is due at the time of service, unless other arrangements have been made. Payments can be made in cash, credit/debit card or check. All charges not covered by insurance are the responsibility of the patient. Clients with outstanding balances will receive a written statement via USPS and payment is expected upon receipt.
_____ Initials

Insurance Claims & Billing: Live, LLC is credentialed with many insurance companies and will discuss our coverage prior to accepting the client for services or commencing those services. You are responsible for providing complete and accurate insurance information or changes to your insurance. To assist you with charges on your account, Live will process payments through your insurance. Depending on your insurance, it is possible that all services may not be covered. Our office will help you by submitting appropriate claims for payment. However, we cannot guarantee that the insurance will pay. If payment is denied, you

acknowledge that you are ultimately responsible for all charges. This form provides authorization for us to bill our insurance company. _____ Initials

Collection of Outstanding Balances : If payment is not made when due and other arrangements are not made, the necessary billing information may be released to a professional collection agency. If that were to happen, you would be required to pay all costs for collection, including attorney fees. Please discuss any questions or concerns about payment with your therapist.
_____ Initials

Returned Check Policy: You are responsible for the amount of any returned check plus a $35 returned to check fee which includes bank fees and administrative costs. _____ Initials

Fee Agreement for Additional Professional Time: At times there are additional services to therapeutic counseling that your therapist may need or be requested to provide. To the extent reasonably possible, these tasks will be identified ahead of time and reviewed prior to carrying them out and billing for them. These are important to serving our clients' best interests and include but are not limited to:

- Telephone consultations with other professionals involved in the past or currently, such as school staff, medical professionals, other mental health providers, or legal professionals.
- Travel time for in person consultation with other professionals
- Telephone consultations with parents
- Preparing documents such as letters, reports or other, to patients and other professionals
- Reviewing legal, educational or past treatment records
- Other non-routine services specific to the client.

As these services require professional time, there is a fee charged for them. Insurance companies do not cover these services and you will be personally responsible for them. Billing is prorated of the full fee in 15-minute increments. (e.g. 15 minutes =$30 ,30 minutes=$60, etc.). If these tasks are performed in preparation for or attendance of legal proceeding the hourly bill rate will be $140. _____Initials

Missed Appointments & Late Cancellation Notice: Insurance companies do not pay for missed appointments. If you must cancel a scheduled session, please call your therapist or our office as soon as possible, but no later than 24 hours in advance. You will not be charged for a session that you cancel 24 or more hours in advance. You will also not be charged for a session canceled by your therapist.

- Missed Appointment- without notification of cancellation is referred to as a No-Show. The **No-Show rate of $120** will be charged to your account. You will be responsible for the cost of this session.

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- Late Cancellation – cancellation is received within 24 hours of the scheduled appointment. This **Late Cancellation fee of $75** will be charged to your account. You will be responsible for the cost of the late cancellation.

If you are a Medicaid client, Live LLC is not allowed to charge you for missed appointments or late cancellations. However, after two "No-Show" appointments Live LLC reserves the right to cease services to you and will provide you with three referral agencies within the community. _____Initials

Termination of Therapy: You may terminate therapy at any time. Your therapist also reserves the right to terminate therapy at their discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client needs are outside the scope of agency practice or competencies, or client in not making adequate progress in therapy. You also have the right to terminate therapy at your discretion. Upon either party's decision to terminate therapy, your therapist may recommend that the client participate in at least one or more termination sessions. These sessions are intended to facilitate a positive termination experience and give all parties an opportunity to reflect on the work that has been done. Your therapist will endeavor to ensure a smooth transition to another therapist offering referrals, if requested. _____ Initials

Emergencies: If you have an emergency when the office is closed, you may call the phone number on the card your therapist has given you. Your therapist will either speak with you directly or return your call as soon as possible. You may also contact the Crisis Unit of the University of New Mexico/County Mental Health Center at 272-2920. If the emergency is immediately life-threatening, call 911 or go to the nearest hospital emergency room. _____ Initials

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I, the undersigned, have read and understand the above explanations regarding Informed Consent and Agreement for Therapy for myself, my child and my family. In signing below, I agree to its terms. I fully understand that I assume any and all risks of treatment presently known or unknown. Except in the case of gross negligence or malpractice, I agree to fully release and hold harmless, Live LLC, and its therapists, agents, representatives against any and all claims or liability whatsoever arising out of or in connection with any therapy sessions.

My signature indicates that I understand and agree to the policies described above.

_____ _____ _____
Name (Please print) Client Signature Date