CHILD, YOUTH AND FAMILY STUDIES
Couple and Family Clinic

Couple and Family Clinic / P.O. Box 830801 / Lincoln, NE 68583-0801 / (402) 472-5035 / FAX (402) 472-2283

Psychotherapy Agreement
(Spring Creek Home, Inavale, NE)

I hereby grant permission for any evaluation, testing, or treatment that may be deemed relevant for the psychotherapy provided by for me, my dependent child or children, my marriage, and/or my family. I understand that it is customary for assessment and treatment sessions to be audio and/or videotaped. While this taping is primarily for training purposes, it may also be used as part of assessment and treatment. I hereby grant permission for the audio and/or videotaping of the assessment and treatment sessions received under this Psychotherapy Agreement.

I am aware that psychotherapy under this Agreement is being provided by the Couple and Family Clinic (CFC) and not by Webster County Community Hospital (WCCH), Spring Creek Home (SCH), their providers, or staffer affiliates, even though I am receiving that care through WCCH and SCH facilities. The CFC is a mental health clinic of the University of Nebraska-Lincoln. All records, reports and documentation associated with services provided under this agreement will be maintained by the CFC and not WCCH/SCH. However, in order to coordinate my care with WCCH/SCH providers, I am aware that there will be communication and participation by WCCH/SCH providers and staff with CFC providers and staff as described below.

I am aware that my mental health therapist is a graduate student in the Marriage and Family Therapy program at the University of Nebraska-Lincoln and is working under the supervision of a supervisor duly licensed in the State of Nebraska to practice psychotherapy. I recognize that any therapy, testing, taping, and diagnostic work will be reviewed by clinical supervisors and other trainees for clinical, supervisory and instructional purposes only.

The CFC and my mental health therapist cannot release information about my treatment without my written consent in most situations. All information about me (and my dependents or family members) and the reasons for which I am seeking treatment, including psychotherapy sessions, records, and tapes, will be kept strictly confidential except a) where Nebraska State law requires the reporting of threats of violence, harm or child abuse and neglect (from evidence or suspicion), b) where information is shared with medical providers and/or the mental health therapist on staff with WCCH/SCH as part of coordinating care (see below), and c) when information is being subpoenaed by the courts. I understand that information about me may be disclosed without my consent or authorization in response to a valid court order. If I have questions about how my health information may be used, I understand that I may request a copy of the Family Resource Center's notice of privacy practices at any time.

I understand that I have the right to request that my mental health therapist amend my personal and/or health information. I also understand that I have the right to request my mental health clinical record with the exception of psychotherapy notes which are protected under the Health Insurance Portability and Accountability Act (HIPAA).

I am aware that it is customary for my mental health therapist to collaborate with my medical provider, mental health therapist and/or service providers on staff with WCCH/SCH. This collaboration shall include consultation and the sharing of information deemed pertinent for my overall health care. I am aware that the Assessment Summary and Care Plan developed by my mental health therapist may be shared with my medical provider.

I am aware that psychotherapy is being provided through the CFC on the University of Nebraska-Lincoln campus using video conferencing technologies. This videoconferencing technology is secure and confidential. I have been given an opportunity to talk with my mental health therapist about the technology and to resolve any concerns that I have about receiving treatment through this medium. Given this medium of treatment delivery, I recognize that personnel at WCCH/SCH will need to be involved in scheduling and other aspects associated with treatment delivery. As a consequence, staff and providers at WCCH/SCH may be aware that I (or my dependent) will be receiving mental health treatment. I am willing to work through the designated personnel at WCCH/SCH to receive this psychotherapy service. In the event that my dependent is receiving mental health treatment in my absence, I give permission to allow designated personnel at WCCH/SCH to assist my dependent child to ensure the appropriate functioning of the technology and to help in any other way deemed necessary by myself or the mental health therapist.

I am aware that because assessment and treatment will be provided at a distance through videoconferencing that there may be limitations in treatment that I will receive. I am aware that these potential limitations are unknown at the outset of treatment. I am also aware that there may need to be accommodations to the videoconferencing technology in psychotherapy treatments and therapeutic conversations. These accommodations may include occasional face-to-face sessions with the mental health therapist. I am willing to make those accommodations to ensure that I participate fully in treatment. My mental health therapist will ensure that I receive the most appropriate treatment for my condition and situation, and may make a referral to a local mental health care resource if needed.

While uncommon, I am aware that technological problems may occur that could affect a scheduled appointment. In the event that this unlikely challenge occurs, my mental health therapist will work to accommodate my needs for treatment and to schedule another appointment. I am aware that problems with the technology could result in frustration and/or other emotional strain that could negatively influence the process of psychotherapy. I agree to address these stresses and strains with my mental health therapist.

Being aware that there may be a potential for emotional strains, stresses and life changes as a result of psychotherapy, I agree to enter the psychotherapy process (or agree to allow my dependent to enter the psychotherapy process). I understand that my mental health therapist, the CFC, and the University of Nebraska-Lincoln do not guarantee any particular results or outcomes.

I am aware that the CFC and the mental health counseling is not an emergency service. In case of emergency, I agree to contact the local emergency crisis line or go to the emergency room at WCCH/SCH (or closest hospital alternative). If needed, my mental health therapist will refer me to a local therapist. In the event of a referral, the payment plan used at the CFC does not apply. I will be responsible for session fees at the rate assessed by the agency or individual to whom I am referred.

The fee for mental health care under this agreement is $0.00 per treatment session (normally 30 minutes). Payment will be made to the Family Resource Center. If I remit payment by personal check and the check is returned due to insufficient funds, I agree to pay, in cash, the amount of the returned check in addition to the check service charge. If a check is returned, I agree to discuss payment options with my mental health therapist to avoid future payment problems. If my account goes unpaid for three consecutive sessions, I understand that mental health services may be discontinued by the CFC. If my mental health therapist, supervisor or representative of the CFC is asked to make an appearance in a court of law on my behalf, I understand that I will be billed a fee of $120.00 an hour. Depositions and any other legal proceedings are subject to the same fee. I agree to give at least 24 hours advance notice should I decide to cancel an appointment. I accept full responsibility for charges I incur during the course of psychotherapy. When I decide to discontinue therapy, I agree to discuss this with my mental health therapist.

I have had an opportunity to discuss all aspects of this Psychotherapy Agreement with my mental health therapist. In the event that my questions cannot be answered by my therapist, I understand that I can contact Vanessa Neuhaus, M.S., Clinic Coordinator of the CFC (402-472-9464).

_____	_____
Signature of Client/Date	Parent/Legal Guardian Signature/Date*
_____	_____
Signature of Client/Date	Witness/Date+

*For dependent children under the age of 19 and still in high school, it is necessary that a parent or legal guardian give permission for mental health treatment to be provided. The permission of only one parent/legal guardian is needed.
+In the event that a parent/legal guardian is giving permission for the mental health treatment of their dependent child, a designated representative of the CFC or of the BCHC must indicate by signature and date that they have witnessed the signing of this document by the parent/legal guardian.