T.C.I. Therapy, LLC

Jeffrey Piercy M.S., LMHC, CCTP, CCATP, ASDCS
1637 Race Track Road Suite 236
St. Johns, FL 32259
(904) 716-3828 jeff@tcitherapy.com www.tcitherapy.com

Welcome to T.C.I. Therapy, LLC. I am honored that you have chosen to work with me to help you reach your goals. It is important for you to know how we will work together, and this document will provide you with answers to questions you may have. Please read this entire document before signing, and note any items you would like to discuss during your initial session.

MY CREDENTIALS AND WORK EXPERIENCE

I am a Licensed Mental Health Counselor (LMHC), a Qualified Supervisor with the state of Florida, a Certified Clinical Trauma Professional (CCTP), a Certified Clinical Anxiety Treatment Professional (CCATP), and an Autism Spectrum Disorder Clinical Specialist (ASDCS). I have a Master of Science in Community Counseling from Austin Peay State University in Clarksville, Tennessee. I was an adolescent and adult therapist for mental/behavioral health and addiction/rehabilitation counseling in an inpatient behavioral health hospital in Kentucky. In addition, I was an outpatient therapist and an adolescent inpatient therapist in Florida. I am highly experienced in providing counseling for individuals, couples, families, and groups with adolescents and adults. I do not discriminate based on or limited to age, race, gender, marital/family status, religious beliefs, ethnic origin, veteran status, disability, health status, sexual orientation, or criminal history.

THERAPY EXPECTATIONS

Limits

I am a counselor; therefore, I cannot provide you any advice from any other profession. Psychotherapy is a professional service, and the American Counseling Association (ACA) places certain limits on clients for their safety and well-being. Our relationship is limited to client and therapist. Any other relationship is considered a "dual relationship" which is not appropriate or ethical. At no time during or after your therapy ends can we have any other type of relationship. If we see each other in a public/social setting, I will not acknowledge you in order to keep your status as a client confidential. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board.

Frequency and Methods

The initial session is used to gather information (mental/behavioral health concerns, birth history, family history, etc.), review financial policies and answer any questions you may have. If you are a returning client and have not been active in therapy with T.C.I. Therapy, LLC for two calendar months or longer, you will be considered a new client and will be required to sign new consent forms. Please note: Any new fees or policy changes will apply. We will work together to create a plan to help you achieve your goals; however, that plan can be changed at any time. I may integrate methods from several theories or styles of psychotherapy in effort to best meet your individual needs. Honesty and follow through are important components for therapy to be successful, and much of therapy work occurs outside of your session. You may be asked to complete worksheets, homework assignments, readings, or research. During sessions, we can manage your progress and goals.

Sessions

Sessions are either 30 minutes or 45 minutes. When the session ends, if your session continues past 5 minutes, there will be a $1.00 fee per minute charged to the credit card on file, including the $5.00 grace period fee. Example: If your session ends at 12:45 and you exit the office at 12:51, the total fee

charged to the credit card on file is $6.00 (this fee is separate from the session rate). This is to ensure consideration of the next client.

Confidentiality
State laws require limits to confidentiality. Verbal information and written records about a client cannot be shared with another party without the client's or client's parent/Legal Guardian's consent. If your records have been requested, I will discuss it with you as you may be required to sign a Release of Information. This form will state what information will be shared, with whom, and for how long. You may consent or rescind the Release of Information at any time. It is T.C.I. Therapy, LLC's policy to destroy a client's records 7 years after the date of the final session. Until then, your record will be kept in a secure place.

If you are in family or couples counseling where there is more than one individual client and you need a copy of your medical record, all individual clients must agree and sign a Release of Information allowing the records to be released.

I am required to keep records/notes of your sessions. You have the right to review your records with me. If I believe there is something in your record that may harm you, I may omit that information.

Information shared during sessions will not be disclosed to anyone, except in limited situations. It is important for you to know these limits, so you do not disclose anything that I am legally required to report. Exceptions are:

Duty to Warn and Protect

- If I suspect that you are threatening to harm another person, I am required to inform the individual, the Florida Department of Children and Families (DCF), or the police.
- If you threaten to or act in a way that is likely to harm yourself, I may initiate the Baker Act process, contact the police, recommend you seek inpatient hospitalization, or contact a family member.
- In an emergency where your life or health is in danger, and I cannot obtain your consent, I may give another professional some information to protect your life.
- If I suspect that you are abusing an elderly person, a disabled person, a child, or you are a child, elderly person, or a disabled person being abused, I must file a report with a state agency.

Court Proceedings
If you become involved in a court proceeding, I may be required to testify or report your progress/lack of progress to the court. Should this situation arise, I will notify you in session or via email. If I am called into court for any reason, you agree to pay $200 for each hour that is accrued; along with any/all expenses (i.e., parking, meals, gas, etc.) I may incur. The first hour begins when I am leaving a location to go to court, the final hour ends when I am no longer needed by the court for that day and have returned to my location. You will be charged a full hour regardless of how many minutes have occurred within the first hour and the final hour.

Minors/Guardianship/Families/Couples
Parents or Legal Guardians of a minor client have the right to access the client's general records. I will use my judgment to determine what information will remain confidential and what information will be shared. In couples/marriage counseling, if you disclose something your spouse/partner does not know and not knowing this information could result in harm, I cannot guarantee to keep it confidential. If you and your spouse/partner decide to divorce and children are involved, you agree **not** to request my testimony regarding custody.

FINANCIAL AUTHORIZATION FOR TREATMENT

It is T.C.I. Therapy, LLC's policy to keep a Financial Authorization form on file to be used for late cancellations, no-shows, or any other fees associated with this professional service. This prevents a past due balance. You are financially responsible for your session rate, copay, deductible, etc. at the time services are rendered. I accept Visa, MasterCard, Discover, debit cards, and cash.

I DO NOT ACCEPT PERSONAL CHECKS.

CANCELLATION POLICY
*** ALL NOW-SHOW AND IMPROPER CANCELLATION FEES ARE NON-REFUNDABLE***

If you need to cancel a session, you are **required** to give a minimum of **24 hours notice** by phone, text, or email. This includes your initial session. Do not assume your cancellation request has been received; your session has not been canceled until you receive confirmation from this therapist. Continue to initiate contact until you have received confirmation of your session being canceled. In the event of a cancellation or no-show due to work, or an unintentional act (forgetting, writing down the incorrect time/date, etc.), you will be charged even if you reschedule the appointment.

No-Show
A no-show is being more than 15 minutes late without prior notice, not attending the session, and/or canceling or rescheduling the session within 24 hours of the scheduled session time. If you do not cancel your session per policy, this will result in a no-show fee charge in the amount of $100.00 for an individual therapy session, and $200.00 for a couples/family/marriage therapy session using the Financial Authorization form on file**. If the card listed on the Financial Authorization form on file is declined, any accumulated or past due fees must be paid before the next session; you will not be able to return to session, reschedule, or schedule a new session until the outstanding balance is paid in full. If an outstanding balance results in legal action being taken, then you agree to pay all fees and costs incurred by T.C.I. Therapy, LLC. (this includes but is not limited to the following: attorney/entity/court fees, travel expenses (gas, parking, meals), etc.).** If you no-show or improperly cancel your initial session two consecutive times, you will no longer be considered appropriate for attending therapy sessions with T.C.I. Therapy, LLC. Repeated (non-consecutive) no-shows or improper cancellations may result in the termination of therapy services.

Emergencies
In the event of a cancellation or no-show due to an emergency (car accident, COVID, etc.), valid proof (accident/police report, COVID test results from a medical facility, etc.) is **required**. **What is considered**

and accepted to be valid proof is at the discretion of this therapist. Work related issues do not constitute emergencies. Without said documentation, the no-show fee will be applied.

Admission for Medical, Mental/Behavioral Health or Rehab
If you are admitted to a hospital or facility for medical reasons, mental/behavioral health reasons, or rehab (substance abuse, alcohol abuse, etc.), then admission and/or discharge documentation is **required**. Without said documentation, the no-show fee will be applied.

Inclement Weather
During most periods of inclement weather, the office will remain open; however, in the event of severe weather conditions (i.e., streets not accessible, bridges closed, etc.) the office may be closed, and you will be notified. If the office remains open and you cancel your session due to inclement weather, the 24 hour Cancellation Policy applies, and you will be charged the non-refundable no-show fee.

During Session
If the therapy session is canceled or stopped for any of the following reasons you will be held responsible for the session's non-refundable no-show fee: (1) If you indicate that you have consumed alcohol or have taken illegal drugs (including medical marijuana) prior to the session, and you appear to be or I believe you to be intoxicated or under the influence (2) If you become or are perceived as being physically or verbally threatening, and I deem it necessary to stop the session (3) If I feel it necessary for the session to be canceled or stopped for any reason based on your actions, behavior, or statements that are found to be inappropriate or threatening (4) If you refuse to enter the office to begin therapy, or walk out of the session prior to completion of the scheduled session time.

CONTACT INFORMATION

To cancel an appointment, you may contact me by phone (904) 716-3828, or by email* jeff@tcitherapy.com. Please leave a message or send an email and I will respond as soon as possible. If you need to contact me via text message, please limit the message to a few sentences/1-2 questions. More than that, I request that you contact me via phone or email. If a response outside of your scheduled session time is necessary for therapeutic reasons, a $15.00 per response text/email/voicemail fee will be charged to the card on file. This is to prevent unscheduled therapy sessions outside of your scheduled session time. **Note: What is considered a necessary response is up to the discretion of this therapist.** I do not provide crisis counseling. If you have an emergency, please dial 911.

** T.C.I. Therapy, LLC's email is encrypted; therefore, you agree not to hold T.C.I. Therapy, LLC or Jeffrey Piercy M.S., LMHC, CCTP, CCATP, ASDCS responsible in the event any email correspondence is sent to the wrong recipient, someone else obtains access to your email account, emails are read by someone else, emails are lost (i.e., never received, accidentally deleted, deleted by the encryption program per their policy, sent to junk or spam mail, etc.) or if T.C.I. Therapy, LLC's email is compromised in any way.*

(Parent/Legal Guardian, if for minor child) **Initials** _____

STATEMENT OF COMPLAINT PROCEDURES

Should you encounter a problem while in counseling, please inform this therapist directly. You can also contact the state counseling association to speak with someone regarding your concern, and they can assist you in filing a complaint.

Department of Health
Board of Clinical Social Work, Marriage & Family Therapy & Mental Health Counseling
4052 Bald Cypress Way
Bin C-08
Tallahassee, FL 32399-3258
PHONE: (850) 245-4474

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OUR AGREEMENT

I have read and understand my rights and responsibilities, including financial responsibilities detailed in this complete document as indicated by my signature below. I agree to abide by and act in accordance with all of the sections and policies covered in this document. I understand that T.C.I. Therapy, LLC policies and fees are subject to change, and that I will be notified in writing **(electronic or paper)** of said changes. I understand that by signing this agreement, I am acknowledging the circumstances under which Jeffrey Piercy M.S., LMHC, CCTP, CCATP, ASDCS is legally obligated to waive confidentiality, and that I understand and acknowledge my complete financial responsibilities. I understand that after therapy begins, I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns with this therapist prior to ending therapy. I agree to enter into therapy with Jeffrey Piercy M.S., LMHC, CCTP, CCATP, ASDCS and to cooperate fully and to the best of my ability. I understand that no specific promises or guarantees have been made by this therapist regarding the results of treatment, the effectiveness of procedures used by this therapist, or the number of sessions necessary for therapy to be effective. My signature below indicates all of my questions about any part of this document have been answered to my satisfaction.

_____

Client Signature Printed Name Date

NOTE: If client is a minor child, Parent/Legal Guardian must also sign below:

_____

Parent/Legal Guardian Signature Printed Name Date

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PRIVACY OF INFORMATION

The information I collect from you is confidential; however, I may need to use the information in the following ways:

- Treatment or referral for treatment
- Processing bills and/or invoices for treatment
- Releasing your records (partial or entire) to your insurance company, if requested
- Releasing the necessary documents to a financial institution in the event of a financial dispute

Clients have certain legal privacy rights regarding their mental health records:

- You can request copies of your medical record
- You can request the name of the individual, entity, and/or facility receiving your information
- You can request to limit the information released to a receiving individual, entity, and/or facility
- You can request to change any incorrect information

CLIENT RIGHTS

Clients have certain legal rights regarding their mental health counseling:

- To know the professional and educational qualifications of your counselor
- To know the limitations of the counselor's areas of expertise or age group
- To receive an explanation of services and/or counseling methods
- To be informed of the release of all documentation requested by any financial institution
- To request copies of the medical record and/or reports sent to other professionals
- To contact the appropriate professional organization if you have complaints
- To end counseling at any time

Client Signature _____ Date _____

NOTE: If client is a minor child, Parent/Legal Guardian also use signature line below:

Parent or Legal Guardian Signature _____ Date _____

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PLAN FOR SAFETY

Print your name on the line below if you agree to what the paragraph is stating. If you do not agree, write "refuse". Then sign and date at the bottom.

I, _____, agree that if I begin to have thoughts of suicide I will call or text 988 (Suicide & Crisis Lifeline), go to the closest emergency room, or contact the appropriate number listed below. I also understand I can and should inform a spouse, parent, guardian, or a trusted adult/authority figure in the event of self-harming, suicidal, or homicidal thoughts.

EMERGENCY NUMBERS

Police/Fire/Ambulance	911
Crisis Hotline (United Way)	211
DCF/Abuse hotline	(800) 962-2873
Missing Persons	(800) 843-5678
Poison Control	(800) 222-1222
Flagler Hospital	(904) 819-5155
Wekiva Springs Center	(904) 296-3533
Youth Crisis Center (YCC)	(904) 725-6662
Baptist Hospital Adult & Adolescent Inpatient	(904) 202-2000
Lakeview Health/Stepping Stone Rehab Center	(904) 704-7692

_____ _____
Client Signature Date

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COUNSELING GOALS

Please check any of the following you would like to address:

- ☐ To improve my communication skills
- ☐ To improve my problem solving skills
- ☐ To improve my parenting skills
- ☐ To learn coping skills
- ☐ To learn time management skills
- ☐ To become more efficient with my finances
- ☐ To become more motivated
- ☐ To manage my moods
- ☐ To decrease my stress
- ☐ To improve my sleep habits
- ☐ To become more physically active
- ☐ To become more social
- ☐ To improve my self-esteem
- ☐ To manage my anxiety
- ☐ To manage my impulsive thoughts/behaviors
- ☐ To discuss my suicidal thoughts/behaviors
- ☐ To discuss my self-harming thoughts/behaviors
- ☐ To discuss problems in my marriage/relationship
- ☐ To discuss sexual problems/concerns
- ☐ To discuss my history of abuse (physical, sexual, emotional, neglect)
- ☐ To manage my anger, aggression, or violent behaviors
- ☐ To overcome my addiction(s) (alcohol, drugs, gambling, gaming, sex, etc.)
- ☐ To discuss the death(s) of someone close to me

If there is anything else you would like to address, please write below:

_____

_____

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FINANCIAL AUTHORIZATION

Card Type: ☐ American Express ☐ MasterCard ☐ Visa ☐ Discover ☐ Debit
(The following are not accepted: Health Saving Accounts, Flexible Spending Accounts, or similar type accounts)

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (MM/YY): _____ CVV Code: _____ Cardholder Zip Code: _____

Cardholder Billing Address: _____

City: _____ State: _____

Cardholder Phone Number: _____

Cardholder Email Address: _____

Client Name: _____

I, _____, the cardholder, authorize Jeffrey Piercy M.S., LMHC, CCTP, CCATP, ASDCS to process any and all fees associated with the identified client, through use of the above financial information as 'signature on file'. Said fees consist of no-shows, improper cancellations, copays, session rates, and/or any other fees related to services for the identified client. In the event a financial transaction associated with this card is disputed, I authorize any and all information needed to be released to the financial institution requesting said documentation.

_____ _____
Cardholder Signature Date