Connie Taylor, LMFT
Connie Taylor Counseling
357 Riverside Drive, Suite 237, Franklin, TN 37064
615.545.7567

Practice Policies

Fee Policy / Payment / Cancellation of Appointment

The initial counseling session fee is $150 for a one hour session. Subsequent regular sessions are $120 and based on a 50-minute hour. Cancellations must be made 24 hours in advance. Otherwise, you will be billed your full session fee of $150/$120 to be paid at your next appointment. Fees for counseling services are due at each session and may be paid by cash, check, credit, HSA, or debit card. In the case of a returned check, a $25 fee will be charged to you. I do not file insurance claims but can give you a superbill receipt on a monthly basis at your request. You may use this receipt to file your insurance claim, but you will still be expected to pay the full fee at each session. If we need to consult on the phone outside our scheduled appointment time, my session fee begins after the first 10 minutes and is pro-rated based on my regular 50-minute counseling session fee of $120. Alternatively, we can schedule a full session to meet together. Of course, touching base briefly or about appointment times is not fee-based.

Confidentiality

Professional ethics and Tennessee law indicate that the client controls confidential information. This means that, as a general rule, information shared in session with a counselor will be held in confidence. There are three exceptions to this general rule. In the case of an emergency when the counselor believes the client is at risk of hurting himself/herself or another person, the counselor may breach the requirement of confidentiality. Secondly, Tennessee law requires that child or elder abuse in any form (physical, emotional, or sexual) be reported to the Department of Human Services or another authority, such as a juvenile judge. Thirdly, if I am subpoenaed for court, I may be required to disclose some confidential information.

If you are referred by a physician or other health care professional, it is professional courtesy to maintain contact, as necessary, with that referral source. However, I will only do this with your expressed written permission.

Clients Who Are Dependents

If you are requesting service as the guardian or parent of a child, or the guardian of a dependent adult, the same general practice as outlined above will apply. However, as your child's counselor, it is important that your child be able to completely trust me. As such, I keep confidential what your child says in the same way that I keep confidential what an adult says. As the parent or guardian, you have the right and responsibility to question and understand the nature of my activities and progress with your child, and I must use my discretion as to what is an appropriate disclosure. In general, I will not release specific information that your child provides to me. However, I feel it is appropriate to discuss your child's progress in broader terms and value your participation in your child's counseling experience.

Professional Boundaries

If we happen to see each other outside of therapy, I will not acknowledge the existence of our relationship unless you initiate it. The therapeutic relationship is a professional relationship and, therefore, cannot be a social relationship. This includes social media such as Facebook, with the exception of sites that are for professional services. A social relationship, in my view, would be detrimental to our purposes of therapy.

Professional Services

I am available for counseling sessions at selected times throughout the week. If you are unable to reach me during an emergency, please obtain assistance by calling 911, the Crisis Help Line at (615) 244-7444, or by going to your local hospital emergency room.

Benefits and Risks of Counseling

Persons contemplating counseling should realize they may make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriages or significant relationships, such as with parents, friends, children, relatives, etc. They may change employment, begin to feel differently about themselves, and may change other aspects of their lives. While I will assist the client in effecting change, I cannot guarantee a specific outcome. Clients are ultimately responsible for their own growth.

Credentials

I have a Master's of Marriage and Family Therapy degree from Trevecca Nazarene University. I am licensed as a Marital and Family Therapist in the State of Tennessee (LMFT license #1035).

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Informed Consent
By signing this document, I authorize and request Connie Taylor, LMFT, to provide consultation deemed necessary or desirable for my welfare and therapeutic growth. Additionally, I consent to participate in consultation and understand the limits of confidentiality as well as the benefits and risks. I understand that I can terminate with Connie Taylor at any time.

Do you have any **questions** about fees, confidentiality, or other matters? **Yes**_____ **No**_____

Do you **agree** with the conditions and provisions of the Practice Policies? **Yes**_____ **No**_____

Is there a conservator or guardian? **Yes**___ **No**___ **If yes,** Name, Address, Phone ____________________________________

For minors under 18, I **agree** to give Connie Taylor, LMFT, permission to work with my child(ren) as his/her counselor and have full decision-making authority to grant such permission: **Yes**_____ **No**_____

Parent/Guardian Signature____________________________**Relationship to Client** _____________**Date** _______

Non-Secure Communication Policy

Email Confidentiality Agreement
It is my normal practice to email my clients at times to touch base or discuss appointment times. When communicating via email, it is important to remember that confidentiality is limited. By signing below, you are saying that you have considered and understand the limitations of confidentiality and agree that you are responsible for keeping your email account private to the extent that you desire it to be private.

Text Messaging Confidentiality Agreement
At times, I text message my clients to inform them of upcoming appointment changes or to reschedule appointments. By signing below, you are saying that you have considered and understand the limitations of confidentiality and agree that you are responsible for keeping your text messages private to the extent that you desire them to be private.

Email ____ **Yes**_____ **No**_____

Text Phone Number ____ **Yes**_____ **No**_____

I, _________________________________, allow Connie Taylor to email and/or text me as indicated above.

The best way(s) to contact me is/are (please check): **Phone**_____ **Email**_____ **Text**_____

Parent/Guardian Signature____________________________**Relationship to Client** _____________**Date** _______

Fee Schedule for Legal Services and Production of Documents

Legal Services
I do not provide depositions or appear in court unless I am judge-ordered to do so. If so ordered, any legal fees I incur on your behalf will be paid in full by you on the day of the service. You will be responsible for any fee I am owed to an attorney for representation, including the cost of being subpoenaed or deposed, and all other legal fees associated with your case. In the case of being ordered by a judge to appear in court or to provide a deposition or testimony of any kind, my hourly fee to you for court or court-related appearances and/or testimonies and/or depositions is $500 per hour, including the time I leave and up to the time I return to my office. The fee for one summary statement is $400.

Production of Documents
You will be responsible for copy costs and the costs of mailing documents. Copy costs for production of documents will be $25 for the first five pages and $1.00 for each additional page after five. Additionally, you will be charged the mailing fee for the documents.

Do you have any **questions** about the Fee Schedule for Legal Services and Production of Documents? **Yes**___ **No**___

Do you **agree** with conditions and provisions of the Fee Schedule for Legal Services and Production of Documents?**Yes**___**No**___

Parent/Guardian Signature____________________________**Relationship to Client** _____________**Date** _______

Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) provides patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health. Mental health care providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. Therefore, you may have already received a similar notice from your other health care providers.

This Patient Notification of Privacy Rights is in its simplest form, and the purpose intended is to inform you of your rights as a patient. Please read this document as it is important you know what protections HIPAA affords all patients. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship. As your therapist, I will follow the regulations set forth to protect the privacy of your mental health records. If you have any questions about this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights. Thank you for your consideration in reading and acknowledging your receipt of this information by providing your signature below.

Connie Taylor

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Licensed Marital and Family Therapist (LMFT)

I, ____ (***parent/guardian printed name***), understand and upon request may receive a copy of this Patient Notification of Privacy Rights which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

____
Print Patient *(Minor)* ***Name***

____ __________________________
If Minor under 18, ***Print Parent/Guardian Name*** *Relationship to Patient (Minor)*

____
If Minor under 18, ***Signature of Parent/Guardian***

____
Date