

# **Michael G. Quirke M.A.**

## **Licensed Marriage and Family Therapist**

**Ca Lic# Mfc 39030**

582 Market Street Suite 706

San Francisco, Ca. 94104

415.820.3943

AGREEMENT FOR SERVICE / INFORMED CONSENT

### **Introduction**

This Agreement is intended to provide \_\_\_\_\_ (herein “Patient”) with important information regarding the practices, policies and procedures of **Michael G. Quirke M.F.T.** (herein “Therapist”), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

### **Risks and Benefits of Therapy**

Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient’s perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

During the therapeutic process, some patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

## **Professional Consultation**

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient.

## **Records and Record Keeping**

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Patient's records for ten years following termination of therapy. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

## **Confidentiality**

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another. Therapist reserves the right to disclose personal information to other parties within the treatment unit during couples and family therapy.

## **Patient Litigation**

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made himself available for such an appearance at Therapist's usual and customary hourly rate of 350.00.

## **Psychotherapist-Patient Privilege**

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

## **Fee and Fee Arrangements**

**The fee for service is**

**225.00** per 50 minute session

**250.00** per 60 minute session.

**300.00** per 75-minute session.

**350.00** per 90-minute session.

Sessions longer than 90-minutes are charged for the additional time pro rata.

**Neurofeedback sessions are scheduled for one hour.** Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance. No form of managed care, insurance, or e.a.p. benefits will be accepted for any services.

**Phone and Skype Fees are**

**225.00** per 50 minute session

**250.00** per 60 minute session.

**300.00** per 75 minute session.

**350.00** per 90-minute session.

**Group intake fee is 175.00** and group registration fees are non-refundable. **Group fee is 95.00 per session** and an initial commitment of 14 consecutive weeks is required. Group participant are expected to attend weekly group meetings. Clients who miss 2 groups may return to group only with permission of therapist. There are no “make ups” or credit for missed groups. Payment may be made in one or two payments. In the event that patient discontinues enrollment in group, payment in full is due and payable.

From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Patient’s request and with Patient’s advance written authorization. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls.

For individual, couples and family session, patients are expected to pay for services at the time services are rendered. Therapist accepts cash and checks. In the event of a returned check, or declined or disputed credit card payment therapist will charge a **35.00 returned payment fee**.

**Any unpaid balances will be reported for collection after 30 days past due.**

**Applicable interest will be applied per California law \_\_\_\_\_ (Please Initial)**

## **Cancellation Policy**

**Patient is responsible for payment of the full session fee for any missed session(s).**

Patient is also responsible for payment of the agreed upon fee for any individual, couples and family session(s) for which Patient failed to give Therapist at least **48 business hours (2 full business days) notice of cancellation**. Please note that appointments scheduled via online scheduler require a minimum of 14 days notice of cancellation. Patients may have no more than 2 canceled appointments per year. There are no “make ups” or credit for any missed groups. Cancellation notice should be left on Therapist’s voice mail at 415 820-3943. If you are ill and wish to have your scheduled appointment please make arrangements to meet via telehealth.

\_\_\_\_\_ **(Please Initial)**

## **Therapist Availability**

Therapist’s office is equipped with a confidential voice mail system that allows Patient to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

## Termination of Therapy

Therapist reserves the right to terminate therapy at his discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Should patient request, Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient. \_\_\_\_\_ . (Please Initial)

## Acknowledgement

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

I understand that I am financially responsible to Therapist for all charges. I understand that therapist accepts no form of insurance or any other third-party payments \_\_\_\_\_ (Please initial).

Signature of Patient (or authorized representative) \_\_\_\_\_

Date \_\_\_\_\_

## Contact Information

Patient Name (please print) \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone Numbers \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Date of Birth \_\_\_\_\_

E-Mail \_\_\_\_\_

**Michael G. Quirke M.F.T.**

582 Market St, Suite 706  
San Francisco, Ca. 94104  
415 820-3943

Credit Card Authorization Form

I, \_\_\_\_\_, am authorizing Michael Quirke M.F.T. to use my credit card information to charge my credit card for scheduled appointments and past due balances. I also authorize payment in the event that I do not notify him of my inability to attend a scheduled individual, couples or family therapy appointment and/or do not cancel my appointment at least 48 hours (business days) in advance as agreed to in the Financial Arrangement policies stated in the signed Client Agreement and Therapists Disclosures Form.

I understand that there are no cancellations for group registration and that no credit or refunds for missed groups will be given.

In case of late cancellations and/or no-shows for scheduled sessions, you will be charged the full session fee. Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

Card Type (circle one): Visa MasterCard Amex Other

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name as Printed on Card: \_\_\_\_\_

Verification/Security Code (3-digit code on back by signature line) \_\_\_\_\_

Billing Address:

\_\_\_\_\_  
Street City State Zip

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

Michael G. Quirke M.F.T.  
582 Market St. Suite 706  
San Francisco, Ca. 94104  
415.820.3943

Please provide contact information if you are currently receiving any other form of mental health care such as psychiatry, couples counseling, group therapy, medication management.

I, \_\_\_\_\_ (Patient Name) hereby grant Michael G. Quirke M.F.T. permission to release treatment information to:

Provider's Name \_\_\_\_\_

Provider's Phone number \_\_\_\_\_

This authorization allows disclosure of information needed for the above mentioned purpose. It shall be valid immediately and shall expire \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Michael G. Quirke M.F.T.  
582 Marlet St Suite 706  
San Francisco, Ca. 94104  
415.820.3943

## HIPAA NOTICE OF PRIVACY PRACTICES

### **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. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).**

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

#### **III. HOW I WILL USE AND DISCLOSE YOUR PHI.**

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

#### **A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.**

I may use and disclose your PHI without your consent for the following reasons:

- 1. For treatment.** I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
- 2. For health care operations.** I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
- 3. To obtain payment for treatment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
- 4. Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

#### **B. Certain Other Uses and Disclosures Do Not Require Your Consent.**

I may use and/or disclose your PHI without your consent or authorization for the following reasons:

- 1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
- 2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
- 3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
- 4. If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations,** such as the Privacy Rule that requires this Notice.
- 5. To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
- 6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
- 7. If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
- 8. If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
- 9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
- 10. For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
- 11. For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
- 12. For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
- 13. For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
- 14. For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.



- 15. Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
- 16. If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
- 17. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.**
- 18. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
- 19. If disclosure is otherwise specifically required by law.**

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

**1. Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

**D. Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

**IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

These are your rights with respect to your PHI:

**A. The Right to See and Get Copies of Your PHI.** In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than \$.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

**B. 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. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

**C. The Right to Choose How I Send Your PHI to You.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

**D. The Right to Get a List of the Disclosures I Have Made.** You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. 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 cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

**E. The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

**F. The Right to Get This Notice by Email** You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

**V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES**

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also 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. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

**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:

**Michael G. Quirke M.F.T.  
582 Market Street Suite 706  
San Francisco, Ca. 94104  
415.820.3943**

**VII. EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on April 14, 2003.

**I acknowledge receipt of this notice**

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