

FRANK BAIRD, LMFT, LPCC

Mindfulness Training, Psychotherapy & Life Coaching

F o r

F r a n k B a i r d ' s

N e w C l i e n t

805/807-0652 • frankbaird@frankbaird.com
Licensed Marriage & Family Therapist #MFC35419
Licensed Professional Clinical Counselor #LPC218
31324 Via Colinas Unit 111, Westlake Village, CA 91362
www.frankbaird.com

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Consultation Agreement

You, the undersigned, agree to enter into a mindfulness training, therapy or coaching relationship with me, Frank Baird, Licensed Marriage and Family Therapist #MFC35419 and Licensed Professional Clinical Counselor #LPC218.

Consultations

I will focus my attention toward your stated goals for mindfulness training, therapy or coaching. You and I will review those goals periodically to measure the usefulness of our work for you. We may meet your initial goals and our work together may conclude, or you may have or develop other goals you would like to pursue.

We will meet as often as you wish and our mutual schedules allow. Our meetings can be more than once a week, once a week, bi-weekly, monthly, semi-annually, or on an as-needed-basis, depending on your needs and goals for our work together. You and I can discuss the possible benefits of different meeting frequencies.

My work is collaborative and solution-oriented and is informed by the guiding frameworks of mindfulness and therapies such as Narrative Therapy, Solution-Oriented Therapy, Collaborative-Language Systems and other therapeutic and coaching practices. I am always available to discuss with you my practices, their effects on you, their effectiveness for you, and alternative ways we might work together.

Fee

My fee for our consultations is \$180 per 50-minute meeting. Please pay before the session begins. There will be a \$35 fee for any checks returned unpaid by the bank. Charges will be accrued by you for all professional services rendered by me (including phone contacts over five minutes, preparation of special forms, reports, court time, etc.). These services will be billed at 25% of your session fee for each 15 minute increment or portion thereof.

Cancellations

Please call me at 805/807-0652 if you cannot make your appointment. If you do not notify me of cancellation at least 48 hours prior to your scheduled appointment time, I will ask you to pay your regular fee for the missed session. Please see the attached Credit Card Authorization form.

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Exception to Confidentiality

Everything you and I discuss between us will be kept confidential by me. You are free to discuss whatever you would like about our meetings with whomever you would like. I am bound by the confidentiality standards of my profession and will not release any information to others without your signed consent with exceptions dictated by California State Law. These exceptions include:

- The necessity of reporting to authorities, with or without the client's consent, any information which may indicate the presence of child abuse, neglect or endangerment, either physical or sexual in nature;
- The necessity of reporting to authorities, with or without the client's consent, any information which may indicate the presence of dependent adult or elder abuse, neglect or endangerment, either physical, sexual or financial in nature;
- When it appears that the client or a person known to the client intends to hurt another person, the therapist has a duty to warn the intended victim and the police authorities; and
- When it appears evident that the client will most probably make a suicide attempt, appropriate steps shall be taken to prevent such an attempt.

If any of the above situations present themselves in our work together, I will attempt to inform you when a report is made. My attempt is not a guarantee. I may also encourage you to make a report yourself.

Minors and Confidentiality

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Use, Disclosure and Access to Protected Health Information

See the attached *Use, Disclosure and Access to Protected Health Information* for a description of how medical information about you may be used and disclosed and how you can get access to this information.

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Frank Baird Availability/Emergencies

Telephone consultations between office visits are welcome. I will attempt to keep such contacts brief due to my belief that important issues are better addressed within scheduled sessions.

You may leave a message for me at any time on my confidential voicemail. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned within 24 hours. If you have an urgent need to speak with your me, please indicate that fact in your message and follow any instructions that are provided by my voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

About the Mindfulness Training, Therapy and Coaching Process

My intention is to provide services that will assist you in reaching your goals. Based upon the information that you provide me and the specifics of your situation, I will provide suggestions and recommendations to you in pursuit of your goals. You and I are partners in this consultation process. You have the right to agree or disagree with my suggestions and recommendations. I will also periodically invite feedback regarding your progress.

I am unable to predict the length of our work together or to guarantee a specific outcome or result. Goals, methods, skills and your own abilities and commitments affect duration and outcomes.

Conclusion of Mindfulness Training, Therapy or Coaching

The length of your mindfulness training, therapy or coaching and the timing of the eventual conclusion of our work together depends on the specifics of your goals and the progress you achieve. It is a good idea to plan for the end of our work together in collaboration with me. We will discuss a plan for ending our work together as you approach the completion of your goals. You may discontinue mindfulness training, therapy or coaching at any time. If you or I determine that you are not benefiting from our work together, either of us may elect to initiate a discussion of your mindfulness training, therapy or coaching alternatives. These alternatives may include, among other possibilities, referral, changing your goals, or concluding our work together.

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Statement of Understanding

I have read and understand all of the above terms and conditions and agree to abide by this agreement as a condition of receiving services from Frank Baird, LMFT, LPCC. If the person signing is the agent, parent or personal representative, then s/he certifies that s/he is legally entitled to act on behalf on the client.

.....
Client Signature

.....
Date

.....
Legal Guardian (If Needed)

.....
Date

Credit Card Authorization

You may pay for your sessions by cash, check or credit card. By signing below, you authorize me to charge your credit card for sessions not paid for otherwise, including any missed session or any session canceled with less than 48 hours notice. You also acknowledge that you are responsible for paying for your sessions. If you would like, I can provide a Superbill to submit to your insurance company. Reimbursement from your insurance company is between you and your insurance company. The undersigned authorizes Frank Baird, LMFT, LPCC to make the following charges on the credit card listed below for payment of services.

Name of Cardholder (as it appears on card): _____

Credit Card Number _____

Expiration Date: _____ Security Code: _____

Billing Address Street: _____

Billing Address City: _____ Billing Address State: _____

Billing Address Zip Code: _____

Signature of Card Holder: _____ Date: _____

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Initial Visit Information

Please provide the following information about yourself or the person who will be seen in mindfulness training, therapy or for coaching. This information will help me better understand the problems that you are having. The information is confidential and will not be released to anyone without your written permission.

Name: _____ Today's Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Preferred phone: _____ Email: _____

Birth Date M/D/YR: _____ Sex: M or F or _____

Others living with you and their relationship to you: _____

In case of emergency contact:

Name: _____ Relationship to You: _____

Address: _____

Home phone: _____ Work phone: _____

How many sessions do you think you might need?

___ 1-3 ___ 4-6 ___ 6-8 ___ 8-12 ___ Other (please specify): _____

How often would you like to meet?

___ More than 1x week ___ Weekly ___ Bi-Weekly ___ Other: _____

Referred by (friend, relative, ad, etc.) _____

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Communications

I may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking the choices listed below. Please be sure to inform me if you do not wish to be contacted at a particular time or place, or by a particular means.

- Frank Baird may call me at my home. Leave message?
- Frank Baird may call me on my cell phone. Leave message?
- Frank Baird may call me at work. Leave message?
- Frank Baird may send mail to me at my home address.
- Frank Baird may communicate with me by email. I acknowledge that email is not a secure form of communication.
- Frank Baird may send a fax to me.

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The Effects of Third Party Payments

Third party payment for therapy can be financially beneficial, however, third party payments can reduce your ability to determine the direction of your therapy. Please consider the following:

Loss of Confidentiality

If you ask a third party to pay for all or part of your therapy, they will have an interest in and a right to information about your work in therapy.

- Information about our meetings may be reviewed by employees of the insurance company and a separate managed care company.
- Some employees of those companies do not have the same training in confidentiality as professionals.
- Insurers put confidential information into computers.
- Industry mergers allow information to change hands.
- Information about your current insurance use may have an effect on future insurance availability and use.

Loss of Control of Treatment

If you ask a third party to pay for all or part of your therapy, they will have an interest in and a right to determine the direction and duration of your therapy.

- Managed care companies make money by reducing treatment.
- Treatment decisions are based on formulas for average cases, not personalized need.
- Managed care treatment may limit the number of sessions.
- Managed care treatment may dictate what should be the focus of sessions.
- Managed care treatment may dictate how sessions should be run.

Effects of Psychiatric Diagnosis

If you ask a third party to pay for all or part of your therapy, they will require a medical-model psychiatric diagnosis for treatment. This diagnosis is for a “mental illness.” While most people’s problems are not the result of or evidence of mental illness, in the medical model and realm of health insurance, you must be “ill” to receive a diagnosis and treatment.

- Health insurance benefits can only be used for treatment of an illness, requiring a medical-model diagnosis of your problem(s). This diagnosis may not provide the best focus of work for your efforts in overcoming your problem(s).
- Choosing to avoid using health insurance benefits means you do not have to have a psychiatric diagnosis.
- A psychiatric diagnosis may have to be divulged to potential future employers and future insurance plans. It may have an effect on your ability to qualify.

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Use, Disclosure and Access to Protected Health Information

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

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI) I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (if applicable). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at www.frankbaird.com.

III. HOW I MAY USE AND DISCLOSE YOUR PHI. I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

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A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

- **For treatment.** I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
- **To obtain payment for treatment.** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
- **For health care operations.** I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
- **Other disclosures.** I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

- **When disclosure is required by federal, state or local law; judicial or**

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administrative proceedings; or, law enforcement. For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.

- **For public health activities.** For example, I may have to report information about you to the county coroner.
- **For health oversight activities.** For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
- **To avoid harm.** In order to avoid a serious threat to the PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
- **For workers' compensation purposes.** I may provide PHI in order to comply with workers' compensation laws.
- **Appointment reminders and health related benefits or services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

- **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

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D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI. You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than \$.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

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D. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

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V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES . If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES. If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Frank Baird, LMFT, LPCC, 141 Duesenberg Drive #1A, Westlake Village, CA 91361, 805/807-0652, frankbaird@frankbaird.com.

VII. EFFECTIVE DATE OF THIS NOTICE . This notice went into effect on September 15, 2007.