Alicia Enciso Litschi, Ph.D.
Licensed Psychologist (Lic. #37098)
512-686-7525
conalmatherapy@gmail.com
2222 Western Trails Blvd., #107
Austin, TX 78745

WORKING RELATIONSHIP AGREEMENT

Welcome. I look forward to our work together. This document outlines our agreements for a working therapeutic relationship. This includes your rights and responsibilities as a client. I have the responsibility to give you the best care possible, to respect your rights, and to recognize your responsibilities as a client. Please keep a copy of this agreement for your records.

FEES: The fee for a 50-minute psychotherapy, supervision, and consultation service is $150. The fee for an 80-minute session is $225. I periodically raise my fees, and I will give you sufficient notice of such a change. I provide a limited number of sliding scale fee opportunities. I am an in-network provider for Blue Cross Blue Shield PPO plans.

PAYMENT FOR SERVICES: You are responsible for the full payment of services by check, credit card, or cash at the end of each session. If at any time you find there are any problems regarding fee payment, I will be glad to speak to you regarding your concern. As a last resort, the law also permits me to release information to a collection agency in order to collect on an overdue account. I will provide you notice of this should this be necessary.

CANCELLATIONS: If you miss an appointment or cancel with less than 24 hours notice, you will still be responsible for paying your full fee. Please note that insurance companies do not provide payment for missed sessions. You will be responsible for the full fee for these sessions, not just the co-pay.

EXTENDED PHONE CONVERSATIONS: Sometimes brief phone contact between sessions is helpful for emotional support. If phone conversations extend beyond 15 minutes, the hourly rate for therapy will be applied (prorated for total time on phone).

INSURANCE: If you request that your insurance company pay for my services, I will share only the minimum information necessary for your insurance company to process claims. Submission of claims to you and your insurance company usually includes: a) name and address of your insurance company; b) your subscriber and group plan numbers; c) your name, birth date, social security number, diagnosis, dates of service, type of service. It is important to note that in order to submit a claim for insurance, a mental health diagnosis is required. I am happy to discuss any questions or concerns about this with you. Please be aware that insurance companies may have limits on number of visits allowed. You are responsible for any fees for service if your insurance company declines payment.

CONFIDENTIALITY: The privacy and confidentiality of our sessions are extremely important to me. I follow the privacy provisions of state and federal laws and rules and of my profession's ethical standards. Identifying information about you or the therapy process will not be disclosed to any person or agency unless you provide a specific, written release to do so.

LIMITS TO CONFIDENTIALITY: There are, however, some situations written into law that limit confidentiality and may permit and/or require me to disclose your information. These situations include:

- Suspected abuse or neglect of a child; and/or suspected abuse, neglect, or financial exploitation of an elderly person or person with a disability requires a report to the appropriate state agency.

- Cause to believe that you are likely to harm yourself or another person may require notifying appropriate law enforcement or medical personnel to protect you or others.

- Records may be released when subject to a subpoena issued by a court judge.

- If you disclose another mental health provider's previous or current sexual misconduct towards you, I must report this to the appropriate agency. You may choose to remain anonymous in the report.

This list is not exhaustive, but these are the most common circumstances that may occur. The situations outlined above are rare and usually have no impact on the large majority of people seeking professional mental health services. If such a situation does arise, I will do my best to discuss the situation with you before disclosing your information.

COMMUNICATING WITH ME:

PHONE: If you need to reach me outside of session, you are welcome to call me at 512-686-7525. If I do not answer, please leave a voice mail message. My intent is to return calls within a business day, Monday through Friday. I typically return calls during the hours of 9 a.m. to 6 p.m.

EMAIL & TEXT: Email and texts are not secure modes of communication. My priority is to protect your confidentiality. If you choose to text or email me, I ask that it be limited to simple scheduling issues. If you are needing support or would like to communicate something more substantive, please contact me via telephone and voice mail.

SOCIAL MEDIA: I do not accept friend or contact requests from current or former clients on any social networking sites (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and 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.

OUTSIDE OF SESSION: If there is ever an occasion in which we encounter each other somewhere outside of the therapy office, please know that it is my priority to protect your confidentiality. Therefore, I will not acknowledge you unless you greet me first, and I will keep our contact as limited as possible. We can further discuss these situations in session.

EMERGENCIES: If you feel that you are in crisis, it is recommended you call a local crisis intervention center. If I am out of town, emergencies may be handled by one of my colleagues.

24-hour Crisis Hotline	512-472-HELP
Seton Shoal Creek Psychiatric Hospital	512-324-2000
General Emergencies	911

INDEPENDENT PRACTICE: I am an independent practitioner, and my practice is independent of any other professionals who practice at my locations. I do not allow other practitioners access to records, and I assume sole responsibility for the care of my clients.

BUSINESS REVIEW SITES: You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. If you should find my listing on any of these sites, please know that my listing is not a request for a testimonial, rating, or endorsement from you as

my client. Feel free to provide a review if you'd like, while keeping your confidentiality in mind. I may not see these reviews, so if you have feedback please express it to me directly.

ADMINISTRATIVE FEES: For supplementary administrative tasks that require more than 15 minutes, I reserve the right to charge for this time at the prorated hourly fee. Examples might include advocacy work, completing court forms, etc.

LEGAL FEES: Under most circumstances, I will not voluntarily participate in any litigation or legal dispute in which you are involved, including written or verbal communication with an attorney or providing testimony. My priority is to prevent harm to the therapeutic process. If I am court ordered to participate in legal issues in any capacity, including preparation of documents, you as the client are responsible for my fee for these services, which will be billed at the rate of $300 per hour.

CONSULTATIONS: If you are receiving services from other health care professionals, I may ask for your written permission to confer with them about your assessment, counseling plan, and progress for the purpose of providing best treatment to you. I may consult about your case with other professionals for the purpose of providing the best services possible. Identifying information will remain confidential.

PROHIBITION OF WEAPONS: Please note that all weapons, including firearms and knives, are prohibited in my therapy office at both Weavings Wellness and Eastside Counseling.

RISKS AND BENEFITS OF THERAPY

Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, anxiety, guilt, anger, loneliness, and helplessness. Making changes in your beliefs and behaviors can be difficult, and can sometimes be disruptive to current relationships. You may find your relationship with me to be a source of strong feelings, both pleasant and unpleasant. On the other hand, psychotherapy has been shown to be beneficial and transformative for participants. Therapy often leads to more satisfying relationships, greater self-care and self-regard, new perspectives to problems, and reductions in feelings of distress. Most people who stay engaged in the process find that therapy is helpful, and I will do what I can to help you maximize positive outcomes.

DURATION AND OUTCOMES OF THERAPY

The duration needed to have positive results from therapy is difficult to predict. Some clients may get the help they were looking for in only a few sessions, while others may choose to continue therapy for several years. Outcomes of therapy depend on many factors, including the nature of change desired, readiness for such a change, time spent in therapy, effort spent by the client both during session and throughout the week, as well as the ability for client and therapist to work well together, etc. In our work together, I invite regular discussion about how we perceive our work together to be progressing.

TERMINATION AND REFERRALS

Therapy is an ongoing practice of mutually assessing how our work together is going. In this process, there may be situations in which it becomes evident that your treatment is outside of the scope of my expertise and practice. There may be other situations that arise that require that we terminate our therapeutic relationship in the interest of best care practices. I will do my best to provide you with referrals that are suited to your ongoing care and treatment.

AGREEMENT

By signing this agreement I acknowledge that I have read the policies and terms outlined above. I consent to an initial visit with Dr. Alicia Enciso Litschi according to these terms. I acknowledge that if we mutually agree to proceed with ongoing therapy thereafter, the terms of this agreement continue to apply. I understand that therapy is a collaborative effort and agree to bring concerns about the process to the attention of Dr. Enciso Litschi.

I acknowledge that I have received and reviewed a copy of the HIPAA Notice of Privacy/Rights and Responsibilities.

Client Signature _____ Date _____

Print Name_____

If under the age of 18

Parent/Guardian Signature _____ Date _____

Print Name_____

Parent/Guardian Signature _____ Date _____

Print Name_____

PLEASE SIGN IF YOU ARE USING INSURANCE:
I authorize Alicia Enciso Litschi, Ph.D. to release any medical, psychological, or other information necessary to my insurance company in order to request preauthorization for treatment and/or to process any insurance claims. I authorize payment of insurance benefits to Alicia Enciso Litschi, Ph.D. for all services provided.

Client Signature _____Date _____

Revised August 2018