

**Harrisonburg Center for Healing**  
**1014 Reservoir Street, Suite A**  
**Harrisonburg, Virginia 22801**  
**Phone: (540) 830-5443**  
**Fax: (540) 707-2190**

## **POLICIES AND NOTICE OF PRIVACY PRACTICES**

The following information is a description of services offered to clients and the policies concerning therapy. Please feel free to discuss this information or any other matter related to the services you, or your minor child, receives at any time during the course of treatment. The clinicians at Harrisonburg Center for Healing are Licensed Professional Counselors in the Commonwealth of Virginia engaged in a private practice to provide mental health services to children, adolescents, and adults.

### **Mental Health Services**

The goal of therapy is to help a person better understand their thoughts and feelings and assist them in resolving difficulties. As a professionals, we make observations and suggestions for new ways to approach problems. It is important for individuals and families to explore their own thoughts and feelings, as well as try new approaches to solving problems in order for positive change to occur. Other family members may be brought to a session if the person feels this would be helpful or if we make this recommendation.

### **Confidentiality**

Mental health services are confidential, private, and personal. Written permission is required for the release of information except in situations where 1) there exists a **substantial likelihood** that as a result of mental illness, the person will, **in the near future**, cause serious physical harm to self or others; 2) a court subpoena, 3) the suspicion of child abuse or neglect, or of adult/elder abuse, neglect or exploitation. Under routine release of information, such as to an insurance company, the minimum information is provided in an effort to protect your privacy.

### **Appointments**

If you are more than 15 minutes late for your appointment, there is the possibility that your session may need to be rescheduled to another day.

### **Telehealth**

When possible, sessions are completed face-to-face, but telehealth services are an option if that is not possible. If you and your therapist are unable to meet in person, telehealth services may be utilized as agreed upon by provider and client. By using telehealth, our session would be conducted over the internet using audio and video on a secured platform, rather than meeting in person.

### **Fees**

- ★ **If you do not cancel your appointment by telephone at least 24 hours in advance you will be charged \$90.00 for the missed appointment.**
- ★ **If your account is more than 90 days past due, your account will be sent to collections agency and you are solely responsible for the owed balance plus the agency's fee of 40% of the balance.**

You (or your legal representative) are solely responsible to pay your bill in full. Failure to pay any outstanding bill or late fees will be viewed as your termination of treatment.

### **Attendance in Court**

If you are involved in a court case involving a divorce or custody issue, your provider will not be able to testify. Testifying in court may harm the therapeutic relationship. Courts appoint professionals who have no prior contact with a family to conduct evaluations and make recommendations. By signing this form and consenting to treatment, you agree not to call your therapist or any representative of Harrisonburg Center for Healing as a witness in domestic litigation.

Clients are discouraged from having their therapist subpoenaed. Even though you are responsible for the testimony fee, it does not mean that my testimony will be solely in your favor. I can only testify to the facts of the case and to my professional opinion.

### **Court Action/Legal Fees**

1. Preparation time (including submission of records): \$220/hr
2. Phone calls: \$220/hr
3. Depositions: \$250/hr
4. Time required in giving testimony: \$250/hr
5. Mileage: \$0.40/mile
6. Copies: \$0.50/page
7. Postage: current rate as determined by the USPS
8. Time away from office due to depositions or testimony: \$220/hr
9. All attorney fees and costs incurred by the therapist as a result of the legal action.
10. Filing a document with the court: \$100
11. The minimum charge for a court appearance: \$1500

A retainer of \$1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional \$250 "express" charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged \$500 (in addition to the retainer of \$1500).

### **Availability**

Harrisonburg Center For Healing can be reached at 540-830-5443 from 9:00 a.m. through 5:00 p.m. Monday through Friday. Telephone messages are private and confidential, and checked throughout the day. We will make every effort to return your call in a timely manner.

**If you have an emergency, please call 911 or go to the nearest hospital emergency department and request to see the Psychiatrist on call.**

When your clinician is out of town or otherwise unavailable, another clinician will be designated to take your call. In the event of death of your clinician, you will be notified that it will be necessary for another licensed therapist to take possession of client records and/or forward them to the therapist of your choice.

### **Privacy and Protected Health Information**

This mental health practice is required by law (The Health Insurance Portability and Privacy Act (HIPPA) 2000) to maintain the privacy of protected health information. Treatment notes will never be released without written permission of the client. Treatment notes must be made available if we have received a subpoena from a court judge. Disclosure of protected health information is permitted for the purpose of treatment, payment, and health care operations. You have the right to complain to the U.S. Secretary of Health and Human Services ([www.hhs.gov](http://www.hhs.gov)) if you believe that your privacy rights have been violated.

### **Consent to Treatment and Termination**

By signing this statement you are agreeing to receive treatment with Ms. Neff as your primary provider. Continuity of care is important, however, you have the right to stop treatment at any time. Verbal or written notice would be appreciated if termination has not been discussed as part of the treatment plan.

If you do not attend sessions regularly, pay any outstanding bill, or become hostile and uncooperative toward my clinician, any of these actions will be grounds to terminate treatment.

**I have read, understand, and agree to the above terms. I have received a copy of this notice.**

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature of client or Legal Representative

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