

Lana Royle, LCMHC  
License # 8408027-6004  
12401 South 450 East Suite B  
Draper, Utah 84020  
(801) 979-0544

**Client Information and Office Policy Statement-Informed Consent**

This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. I, Lana Royle, will answer any questions you have regarding any of these policies. I appreciate the opportunity to work with you. I provide adolescent and adult therapy to individuals, couples, and families, as well as parent coaching services. Therapy involves a collaborative relationship between the therapist and client to modify troublesome thoughts, feelings or behaviors through the development of self-awareness, interpersonal understanding, and problem solving to enhance one's ability to cope, alleviate distress, or achieve life goals. As we address these issues and explore their origins together you may feel that you feel worse before you feel better.

Our relationship is a collaborative one. I encourage you to ask questions about therapy, including questions about methods and progress.

**Appointments/Termination**

Appointments are usually scheduled for 50-60 minutes. Patients generally are seen weekly or more/less frequently as acuity dictates and you and I agree.

You may discontinue treatment at any time, but it is advised to discuss any decision to do so with your therapist at least two weeks ahead of time. You have the right to terminate therapy at any time.

In a few specific instances, it may be decided to discontinue therapy with you even though you wish to continue. This includes but is not limited to: a failure to meet the terms of our fee agreement, a need for special services outside of the area of my competency, and consistent resistance to follow your treatment plan. Should this occur, I will assist you in choosing another therapist.

I make every effort to avoid cancellations; however, sometimes it is unavoidable. In this event, I will contact you with as much notice as possible and special arrangements will be made to make up your appointment. It is very important that I have current phone numbers for you, so please keep me updated as your numbers may change.

**Cancellation Policy**

In order for therapy to be effective, therapy needs to take place on a regular basis. Clients are responsible for the full fee for missed appointments and appointments canceled less than 24 hours in advanced.

**Fees**

Intake Mental Health Assessment	\$125
Individual Therapy 50-60 minutes	\$125
Couples/Family Therapy 50-60 minutes	\$125
Hourly Rate (\$31.25 per quarter hour increments)	\$125

**Financial Payment Agreement**

I ( \_\_\_\_\_ , Client, Parent/Guardian, Guarantor ) understand that I am responsible for full payment of all charges for services rendered. I agree to pay the full amount at the time of service. Please have your check made payable to Lana Royle, Royle LLC before the session begins, or she does have means to pay with credit card. Of course, cash can also be accepted but please bring exact change.

Initial: Client (or Parent/Guardian/Guarantor)\_\_\_\_\_

If I ( \_\_\_\_\_ , Client, Parent/Guardian, Guarantor ) am using my insurance benefits, I understand that I am responsible to pay my visit copayment and/or other “member” responsibilities charges at the time of service. Cash and/or checks are made payable to Lana Royle. Credit/Debit cards are also accepted, as well as HSA payments.

Initial: Client (or Parent/Guardian/Guarantor)\_\_\_\_\_

I ( \_\_\_\_\_ , Client, Parent/Guardian, Guarantor) understand that I will be charged for broken appointments and/or appointments cancelled without a 24 hour advance notice.

Initial: Client (or Parent/Guardian/Guarantor)\_\_\_\_\_

I ( \_\_\_\_\_ , Client, Parent/Guardian, Guarantor) understand that I will be billed the hourly rate of \$125 (\$31.25/quarter hour increments) for time spent on Case Management. This includes but is not limited to: time for the completion of letters, reports or email/phone consultation, telephone calls longer then 15 minutes, and attendance at meetings with other professionals the therapist authorizes in advance.

Initial: Client (or Parent/Guardian/Guarantor)\_\_\_\_\_

**Binding Statement**

All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee not to exceed 40% of the unpaid balance. In the event a lawsuit is brought against you to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees in addition to the collection fee. The undersigned further authorizes Lana Royle, Royle LLC or her agent to call you at any number you provide or at any number at which she or her agent reasonably believes we can contact you, including calls to mobile, cellular, or similar devices for any lawful purpose. The undersigned also agrees to any fee(s) or charge(s) that may be incurred for incoming calls from Lana Royle, Royle LLC or her agent, and/or outgoing calls to her or her agent, to or from any such number, without reimbursement.

Initial: Client (or Parent/Guardian/Guarantor)\_\_\_\_\_

**Confidentiality**

Communications between therapist and client are generally legally protected as both confidential and “privileged.” However, there are limits to the privilege of confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly person or a disabled person, 2) when your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3) if you report that you intend to physically injure someone, the law requires your therapist to inform the intended victim as well as the legal authorities, 4) if your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc., 5) when your insurance company is involved, e.g., in filing a claim, insurance audits, case review or appeals, etc., 6) in natural disasters whereby protected records may become exposed or 7) when otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other mental health professionals, school personnel, and physicians or to family members, etc.

**Treatment of Minors as Individual Clients**

If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. If I think it is appropriate, I will involve them if I feel that there is a high risk that you will seriously harm yourself or others. Before giving them any verbal or written information, I will discuss this matter with you, if possible. When a client who is a minor is in individual therapy, the parent or legal guardian has the right to ask for information about the minor's therapy, and the therapist, acting in the best interest of the minor, has the right to limit the amount of information disclosed. To treat a minor I ask the parent(s) to attend a part of the intake session to discuss this policy.

**Consultation**

Lana Royle, MC, LCMHC consults regularly with other professionals regarding her clients; however, client’s names or other identifying information is never mentioned. The client’s identity remains completely anonymous, and confidentiality is fully maintained.

**Litigation Limitation**

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce or custody disputes, injuries, lawsuits, etc.) neither you (client’s) nor your attorney’s, nor anyone else acting on your behalf will call on Lana Royle to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

**Record Keeping**

Clinical information is maintained and includes dates of and fees for sessions and notes describing each therapy session. A diagnosis and treatment plan will not be kept on record unless requested by you the client. Your records will not be released without your written consent, unless in those situations outlined in the Confidentiality section above. Clinical information is kept secure and compliant with regulations of HIPPA.

**Consent for Treatment**

Participation in therapy can result in a number of benefits to you. Working towards these benefits; however, requires effort on your part. During therapy, remembering or talking about unpleasant events, feelings or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. There is no guarantee that psychotherapy will yield positive or intended results. By signing below, you are stating that you have read and understood this 4-page policy statement and you have had your questions answered to your satisfaction.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Client name(s) (printed) \_\_\_\_\_

Client  
Signature: \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian  
Signature \_\_\_\_\_ Date \_\_\_\_\_