

## CLIENT'S STATEMENT OF RIGHTS AND RESPONSIBILITIES

The following information is provided to ensure a clear and mutual understanding of your rights and responsibilities as a client in counseling with Frances Bell, Masters of Science (MS), Licensed Marriage and Family Therapist (LMFT). *Please read this information carefully; and ask about any information that is not clear. Your signature indicates consent.*

### CLIENT'S RIGHTS

**CONFIDENTIALITY** All client information is confidential and will not be released to anyone except at the specific written request or authorization of the client. If two or more adults are seen together, all must give written permission to release requested information. Frances Bell MS LMFT complies with all Federal HIPAA regulations regarding protected health information. Please refer to the **Notice of Privacy Practices** for a detailed description.

**TREATMENT** Clients have the right to know the cost of services and treatment. You have the right to participate in the development of any personalized service or treatment plan and the right to refuse recommended treatment and/or referral services. However, Frances Bell MS LMFT reserves the right to terminate service in the context of a client's refusal to participate in recommended treatment.

**PROFESSIONALISM** Frances Bell MS LMFT is dedicated to providing service that meets the highest standards of professionalism and ethical responsibility. Frances Bell has a Masters of Science in Marriage and Family Therapy from Virginia Tech. She is a Clinical Member of the American Association of Marriage and Family Therapists. She is Licensed in the Commonwealth of Virginia as a Marriage and Family Therapist.

**GRIEVANCES** If any doubts or complaints about the conduct of Frances Bell MS LMFT, you are encouraged to discuss them directly with her first. If you are not satisfied, you may initiate a written complaint and be assured of a written response that is prompt, well considered, and personal.

### CLIENT'S RESPONSIBILITIES

**TREATMENT** Clients agree to participate in setting goals for counseling and in evaluating these goals as treatment progresses toward successful termination. Evaluation includes following through on agreed upon between session homework, and informing the counselor about progress made or obstacles encountered.

**FEES** Clients have the responsibility to pay fees at the beginning of each appointment, unless specific alternate arrangements are made. For some, medical insurance will pay part of the cost of therapy. Deductibles, co-payments and balances not covered by your insurance company are your responsibility. Clients using insurance must pay the full fee if you fail to cancel at least 24 hours in advance. The fee for checks returned by a bank is 25.00.

**CANCELLATIONS** Clients are responsible for setting and keeping scheduled appointments. You are responsible for notifying Frances Bell MS LMFT 24 hours in advance if an appointment will be missed or you will be charged your usual fee for the missed appointment. If clients are late for appointments, that portion of the time will be considered part of the agreed upon session time.

**COURT** Frances Bell MS LMFT does not provide forensic evaluation services or serve as an "expert witness." She is a treating therapist. If you or an attorney subpoena her for court testimony, you agree to pay \$100 per hour for her preparation, travel, waiting, and testifying time. These charges will apply even if Frances Bell MS LMFT is present in court, but excused from testifying.

**EMERGENCY CARE** Frances Bell MS LMFT is not an emergency service. In an emergency situation, call 911 or go to your nearest hospital emergency room or local Mental Health Center. Once the emergency is taken care of please call Frances Bell MS LMFT at 703-338-5050. If she does not immediately answer, please leave her a voicemail and she will respond at her first opportunity.

*I have read, understand, and agree with my rights and responsibilities as stated above. I also hereby acknowledge that I have received, reviewed and had an opportunity to ask questions about the HIPAA "Notice of Privacy Practices."*

**MY SIGNATURE INDICATES CONSENT TO TREATMENT WITHIN THE GUIDELINES SPECIFIED:**

**Printed Name of Client(s)** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Client's**

**Signature(s)** \_\_\_\_\_

**Printed Name of Parent/Guardian/Representative and Signature** \_\_\_\_\_

**Description of Representative's Authority to Act for Client:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Therapist Signature and Date** \_\_\_\_\_