

INFORMED CONSENT FOR PSYCHOTHERAPY



General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing at the end of this document.

Confidentiality

Trust is an important aspect of the therapeutic relationship. Your confidentiality is of utmost importance for maintaining this trust. However, there are times when I am legally and ethically required to release information about our work together.

In such circumstances I only disclose the least amount of information necessary to meet legal and ethical guidelines. If this occurs, and as soon as I am able to do so, I will inform you of any releases of your confidential information.

Below are situations in which I am required to release information to a necessary entity:

1. If a client threatens or attempts to commit suicide or otherwise conducts himself or herself in a way that there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person (over age 65) who may be subjected to these abuses.
5. Suspected neglect of a child under the age of 18 years or of an elderly person over age 65.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If I believe it would benefit you for me to consult with other professionals about your case (for example, teachers or social workers), I will talk with you about this. I will never consult with other professionals without your prior and written consent.

If you request in writing to have all or portions of information related to our work together released to a specifically named person or persons, then you will sign a consent form and information disclosed per your request.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Minors

If you are a minor, your parents (or legal guardians) may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Scope of Practice

Dr. Dave Frieze is certified as a Pastoral Counselor through the Board of Christian Professional and Pastoral Counselors. His scope of practice is limited to therapeutic services, and he is not a medical professional. My priority is to ensure you receive the appropriate services, and this means I may need to refer you to other services if I feel that is necessary and/or outside my scope of practice.

Risks and Benefits of Psychotherapy

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and your repeating patterns, as well as to help you clarify what it is that you want for yourself.

I cannot guarantee that you will see improvement in your relationships or emotions as a result of working together. Therapy requires multiple things in order to be considered “successful.” These include involvement from you and a comfortable connection between you and your therapist, as well as clear expectations for what may be possible as a result of the work together.

I encourage you to discuss your goals, expectations and concerns at all points during our work together. We will continuously discuss how treatment is working for you. If at any time I feel that treating you may be detrimental then I will recommend you discontinue treatment and provide you with appropriate referrals.

There are times when psychotherapy may bring up unexpected emotions or reactions to relationships. Some things we discuss may surprise you as you learn more about yourself and gain insight. It is possible that you may actually start to feel “worse” before feeling you have attained your goals. If that is the case, it’s important we discuss these feelings along the way.

It is also possible that as a result of working together, you may wish to adjust how you interact with people in your life. That may mean engaging in some relationships more or disconnecting from other relationships. It is important you discuss any concerns about these things if they arise.

Course of Treatment

We will spend the first several sessions determining your needs and goals, as well as discerning if we are a good fit to work together. We will revisit your goals throughout working together, as these often change over time.

Once we mutually agree that your goals for treatment have been met we will determine an appropriate timeframe for ending work together. Many clients prefer to do this slowly by reducing the frequency of sessions, and some return periodically during stressful times later in life. Please know this process will be very transparent as we mutually determine what is best for you.

I may also terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. If the therapy is terminated for any reason or you request another therapist, you may request referrals from me or can choose someone on your own.

Medications

Psychotherapists are not medical providers and do not provide medical advice or prescriptions for medication. However, we do coordinate care with applicable medical professionals and may ask about basic medication compliance. I will always let you know before communicating with any other professionals and request you provide their contact information. Any changes in your medication should always be first discussed with and approved by your prescribing physician or nurse practitioner.

Emergency Procedures

If something were to happen to me, one of my colleagues at Restore & Rebuild Counseling will contact you to discuss the situation. We will do our best to ensure you continue to receive services without significant interruption.

If you believe you are experiencing a life-threatening emergency, please call 911.

Collateral Involvement

It may be helpful to involve important people in your life during the psychotherapy process. If this is something that we both feel is helpful, we will discuss how much information you are comfortable disclosing and in what way. For all adult clients, I will never speak with any of your family members about your treatment, or even confirm whether or not you are a client, without first having your written consent.

Exceptions include any circumstances listed above in the section on Confidentiality.

Court Policy

Please be advised that for any request to write a letter on any court related matter, I will NOT provide, in writing or in person, an *opinion*. As your therapist, I may only provide observations and feedback (fact-based information). The therapist-client relationship does not include advocating on your behalf in court matters. *At no time will I make a recommendation regarding custody or any other court-related matter.*

If a court order (subpoena) is served and requests that I be present in person and/or there is a request for records, I will request your consent before turning over confidential information. We will discuss exactly

what has been requested by the court. *I will do my best to maintain the confidentiality of your records as releasing them may not be in your best interest. However, please be advised that there is no guarantee your records will be kept confidential, as this will be determined by the judge.* This information includes mental health history, diagnosis, treatment details, current status and any other records included in the request.

Fees:

Should I be ordered by court to write a letter to the court, the time will be billed at your regular hourly session rate.

Should I be court ordered to appear in court, the fee stipulation is as follows:

- \$750 per day (this includes travel to and from court)
- Regular hourly session rate for preparation

I hold the right to waive these fees, depending upon circumstances and at my discretion.

I will not be on-call for court-related matters at any time. Should a case be rescheduled or if I am required to appear on more than one day, I will be paid in full for each day as it hinders my ability to be available to other clients. If the court reschedules the hearing at any time, I must be re-issued a court order with the new court hearing date. Should I be on vacation or otherwise unavailable, the party initiating the court order must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena.

Access to Medical Records

As a mental health professional, I keep records about our work together. This includes notes on sessions, meetings, phone calls and any other communication with or about you. Unless I feel it would be significantly harmful to you, you are able to access your records at any time.

I require 5 days of notice prior to allowing you to *view* your records. If you would like a copy of your records, I require 15 days of notice and will charge a fee of 0.25¢ per page, plus postage fees if you would like your copies mailed.

Oftentimes, clients request copies of records with the intent of securing a treatment summary for an outside entity. Requesting a summary of treatment instead may be in your best interest, as it provides more confidentiality. This is often preferable to giving someone access to your entire treatment record.

If that is the case, I am happy to provide such a summary, billed at your regular hourly session rate. I require 10 business days to prepare your summary. If this is related to a court matter, please see the "Court Policy" above.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ Name of Client (or parent/guardian if client is a minor)	_____ Signature of Client (or parent/ guardian if client is a minor)	_____ Date
_____ Name of Client #2 (Print)	_____ Signature of Client #2	_____ Date



CONSENT TO TREAT A MINOR

Child's Name: _____ Birth Date: _____

Address: _____

I, the undersigned, (check the applicable statement)

- _____ One of the parents having legal custody
- _____ Both of the parents having legal custody
- _____ The only parent having legal custody
- _____ The person having legal custody

Of _____ a minor, do hereby authorize

_____, a counselor at Restore & Rebuild Counseling, to provide psychological treatment to said minor.

This authorization shall remain in effect until termination of therapeutic duty unless person having legal custody of said minor revokes the authorization in writing before that date.

Name of Parent(s)/Legal Guardian (print)

Date

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date

PRACTICE POLICIES



Appointments and Cancellations

The standard meeting time for a therapy session is 50 minutes. Requests to change the 50-minute session need to be discussed with the therapist in order for time to be scheduled in advance.

Please remember to cancel or reschedule AT LEAST 24 hours in advance. If you cancel a session the day of the scheduled session, you will be charged the full session fee. If you fail to show up at a scheduled session you will be charged the full session fee.

You will be responsible to pay a \$50 late cancellation fee if cancellation of a session takes place less than 24 hours before a scheduled session the day prior to session.

Cancellations and re-scheduled sessions will be subject to a \$50 late cancellation fee OR the full session fee, as described above, if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

Fees and Payment

Your session fee will be agreed on ahead of time with your therapist. Payment is due at the time of service. We also accept payment by cash (if in person) or by check. You may receive a receipt for your payments upon request. A \$10.00 service charge will be charged for any checks returned for any reason for special handling.

If at any time you are having difficulty paying your session fee, please discuss this with me as soon as possible.

Insurance

I am **not** an in-network provider for any insurance company. Some insurance companies will reimburse you for costs related to attending therapy. However, what you and I determine to be clinically relevant may or may not be deemed "medically necessary" and covered by insurance.

If you would like to seek reimbursement with your insurance company, I will provide you with a monthly statement (known as a superbill) of fees paid and services provided.

Please note that when you choose to allow your insurance company to contribute payment to your treatment, you do allow them access to your clinical records. They will also require a mental health diagnosis. If you have questions or concerns about this, please speak with me before submitting any forms to your insurance company.

Between Sessions Communication and Emergencies

If you need to contact me between sessions, you may text me, email me, or leave a message on my voice mail. *Texts, emails, and phone calls are not considered secure communications. Although I will use various*

means to discuss scheduling sessions, I will not discuss deeper clinical issues with you via insecure communications.

I am often not immediately available; however, if you reach out, I will attempt to get back to you within 24 hours.

If a true emergency situation arises, please call 911 or any local emergency room. If I do not hear from you after a missed appointment and have reason for concern, I may reach out to your identified emergency contact to ensure your well-being.

Social Media

I maintain social media accounts, some personal and others for business purposes. I do not interact with clients via social media. If you choose to follow an account and reach out to me via that method, I am unlikely to reply using the social media platform. Instead, I encourage you to reach out to me directly or talk to me in a session.

“Good Faith Estimate”

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost. Under the law, health care providers need to give patients who don’t have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your health care provider for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.
- For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ Name of Client (or parent/guardian if client is a minor)	_____ Signature of Client (or parent/ guardian if client is a minor)	_____ Date
_____ Name of Client #2 (Print)	_____ Signature of Client #2	_____ Date

FINANCIAL INFORMATION and Sliding Scale Rates



At Restore and Rebuild, we don't want finances to be an obstacle to people receiving the help they need. We offer a standardized sliding scale of fees for services based on annual gross household income and household size. For Board Certified Pastoral Counselor Dr. Dave Frieze and for Licensed Marriage and Family Therapist Rebecca Frieze, our rates are as follows:

Sliding Scale Rates

Gross Household Income per Year	Cost Per Session
more than \$150,000	\$190
\$110,000 - 150,000	155
\$80,000 - 110,000	130
\$50,000 - 80,000	110
less than \$50,000	75

Please note: *If you are paying for therapy yourself, then the cost per session is based on your own gross household income per year. However, if your parents are paying for your therapy, then the cost per session is based on your parents' gross household income per year.*

My annual gross household income (including income from all sources): _____

If you agree to pay the session fee as determined by your income level, please check the appropriate box below and sign this form.

If you believe you cannot afford to pay the sliding scale rate determined by your income, we invite you to request a discounted fee. Please check the appropriate box below and complete the rest of this form. Based on the availability of our scholarship funds, we may approve your request for a predetermined number of sessions.

- ☐ I agree to pay the session fee for my income level as determined by the sliding scale
- ☐ I am requesting a discounted fee (see below)

Request for Discounted Fee

My reason for requesting a discounted fee: _____

The amount per session I am requesting to pay: _____

I understand that scholarship funds may or may not be available.

Name of Client (or parent/guardian
if client is a minor)

Signature of Client (or parent/
guardian if client is a minor)

Date

Office Use Only:

Amount Approved Per Session: _____ Number of Sessions Approved at Discounted Rate: _____



INTAKE FORM

Name _____ Today's Date _____
Address _____ City _____ Zip _____
Phone: _____ E-mail address: _____
Age _____ Birth Date _____ Place of Birth _____
Church/Religion _____ Race/Ethnicity _____
Employer _____ Occupation _____
How did you hear about us? _____ May we thank that person? _____
Emergency Contact _____

Name

Relationship

Phone Number

Reason you are seeking counseling today _____

Marital Status (please check one, and fill in detail if applicable)

Single _____ Living with Significant Other _____ How long together _____

Engaged _____ Wedding date _____ How long together _____

Married _____ Years married _____ Number of previous marriages _____

Separated _____ How long _____ Divorced _____ How long _____

Widowed _____ How long _____

Name of spouse or significant other _____

Describe your relationship _____

Children (if more than four please list on back of page)

Name	Relationship	Age	Sex	Living at home?
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Who has legal custody of your children? _____

Describe what it is like to live in your household today. _____

Describe your family and household when you were growing up. _____

Are there any current addictions or history of addictions in you or immediate/extended family members (drugs, alcohol, sex, gambling, eating, pornography, prescription drugs, work, etc.)? _____
Who, how long, and what addiction? _____

Is there any mental illness currently or historically in you or your immediate/extended family members? Who, and what mental illness? _____

Have you ever experienced or witnessed physical, emotional, sexual abuse, or a violent crime? If yes, please explain: _____

Previous participation in counseling? Y/N When _____ With Whom _____
What was the focus of your treatment? _____

Have you ever taken medication for a mental/emotional condition? Y/N _____ If yes, complete the following:

Medication Name	Prescribed For	When Prescribed	How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all other medications you are taking currently and what they are for. _____

Previous hospitalization for mental/emotional problems? Y/N _____ When _____ How long _____
Have you ever thought about killing yourself or attempted suicide? Y/N _____ If yes, when _____
Please explain: _____

Describe any other significant or traumatic life experience. _____

If you have ever been diagnosed with a serious illness, please describe. _____

If you have any medical conditions that may affect your mental health treatment, please describe.

If you are experiencing any medical/physical symptoms that you attribute to a mental/emotional/stress related condition, please describe.

Describe your overall health today.

Physical activity you participate in.

Symptoms or Concerns

Check all that apply:

- | | | |
|---|--|--|
| ☐ Feeling out of control | ☐ Poor concentration | ☐ Isolation/withdrawal |
| ☐ Self-hatred | ☐ Thoughts about suicide | ☐ Thoughts about hurting myself |
| ☐ Suicide attempts | ☐ Agitation | ☐ Fearful |
| ☐ Hopeless | ☐ Mood changes | ☐ Sadness |
| ☐ Tearfulness | ☐ Fatigue/tiredness | ☐ Emptiness |
| ☐ Indecision | ☐ Overwhelmed | ☐ Insomnia/oversleeping |
| ☐ Weight change | ☐ Angry outbursts | ☐ Overeating/Loss of appetite |
| ☐ Anxiety/nervousness | ☐ Panic Attacks | ☐ Irritability |
| ☐ Obsessive thoughts | ☐ Hostility/rages | ☐ Loss of control |
| ☐ Stealing | ☐ Gambling | ☐ Alcohol/drug addiction |
| ☐ Impulsiveness | ☐ Pornography | ☐ Sexual addiction |
| ☐ Feelings of isolation | ☐ Shyness | ☐ Feelings of inferiority |
| ☐ Procrastination | ☐ Insecurity | ☐ Feelings of failure |
| ☐ Grief | ☐ Sexual Problems | ☐ Money problems |
| ☐ Physical problems | ☐ Disruptive/conduct | ☐ Inappropriate speech |
| ☐ Hallucinations | ☐ Dissociative episodes | ☐ Someone is trying to hurt me |
| ☐ Hearing voices | ☐ Bothering memories | ☐ Recent crisis |
| ☐ Recent loss | ☐ Interpersonal conflicts | ☐ Domestic violence |
| ☐ Legal problems | ☐ Work problems | ☐ Family problems |
| ☐ Menopause problems | ☐ School problem | ☐ Social problems |
| ☐ Learning problems | ☐ Lack of Motivation | ☐ Worthlessness |
| ☐ Thoughts of dying | ☐ Guilt | ☐ Restless/Keyed up |
| | ☐ Slowed down | |

Any other important symptoms or concerns for your therapist to know:

NOTICE OF PRIVACY PRACTICES



THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client’s personal health information without the patient’s written authorization, to carry out the health care provider’s own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. **Psychotherapy Notes.** I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
 - a. For my use in treating you.
 - b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
 - c. For my use in defending myself in legal proceedings instituted by you.
 - d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
 - e. Required by law and the use or disclosure is limited to the requirements of such law.
 - f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
 - g. Required by a coroner who is performing duties authorized by law.
 - h. Required to help avert a serious threat to the health and safety of others.
2. **Marketing Purposes.** As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. **Sale of PHI.** As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence

operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on November 17, 2014

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ Name of Client (or parent/guardian if client is a minor)	_____ Signature of Client (or parent/ guardian if client is a minor)	_____ Date
_____ Name of Client #2 (Print)	_____ Signature of Client #2	_____ Date

GOOD FAITH ESTIMATE



This Good Faith Estimate is to comply with the “No Surprises Act.” As of January 1, 2022, the “No Surprises Act” requires providers to inform their uninsured and private pay clients that they have a right to a Good Faith Estimate to help them estimate the expected charges they may be billed.

You are entitled to receive this Good Faith Estimate of what the charges could be for psychotherapy services provided to you. While it is not possible for a therapist to know in advance how many therapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created, and does not include any unknown or unexpected costs that may arise during treatment.

Your therapist may recommend additional items or services as part of your care that must be scheduled or requested separately and are not reflected in this Good Faith Estimate. This estimate is not a contract and does not obligate you to obtain any services from the provider listed, nor does it include any services rendered to you that are not identified here.

Client Information

Date of Good Faith Estimate (today's date): _____

Client Name: _____

Client Date of Birth: _____

Provider Information

Provider Name: Dr. Dave Friese

Restore & Rebuild Counseling

1831 S. El Camino Real

Encinitas, CA 92024

Phone: 760 456-9035

Email: dave@restoreandrebuiltministries.com

Taxpayer Identification Number (TIN): #33-0310704

Expected Charges

The standard full fee for one 50-minute psychotherapy session (in person or via telehealth) is \$190.00. Most clients will attend one session per week, but the frequency of sessions that are appropriate in your case may be more or less than once per week, depending on your needs.

Based upon a fee of \$190.00 per visit, if you attend one session per week, your estimated charge would be:

\$760.00 for four visits provided over the course of one month

\$1520.00 for eight visits over two months

\$2280.00 for twelve visits over three months.

If you attend therapy for a longer period of time, your total estimated charges will increase accordingly.

If you have agreed with your therapist that you will be paying an amount per session lower than the standard full fee (a lower sliding scale fee, or a subsidized fee), then your total estimated charges will decrease accordingly.

If you are using your health insurance to reimburse you for some or all of your psychotherapy charges, then the total amount you end up paying may differ from this estimate, depending on your insurance coverage.

Disclaimer

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means \$400 or more beyond the estimated charges).

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit <https://www.cms.gov/nosurprises/consumers> or call 1-800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy sessions. The number of sessions that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan or the information provided to you in this Good Faith Estimate.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

This Good Faith Estimate expires one year from the date issued.

OMB Control Number: 0938-XXXX