



## Leigh Reineke Therapy, LLC

### Official Practice Policies

**APPOINTMENTS AND CANCELLATIONS:** Appointments are 53 minutes long. Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours. Requests to change the standard session time need to be discussed with the therapist at least 48 hours ahead in order for time to be scheduled in advance.

**PAYMENT AND BILLING:** My fee is \$120 per 53-minute session. I do accept insurance, so your actual cost may be different. For insurance clients I use a company called Headway to do billing for me, and you will set up payment with them. Clients without insurance may request superbills. Clients are responsible for determining whether their insurance company reimburses for out of network providers. I also accept clients on a sliding scale fee, which may lower your \$120 per session cost. The sliding scale is done with me (meaning it does not involve Headway). Full payment is expected at the time of each appointment unless otherwise arranged. Cash, Checks, Visa, MasterCard, and American Express are each acceptable forms of payment. Checks should be payable to “Leigh Reineke Therapy, LLC.” Upon request, monthly statements can be provided containing all pertinent data necessary. Fees are reviewed and modified annually. Clients are notified of any change in fee 30 days prior to it taking effect. A \$50 service charge will be charged for any checks returned for any reason for special handling. Cancellations and re-scheduled sessions will be subject to a full charge 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 more than 15 minutes late for your session, your session will be considered a no-show and the remainder of your session time will be forfeited.

**TELEPHONE ACCESSIBILITY:** If you need to contact me between sessions, please leave a voicemail message. My voicemail cannot be used as an emergency service. If am not immediately available, I will attempt to return your call within 24 hours. If a true emergency situation arises, please call 911 or any local emergency room. I return text messages between the hours of 9 am and 5 pm on weekdays. Please note, if you text me, please do not assume I have received it and text me again or give me a call if you have not heard back from me within 24 hours unless over the weekend, in which case I will return your text message the following Monday.

**PARENTS OF TEEN CLIENTS:** Parents need to stay on the premises while their child is doing therapy. This can include waiting in your car. Please know that once therapy has ended after 53 minutes your child will be unattended if you are not there. Clients whose parents leave their child unattended before or after therapy will be discharged immediately and referred elsewhere.

**SOCIAL MEDIA AND TELECOMMUNICATION:** Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can discuss further.

**ELECTRONIC COMMUNICATION:** I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that: (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. (2) All existing confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.



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**CLINICAL NOTES:** Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information that you may not recognize as significant to present verbally to the therapist.

**MINORS:** If you are a minor, your parents 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.

**TERMINATION:** Ending relationships can be difficult. Therefore, it is important to have a termination process in place in order to achieve closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may 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. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating (with the exception of adolescent clients left unattended). If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.



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**COURT ACTION AND LEGAL FEES:** Clients are strongly discouraged from having their therapist subpoenaed or having them provide records for the purpose of litigation. Even though you are responsible for the testimony fee, it does not mean that the therapist's testimony will be solely in your favor. I can only testify to the facts of the case and, if qualified to do so by the court, in their professional opinion. Asking a therapist to provide confidential records or testify can damage the trust built in a counseling relationship with a client, especially if the therapist is still seeing that client in therapy.

If I receive a subpoena, then the attorney or office staff will need to call my office and set up a time for the subpoena to be served during office hours. I will request a minimum of 72 business hours' notice of any Court appearance so that schedule changes for their clients can be made within a reasonable time frame.

Please note: If a subpoena or notice to meet attorney(s) is received without a minimum of 72 business hours' notice, there will be an additional \$250 express charge.

When it comes to court action, the following fees are in effect:

Preparation Time (including submission of records): \$220/hour (billable in 15-minute increments)

Phone calls: \$220/hour (billable in 15-minute increments)

Depositions: \$250/hour

Time required in Giving Testimony: \$250/hour.

Mileage: .56/mile

Time Away from office due to Depositions or Testimony: \$220/hour

All attorney fees and costs that are incurred by the therapist as a result of the legal action.

Filing document with the court: \$100

The minimum charge for a court appearance: \$1500

A retainer of \$1500 is due at least 72 business hours before the scheduled court appearance. The remainder of the costs will be billed after the court appearance and will be due upon receipt. If the therapist is subpoenaed and the case is reset with less than 72 business hours' notice prior to the beginning of the day of the scheduled subpoena, trial, and/or testimony is not given, then the client will be charged \$500 (in addition to the original retainer of \$1500 for having to appear in court). All fees listed above are doubled if the therapist has priorly been scheduled to be out of town at the time of the court appearance.

## Acknowledgement of Receipt General Practice Policies

By signing below, I certify:

That I have read or had this form read and/or explained to me.

That I fully understand its contents including the risks and benefits of telehealth.

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_