Therapist/Client Services Agreement

This document contains important information about the professional services and business policies of the practice named "Simple To Be, LLC." and any licensed therapist/contractor with this practice. It also contains your Client Rights and summary information about the Health Insurance Portability and Accountability Act (HIPPA) in the Notice of Privacy Practices. I am required by law to obtain your signature acknowledging that I have provided you with this information at the first session. Please read this document carefully and ask me any questions you may have. When you sign this document, it will represent an agreement between us. This is your informed consent.

1 Client Rights

1. You have the right to request information about your therapist's qualifications, credentials, experience, specialization, and education.
2. You have the right to obtain, from another therapist, a second opinion regarding the assessment and treatment plan developed to assist with your presenting problem.
3. You have the right to ask for an alternative referral at any time.
4. You have the right to inquire about fees for therapy, billing practices, insurance reimbursement, and any other methods of payment.
5. You have the right to terminate therapy when you have reached your goals or believe therapy is no longer necessary.
6. You have the right to refuse the suggested intervention or treatment strategy indicated by your therapist.
7. The frequency and duration of therapy depends on many factors. It is your right to be a part of determining jointly with your therapist how long and often you will receive therapy.
8. You have the right to renegotiate therapies as often as needed.
9. You have the right to receive complete and accurate information regarding your diagnosis, treatment, risks, and prognosis.
10. You have the right to confidentiality unless you report to be in danger to yourself or others (Therapist must report to appropriate agencies if you are suicidal or homicidal). Limits also include misconduct of other therapists, suspected child abuse, abuse to vulnerable adults, prenatal exposure to controlled substances, court ordered reports, potential use of a collection agency and insurance agencies. In these situations, there are limits to confidentiality.
11. The following person(s) have permission to obtain medical records and/or discuss therapy interventions from this provider, listed as Simple To Be, LLC. Any request made by family members other than legal guardians will be denied. Records will be shared with the parent(s) or legal guardian only and will be the responsibility of that party to share records with others they deem appropriate. Records provided to the parent(s)/legal guardian will be under the sole discretion of stated persons to determine who is allowed access and will not hold Simple Be To Be or those under that provider name liable or responsible for information shared with others other than stated persons below.

_____Mother _____Father _____ Legal Guardian (please print name)_____

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2 Consent for Treatment

I understand that *Simple To Be, LLC* will maintain my privacy to the highest standards and may use or disclose mine or my child's personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

_____ I agree to allow Suzanne Kessner, PT, DPT, PCS to communicate directly with me, the client and/or legal guardian, through electronic mail any requested documentation, including but not limited to billing statements, that may contain personal medical information regarding the treatment(s) received, mailing address, phone number, or other information considered part of the medical record.

_____ I understand that electronic email for the purpose of communicating my medical information may not be encrypted and will not hold Simple to BE, LLC or its agents responsible for incidences where my personal medical information may be at risk for viewing by others outside of this contract between Simple to BE, LLC and myself as the patient/legal guardian.

3 Professional Fees- effective 01/02/2023

1. One (1) hour of individual treatment therapy $150.00
2. One (1) hour Initial Evaluations and POC development $160.00
3. Cancellations made with less than 24 hours' notice and failure to show for an appointment may be subject to a partial charge of $100.00.
4. The client understands that *Simple To Be, LLC* is a private practice that does not bill insurance policies for therapy services provided. Payment is Due at the time services are rendered unless prior arrangements have been made with the owner. A billing statement will be available upon request.
5. It is the client's responsibility to be aware of insurance coverage and submission to insurance for reimbursement potential by oneself. The therapist will provide any necessary documentation for the purpose of client submission that is within the legal expectations for documentation only. This documentation will be provided within one (1) week of request. The therapist will not be responsible for any electronic or paper submission to an insurance company and it is understood by you, the client, that communication requests with any insurance company is the client's responsibility.

4 Contacting Me

To schedule an appointment or make changes to your appointment schedule with me please call or text at (602) 312-1070. Since I am often seeing other clients, you may reach my voicemail. Please leave a message with your name and phone number and a suitable time to reach you. You may also email me at suzanne@simpletobe.com. I check my messages throughout the day Monday through Friday and will return your call within one (1) business day. In an emergency, you should contact your pediatrician or 911 services.

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5 Limits on Confidentiality

In most situations, I can only release information about you or your child to others if you sign a written Authorization form that meets certain legal requirements. Other situations require only that you provide written, advance consent. Your signature on this Agreement provides consent for the following activities:

- Consultation with other health professional during which I will make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential.
- I also may have contracts with secretarial services, billing services or accounting services. As required by HIPPA, I will have a formal business contract with these businesses in which they are required to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

There are situations that may occur in which I am legally obligated to take actions such as in cases of possible child/elder abuse, neglect, or self-harm. These are detailed further in the Notice of Privacy Practices.

_____ _____

Patient/Legal Guardian Printed name Relationship to Child

_____ _____

Patient/Legal Guardian Signature Date

PT, DPT, RCS

Suzanne Kessner, PT, DPT #2744
Board Certified Pediatric Specialist #50994
Simple To Be, LLC