



# SHANNON E. SMITH, LPC

*Counseling, Consultation & Training*

## **PRACTICE POLICIES**

(Effective 1/1/2022)

### **PAYMENTS AND THE USE OF INSURANCE**

Payment is due at the time of service. I accept cash, credit cards, personal checks, and money orders. If you save a credit card in your profile, that card will be billed by the end of the day on the date of your appointment. If payment is declined, I will reach out to you for another form of payment prior to your next appointment. A \$30.00 service charge will be charged for any checks returned for any reason for special handling.

If you are using insurance to cover your sessions, I will verify your benefits, estimate your portion due, and file the claims as a courtesy. Please note that estimates and coverage cannot be guaranteed, and you will be responsible for any cost above estimated fees. If your insurance company denies claims, you will be responsible for the full cost of services completed.

You must notify me of any changes to your insurance coverage, and you must provide proof of insurance at the onset of services and at the beginning of each year after then.

### **APPOINTMENTS AND CANCELLATIONS**

Missed sessions and late cancellations will be subject to a fee if **NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE**. This is necessary because a time commitment is made to you and is held exclusively for you. I will excuse one late cancellation/missed session per year, and I may use my discretion to excuse or discount a late cancellation fee after then. Services may be terminated after two consecutive missed sessions. Please remember to cancel or reschedule 24 hours in advance.

The standard meeting time for psychotherapy is 45-50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to extend the session need to be discussed with the therapist in order for time to be scheduled in advance. Please be aware that insurance may not cover extended sessions. If you are late for a session, you may lose some of that session time.

### **TELEPHONE ACCESSIBILITY**

If you need to contact me between sessions, please leave a message on my voice mail or text me at the same number. I am often not immediately available; however, I will attempt to return your

call within 24 hours. If a true emergency situation arises, please call 911 or any local emergency room. Text messaging should never be interpreted as counseling.

## **SOCIAL MEDIA**

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.). I believe that 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 talk more about it. If you would like to “Like” my professional Facebook page or “Follow” my professional profile on Instagram, you may do so at your own risk. This is not at any time a way to contact me for therapy-related discussion, even in an emergency.

If you would like me to review your (or your child’s) social media interactions as part of our therapeutic work, please print what you would like me to review and bring it with you to session. Even if your or your child’s social media accounts are public, I will not examine them without your specific consent and direction.

Please note that any social media apps you use may seek to connect you with me or with other visitors to this office, through a “people you may know” or similar feature. I have no control over apps that may intrude on the privacy of your treatment in this way. If you would like to minimize the risk of others becoming aware of your connection to me or this office, please make use of the privacy controls available on your phone. Turning off a social media app’s ability to know your location, and refusing it access to your email account and the contacts and history in your phone, protect your privacy and confidentiality.

## **ELECTRONIC COMMUNICATION/TELEMEDICINE**

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.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. 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.

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 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. In the case of separated/divorced parents, it will be necessary for parent(s) to provide proof of custody. When there is a shared custody arrangement, both parents must consent to treatment and sign all documentation.

## **EMOTIONAL SUPPORT ANIMALS**

If you are interested in obtaining an Emotional Support Animal letter, please be aware that I do not write these letters.

## **ANIMALS IN THE OFFICE**

On occasion, you may ask to bring your pet or emotional support animal to session with you. To ensure the safety and comfort of everyone in the office, you may not bring your animal to session unless we have specifically discussed it and I have approved it. If you do bring an animal to the office, you must maintain control of your animal at all times, and agree to take full responsibility for the animal, including any cleanup or repairs that may be needed.

## **RECORDING DEVICES**

I have smart devices that have microphones in the office, including my cell phone and laptop. These devices generally have voice control turned off, and so they are not recording.

If you bring a smart device to session, that device likely has the option of voice control built in. If voice control on your device is enabled, the microphone may be always on, and snippets of conversation may be recorded and sent to the device maker. If you prefer not to take this risk, please disable voice control on your devices while in session.

Please feel free to take notes in session if you believe it will be helpful in remembering key points of discussion. However, audio or video recording of sessions is prohibited.

## **COMMUNICATION WITH LEGAL PROFESSIONALS AND COURT APPEARANCES**

Please tell me immediately if you are involved in a legal case (criminal or civil/family). I charge a fee for letters and status updates provided to attorneys, and a specific written release must be on file prior to me communicating with an attorney. Many people believe that a counselor's testimony in court or the release of their treatment notes can be beneficial to their case. Most often, this is inaccurate. If, however, you choose to release your notes to an attorney/court or request my testimony, I charge fees related to the work requested, include time spent in preparing documents, copying fees, travel, and missed work. These fees will be discussed and will be required in advance.

## **COUNSELOR EMERGENCY OR INCAPICITATION**

In the event of my unplanned absence from practice, whether due to injury, illness, death, or any other reason, I maintain a detailed Professional Will with instructions for an Executor to inform you of my status and ensure your continued care in accordance with your needs. Please let me know if you would like the names of my Executor and Secondary Executor. You authorize the Executor and Secondary Executor to access your treatment and financial records only in accordance with the terms of my Professional Will, and only in the event that I experience an event that has caused or is likely to cause a significant unplanned absence from practice.

**THREATS, HARASSMENT, OR INTIMIDATION**

If you engage in threats, harassment, or intimidation toward me or others in this office, this may be grounds for immediate termination of therapy. You also grant permission for me to share information about any threatening behavior with law enforcement and/or others as I believe necessary to protect my safety and that of others.

**TERMINATION**

Ending relationships can be difficult. Therefore, I recommend that we discuss and decide together how to terminate treatment when that time arrives. I may terminate treatment after appropriate discussion with you 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. If therapy is terminated for any reason and 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 four consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

By signing below, I assert that I have read, understood, and agree to the items contained in this document.

\_\_\_\_\_  
Client Signature (Client’s Parent/Guardian if under 18)

\_\_\_\_\_  
Date