Anne Wiser, PhD, LISW
awiserpsychotherapy.com
332 S. Linn St., Suite 25, Iowa City, IA 52240 / (319) 383-8915

Welcome! It is my desire to insure that your participation in counseling will be a most productive and satisfying one. In order to facilitate a therapeutic relationship, I have set forth certain information which will enable you to make an informed consent to counseling.

Psychotherapist Qualifications: I am a clinical social worker licensed by the States of Iowa to provide mental health services. I obtained my masters of social work from The University of Iowa. Prior to this, I obtained a PhD in neuroscience from the University of Colorado and as such, conducted brain research. My knowledge of how the brain functions guides my psychotherapy practice.

Mental Health Services: While it may not be easy to seek help from a mental health professional, it is hoped that through therapy you will achieve change in the following ways: 1) gain greater insight into your situation and feelings, 2) develop expanded conceptualizations of your life, relationships, circumstances, and future, 3) move toward resolving your concerns, and 4) forge a life plan that promotes greater realization of your human potential, happiness, and success. As your psychotherapist, using my knowledge of the human brain, human behavior and human change process, I will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own thoughts and feelings and to try new approaches in order for change to occur.

Relationship: Your relationship with me is a professional and therapeutic one. In order to preserve this relationship, it is imperative that I have no other relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. I care about helping you but I am not in a position to have a personal relationship with you. Gifts, bartering and trading services are specifically disallowed in the legal code of ethics of my profession.

Effects of Psychotherapy: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspective and decisions you make. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Risks of Psychotherapy: Therapy is about change. You may learn things about yourself that you don't like. Often, growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the effort you are prepared to give to this endeavor and the realization that you are responsible for changes that may result from therapy.

Client Rights: Some clients only need a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you are in complete control and

may end our counseling relationship at any time, though I do recommend you participate in a discharge session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might not be beneficial to you.
My services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please notify me in person or in writing and I will work with you to resolve your concerns. It is my pledge that any problems will be resolved to your satisfaction.

Confidentiality: Conversations between a psychotherapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: abuse or neglect of a child or a dependent adult (elderly or disabled); criminal prosecutions; lawsuits in which the mental health of a party is an issue; situations where the psychotherapist has a duty to disclose, or where, in the psychotherapist's judgment, it is necessary to warn or disclose; fee disputes between the psychotherapist and the client; a negligence suit brought by the client against the psychotherapist; or the filing of a complaint with the licensing board.
In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and a $200 hourly rate for the time involved in preparing for and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered. If you are involved in a divorce or custody litigation, you need to understand that my role as a psychotherapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in litigation. By signing this document, you agree not to call me as a witness in any such litigation.
If you have any questions regarding confidentiality, you should bring them to my attention when we discuss this matter further. By signing this information and consent form, you are giving your consent to me to share confidential information with all persons mandated by law and with the health insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless this psychotherapist from any departure from your right of confidentiality that may result.

Duty to Warn: In the event my psychotherapist reasonably believes that I, the undersigned client, am a danger, physically or emotionally, to myself or another person, I specifically consent for the psychotherapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

Name(s)	**Telephone Number(s)**	**e-mail Address(es)**

Therapist's Incapacity or Death: I, the undersigned client, acknowledge that, in the event my therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my clients' records. By signing this information and consent form, I give my

consent to allowing another licensed mental health professional selected by my therapist to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice.

Appointments: Appointments are for 50-minute sessions. Clients are seen in the office on an appointment basis. Initial appointments may be made by calling (319) 383-8915. I maintain my own appointment calendar. Please leave your name and number in my Voice Mail and I will call you back for scheduling the appointment.

Appointment Reminders: You can receive an appointment reminder to your email address, your cell phone (via a text message), or any phone (via a voice message).

Where would you like to receive appointment reminders? (check one)

_____ Via a text message on this cell phone number_____

_____ Via an email message to this email address:_____

_____ Via an automated telephone message to this phone number
_____

_____ None of the above. I will remember my appointments on my own.

In the event that you do not receive the appointment reminder you are still expected to attend your session and missed appointment fees may apply.

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

I, the undersigned client, consent for my psychotherapist to communicate with me by mail, phone, text and e-mail, at the following addresses and phone numbers and I will promptly advise the psychotherapist in the event of any change:

My Mailing Address _____

My Telephone Number(s) _____

_____

Is it OK to leave messages on your answering machine and/or voice mail or with a family member/roommate? Yes ____ No ____

My e-mail Address(es) _____

Anne Wiser, PhD, LISW
awiserpsychotherapy.com
332 S. Linn St., Suite 25, Iowa City, IA 52240 / (319) 383-8915

Emergency Services: I am unable to provide 24 hour per day, seven days per week psychotherapy services. In the event that you become in need of emergency services, please contact the following: **the Iowa Help Line (855) 800-1239, the crisis line (319) 351-0140; 911, or go to the nearest emergency room for thoughts of suicide, self-harm, or homicide.**

VOLUNTARY CONSENT TO TREATMENT

I, the undersigned client, voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize the undersigned psychotherapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned psychotherapist at any time. However, premature termination may result in failure to achieve therapeutic outcomes.

By signing this form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client (or parent/legal guardian) Name: _____

_____ _____
Signature **Date**

2nd parent/legal guardian name (if client is a minor):_____

_____ _____
Signature **Date**

As witnessed by:

_____ _____
Anne Wiser, PhD, LISW **Date**
Psychotherapist

Anne Wiser, PhD, LISW
awiserpsychotherapy.com
332 S. Linn St., Suite 25, Iowa City, IA 52240 / (319) 383-8915

CLIENT FEE AGREEMENT

Payment for Services: The Standard fees for psychotherapy is $150 per session except for the initial (intake) session or evaluation which is $200.
I offer two plans for payment of fees. Please check the payment plan you would like to use.
1. Private pay which means you pay in full at each appointment by cash or check to be made to A Wiser Psychotherapy. There will be a processing fee of $40 for returned checks. I do not accept debit or credit cards at this time.
2. I bill your insurance (I only take Blue Cross Blue Shield/Wellmark at this time) and you pay your copay with cash or by check at each visit.

It is my policy to bill your insurance company as a courtesy. Please remember that you are responsible for claims rejected by your insurance or fees not covered by your insurance. Some services and charges may not be reimbursable by your health insurance. These include but are not limited to missed appointments and exceedingly long telephone calls for reasons other than emergencies. Because health insurance companies do not cover psychotherapy sessions conducted over the phone, calls that are longer than 5 min or what I, as your psychotherapist, deem medically necessary for the situation (whichever is longer) are billed at the standard psychotherapy fee prorated for the time exceeding what is medically necessary. I will let you know when a call is about to become billable to give you the choice to end to call and save the conversation for our next appointment or to continue at the pro-rated amount.

You are responsible for checking with your insurance to:
1. make sure you have mental health coverage
2. know what your copay will be if you have one
3. know if you have a deductible and if so if you have met it or how far away you are from meeting it.
4. ask if there is a limit on the number of visits it covers.

Please come to your first appointment with that knowledge in mind and with your insurance card.

Cancelations: If you are unable to keep a scheduled appointment, I ask that you notify me at least 24h in advance in order to make that time available to other clients. If you do not cancel your appointment or cancel without adequate notice or justifiable cause, you may be charged a missed appointment fee up to the full appointment fee for that missed appointment. Such charges are not covered by insurance.

I have read and understand the client fee agreement. I am responsible for all outstanding balances incurred by me. I also understand that payment is due at the time of the session unless prior arrangements have been made. My signature below signifies that I have read, understand, and agree to abide by the above policies.

Client Signature _____ Date _____

Anne Wiser, PhD, LISW
awiserpsychotherapy.com
332 S. Linn St., Suite 25, Iowa City, IA 52240 / (319) 383-8915

NOTICE OF PRIVACY PRACTICES

Background: The Health Insurance Portability and Accountability Act (**HIPAA**) of 1996 was enacted by congress to help protect health coverage for workers and their families. It also addresses electronic transaction standards and the need to ensure the security and privacy of health data. I am required by law to maintain the privacy of protected health information, and must inform you of my privacy practices and legal duties. The security and privacy of your protected health information is important to me and is the subject of this Privacy Notice.

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IT. PLEASE REVIEW IT CAREFULLY.

I. Use and Disclosure of Your Protected Health Information for Treatment, Payment, and Health Care Operations

I may use or disclose information in your records for treatment, payment, and health care operations purposes with your consent. Protected Health Information (PHI) refers to information in a client's health record that could identify that client. Use of this information refers only to activities within my office such as sharing, employing, applying, examining, and analyzing information that identifies you. Disclosure of information refers to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties. Throughout this notice, the term "you" may refer to the individual who is the client or the individual's parent, legal guardian or adult who has been legally determined to be responsible for the client. In providing for your treatment I may use or disclose information in your record to help you obtain health care services from another provider, or to assist me in providing for your care. In order to obtain payment for services, I may use or disclose information from your record, with your consent. For example, I may submit the appropriate diagnosis to your health insurer to help you obtain reimbursement for your care. I also may use or disclose information from your record to allow health care operations (e.g., quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination).

II. Use and Disclosure Requiring Authorization

Except as described in this Notice, I may not make any use or disclosure of information from your record for purposes outside of treatment, payment, and health care operations unless you give your written authorization. In particular, I will need to secure an authorization before releasing psychotherapy notes which are kept separate from the rest of your treatment records. These are notes I may have made about our conversations during treatment and evaluation sessions. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by me before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

III. Use and Disclosure Without Consent or Authorization

There are certain circumstances, listed below, in which I am permitted (or, in some cases, required) to use or disclose information from your record without your permission:

Child Abuse: If I know, or have reasonable cause to suspect, that a child is or has been abused, abandoned, or neglected, the law requires that I report such knowledge or suspicion to the appropriate authorities.

Adult and Domestic Abuse: If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to report such knowledge or suspicion to the appropriate authorities.

Health Oversight: If I receive a subpoena from the Iowa Board of Social Workers for your protected health information, I must comply with the subpoena and disclose the information.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for your records, I will not release information without your written authorization or a subpoena of which you have been properly notified, or a court order. The privilege does not apply if you are being evaluated for a third party, or if the evaluation is court-ordered, or in certain other limited instances. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: If you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or appropriate authorities.

Workers' Compensation: If you file a workers' compensation claim, I may disclose information from your record as authorized by workers' compensation laws.

IV. Client's Rights

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Location: You have the right to request to have confidential communications of PHI delivered by alternative means and/or at alternative locations. (For example, you may not want a family member to know that you are seeing a psychotherapist. Upon your request, I may be able to arrange to send your bills to another address.)

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. This may be subject to certain limitations and fees. Upon request, I will discuss with you the details of the request process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request must be in writing, and I may deny your request.

Right to an Accounting: You have the right to request an accounting of certain disclosures made by me. Upon request, I will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

V. Social Worker's Duties

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I make significant revisions to these policies and procedures I will provide you with a copy of those revisions. Updated notices of A Wiser Psychotherapy LLC's privacy policies will always be available for review upon request.

This notice will go into effect on June 6, 2016

Anne Wiser, PhD, LISW
awiserpsychotherapy.com
332 S. Linn St., Suite 25, Iowa City, IA 52240 / (319) 383-8915

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES FOR ANNE WISER, PhD, LISW

Please sign and return this page.
You may keep the Notice of Privacy Practices for your records.

Client Name (printed) _____

Date of Birth _____/_____/_____

Parent/Guardian Name (if client is under 18) _____

I acknowledge receiving a copy of the Notice of Anne Wiser's Privacy Practices on

_____/_____/_____

_____
Client Signature (or Parent/Guardian signature if client is under 18)

For Office use only.
If written acknowledgment was not obtained, please explain below: