FULL HEART
THERAPY

CONSENT FOR SERVICES

I welcome you to my physical or virtual office, and hope our work together benefits you. Your goals are more likely to be met when you understand the nature and limitations of therapy, both as a uniquely personal experience and as a contractual agreement. **Your signature below indicates you have read this document and consent to entering therapy through an informed decision.**

BENEFITS AND RISKS

Generally, therapy is most useful for empowering clients in improving their lives and relationships. As the client, you determine the nature and number of changes made. Most experience improvement with reduction of symptoms, improved relationships, or resolution to concerns that brought them to therapy, but there are no guarantees and there are some risks. For example, therapy could create new levels of awareness that may be uncomfortable or your significant relationships may change or even end. You have the right to discuss the services you are receiving with me and I invite you to communicate openly and directly with me about your reactions to therapy and our therapeutic relationship. Your investment and participation are essential to the success of achieving your therapeutic goals. Online: For safety reasons and to give your full attention to your session, do not travel, drive, or sit in the driver's seat during your session.

LENGTH OF THERAPY

The length of therapy is based on your wants and needs. Some seek therapy for an acute stressor so therapy is brief. Others want or need ongoing processing. Some want maintenance therapy to prevent a relapse of symptoms. Feel free to consult with me about the length of your therapy at any time. It is possible my clinical judgement (based on ethical and legal principles that I not practice beyond the level of my competence) may determine I am no longer the best fit for your care, at which time I will provide you with appropriate referrals. I may determine you would benefit from additional or alternative services and will provide you with referrals.

You have the right to discontinue services with me at any time. If you decide to end therapy, you are encouraged to discuss this in a session. If you are dissatisfied with my services, please let me know. We can work together to resolve your concerns, and at a minimum, I want to provide an opportunity for your concerns to be heard. If I am unable to resolve your concerns, I will provide referrals. If you do not schedule an appointment for 60 days, I will close your file as I cannot legally and ethically call someone a client who is not attending sessions. If you wish to return to therapy, contact me to discuss the possibility of reopening your file. If I am unable to work with you again, I will provide you with referrals. After the therapeutic relationship ends, a minimum of five years must pass before you can contact me for a personal relationship.

METHODS OF CONTACT/EMERGENCIES

On occasion, there may be a need to have contact outside of sessions. **I am not immediately available by telephone or email**. I will make efforts to respond to communications within two business days. Emails requiring more than 5 minutes to read and/or respond will be read and addressed in your next scheduled session. It is most secure to only email me to schedule appointments. I reply to emails with encrypted software requiring you to use a passphrase. Please check your junk/spam folders for my replies. If you choose to communicate via non-secure methods you will be given an additional form to sign. Phone calls 15+ minutes are charged a rate of $35 for each additional 15 minutes. All communications are documented in your medical record. **These communications may be revealed if your records are audited by your insurance provider or summoned by a legal entity.**

I am not available for emergencies. Consider your safety needs and my practice limitations. **If you need a therapist who provides crisis interventions or on-call services, we will not be a good fit.** If you have an emergency or crisis and I do not answer the phone, please contact Foundation 2's Crisis Hotline 319.362.2174/1.800.332.4224 (Iowa), text or call 988, call 911, or go to the nearest emergency room and request mental health services. Do not send emergency or crisis information through email.

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I do not interact with clients on any social media platform. Should we see one another in public, I will not acknowledge you first, respecting your privacy and confidentiality. If you choose to acknowledge me, I will be happy to briefly chat. I will not discuss anything related to your treatment outside of my office. If you introduce me to your party, I will agree to your description of how you know me.
Appointment reminders are sent via email but are not guaranteed to be delivered.

CONFIDENTIALTY
The information you share in therapy is very personal. By signing this ***Consent for Services,*** **you acknowledge receipt of the** ***Notice of Privacy Practices (HIPAA)*** as offered in my office, on my website, and in your file in the scheduling system**.** HIPAA describes your rights and my obligations regarding the use and disclosure of your client information, including additional items to the list below. I am required to hold information about sessions and clients in confidence and not allowed to disclose information without the written consent of those involved in treatment, except in the following circumstances:
1) Iowa Law 282.2(4) There is clear and imminent danger to you or others, in which case I am required to inform appropriate authorities and warn the identified victim. While common for a depressed person to have suicidal thoughts or plans, if I believe you are going to carry out these plans imminently or harm another, I am required to share this information with appropriate authorities to prevent you from doing so.
2) In situations of disclosed or suspected cases of physical, emotional, mental, sexual abuse or neglect of a child, or dependent adult, including the aforementioned and financial abuse, I am mandated by Iowa Law to submit a report to the Department of Human Services and may be required to contact authorities as well.
3) To better guide your treatment, I may consult with a colleague, but never divulge identifying characteristics. You may request restrictions as to how your case information, such as first name(s), may be used or shared among my consultants.
4) You waive the privilege of confidentiality by bringing any legal charges (administrative, civil, criminal, or any other kinds of actions) against me.
5) I have Business Associate Agreements (BAA) with professional service providers (ex: technical support, collections) to assist in maintaining my business. BAA bind these entities to HIPAA regulations. They may have limited access to some of your data for the purpose of providing necessary business services.
6) Iowa Code 33.2(23) mandates me to report to the Iowa State Board of Behavioral Science any current or previous therapist ethical code violations, including if you are a mental health provider and disclose an ethical violation with a client of yours.

PAYMENT POLICY AND FEE STRUCTURE
Rates Individual 60-minute sessions are $140/hour and increase to $150 June 1, 2023. Interpersonal relationship 60-minute sessions are $160/hour and increase to $170 June 1, 2023. Planned or unplanned time beyond a 60-minute session is charged $35 in increments of 15 minutes and not likely to be reimbursed by insurance. Individual 90-minute session is $220. Interpersonal relationship 90-minute session is $250. *When scheduling 90-minute or longer sessions, select two appointments sequentially.* Intensive weekend sessions must be pre-paid and only 50% refunded if you cancel: 5 hours on Saturday and 3 hours on Sunday for $1100 individual and $1300 interpersonal. Rates will increase periodically to adjust for inflation and business costs. You will be informed of rate increases via letter at least 30 days in advance.
If you arrive late to your session or need to end early, you will still be charged the full session fee. All fees are due and collected at the end of each session, unless other arrangements are agreed upon. Your account balance must be paid in full before your next session.

Payments can be made by cash, check or credit card. Credit card transactions are run through the Client Portal. Returned check fee is $30. Chargeback and DDA Rejects are $25 per event and Retrieval Fees are $15 per event. Please ensure your card information stored in the scheduling system is current and funds are available. There are no refunds for rendered services. To

settle a financial dispute your personal information such as name, address, and demographics may be necessary to disclose to a third party and you agree to pay all court costs and attorney fees by signing this document.

Insurance Per your request, I will happily provide direction or assistance in filling out your insurance company's Reimbursement Form and a Superbill you submit to your carrier. I suggest you contact your insurance company to see if they will reimburse for an Out-of-Network Provider and telehealth sessions. My website has a Reimbursement Form questionnaire you can reference. By signing this consent form and initialing below, you are agreeing to authorize Full Heart Therapy, LLC by Andrea Nus, LMFT member, to release any psychological, mental health, and/or substance abuse information to your insurance carrier(s) should they audit your client file. You understand this authorization continues indefinitely until you rescind it in writing. You understand Late Cancelation and No Show fees are not reimbursed by insurance. You understand should insurance determine through an audit that services you received were not deemed necessary, you may be asked to return reimbursements to them. **Initial Here**_____

Legal Court appearance fees, whether by subpoena or your request, are $300 per hour. The rate applies to all court related services including travel, reading and responding to documents, deposition, testimony. My own attorney fees will be paid by you. Emails and/or phone calls with attorneys, even at your request, are charged $100 per incident. These fees will be collected in advance as retainer for services in the form of $3000 paid by money order. **I can only testify to facts, cannot provide opinion, and am not an expert witness.** If I am under subpoena to testify, you may assert my testimony is privileged, but it is the court, not I, that determines the extent of that privilege. If there is no privilege or privilege is waived, I will be required to testify to answer what is asked of me.

Records In addition, there is a reasonable **processing fee for records or summary** to be released to you, court, attorney, agency, or other individual. Such fees are incurred on top of regular session fees and based upon hourly rate and cost of materials. A request for records **must** be provided in writing and a Release of Information form completed when appropriate. When appropriate, I reserve the right to provide a Summary of Treatment instead of records and the right to not respond to requests to appear in court or provide documents.

Except in unusual circumstances that involve danger to yourself or others, you have the right to a copy of your medical record that includes your assessments, treatment plan, and session notes. These are professional records and it is recommended you review them with me or another mental health professional as they contain professional language that may raise questions or concerns. If you want to exercise this right, let me know. There are benefits in doing this, such as viewing your progress. Some risks are viewing the file without support or clarification if there are questions or concerns.

Except in the case of malpractice, you or your representative(s) agree to full release and hold Full Heath Therapy, LLC by Andrea M. Nus, LMFT, member, from and against any, and all claims or liability of whatsoever kind of nature rising out of or in connection with your session(s).

CANCELATIONS, TARDINESS, AND MISSED APPOINTMENTS

I require a notice of 24 business hours for canceling appointments. If given less than 24 business hours, the full session fee will be charged. This timeframe allows me to contact others waiting for an open slot. Your appointment time is reserved for you and ensures unless I have an emergency, I am available to you at that time. The notice allows me to assist as many people as possible in my practice schedule.

If you will be more than 5 minutes late, please notify me. If you are late and I have not heard from you, I will call you up to 15 minutes after the session begins. If you do not attend within the first 15 minutes of the session and/or respond to my call, the

session is recorded as a No Show. If you communicate with me before 5pm the same day with the reason for missing the session, I will relabel the No Show as a Late Cancelation.

A No Show is billed at full session rate. After two No Shows, you will be asked to seek services elsewhere and your file will be closed immediately. You will be notified of closure via letter and subsequent scheduled appointments will be cancelled. After three Late Cancellations, you may be asked to seek services elsewhere. I reserve the right to waive Late Cancelation and No Show fees or provide exceptions when determined to be an emergency, as I define it. Late Cancelation and No Show fees are not reimbursed by insurance.

OFFICE HOURS *Central Standard Time*

My office hours are posted on www.fullhearttherapy.com. Current schedule: Monday 9am – 4:45pm (in-person for Somatic Experience and touch therapy clients); Tuesday 8am – 4:30pm; Wednesday 9am – 5:30pm; and Thursday 8am – 3:15pm.

AGREEMENT

By signing below, I am accepting responsibility for the above-mentioned terms, including not disputing charges for rendered services. I have read the above information, and understand I am encouraged to ask questions, and give input regarding the therapy process at any time. If there is anything in this form I do not understand, it is my responsibility to seek clarification. I understand this document represents a contract for services between myself and Full Hearth Therapy, LLC by Andrea M. Nus, LMFT, member.

Client Printed Name _____ Client Signature _____ Date _____

_____ _____

Andrea Nus, LMFT Date

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