



The Family Network

Collaborative Center for Positive Growth and Change

Randy Heller, PhD, LMFT, LMHC

CLIENT HANDBOOK

This handbook explains the rights and responsibilities of you, the client, and me, the clinician. Florida law imposes some of these rights and obligations; others are established herein by contractual agreement between us. Any concerns regarding the matters stated herein should be discussed with me. Absent a memorandum signed by both of us indicating otherwise, this handbook establishes the terms and conditions pursuant to which services are provided and is binding upon both of us.

Randy J. Heller, PhD, LMHC, LMFT, CHT, is the founder, owner and director of The Family Network, Inc. The Family Network provides a full range of multi-dimensional counseling services for children, adolescents and adults. Randy has been dedicating herself to her work for the past 25 years. Randy has Bachelors degree in Exceptional Student Education, a Masters degree in Counselor Education and a Doctorate in Marriage and Family Therapy from Nova Southeastern University. She has served as an Educator, Exceptional Student Specialist and Family Counselor for The Broward County School Board and is currently in private practice as a Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Certified Supreme Court Family Mediator and Certified Hypnotherapist. She has had highly successful experience working with all aged individuals, parents, couples, groups, step-families, children of divorce, and students with educational, motivational, and behavioral challenges; facilitating positive change in their behavior, interactions, and relationships.

At the Family Network, Dr. Randy Heller utilizes an integrated, systemic approach to counseling; empowering people to define what is not "working for them" in their lives and to discover the possibilities for "making life work." In doing this, clients are guided towards identifying their strengths, accessing their resources, tapping into their own potential for success, and taking action toward achieving their desired goals. Initially when meeting with clients, Randy will conduct a clinical interview with clients and consider the context in which they are in, such as the family, the school or workplace. The focus of this clinical interview is not just the individual. Once the current concerns are clearly understood, a plan will be developed in collaboration with the client(s). The benefits of this approach have



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been reviewed in the literature as being strength based, useful in minimizing a person's limitations and weaknesses and allowing them to experience hope for the possibilities of more positive outcome. There can be circumstances that may not be appropriate for this type of approach alone; and at that time a referral will be made to work in conjunction with other professionals on implementation of the best approach to address these issues. Randy established a new corporation in 2013, **The Collaborative Alliance, Inc.**, in which diversified professionals will collaborate together to provide you with services to meet your unique needs

Over the years Randy has earned an excellent reputation as an effective, resourceful, innovative psychotherapist. Randy is passionate about her work and driven toward making a difference in the lives of the people who cross her path.

CONFIDENTIALITY

All communications between you and me in the course and furtherance of the psychotherapeutic/consulting relationship will be treated as strictly confidential. As the client, you control whether or not I may disclose confidential information. You have the right to waive confidentiality. As a matter of office policy, I ask that all waivers of confidentiality, in whole or in part, be on forms provided by me. I may, in my sole discretion, accept a waiver of confidentiality in some other form.

There are exceptions to confidentiality mandated or implied by Florida Law. Under the following circumstances, I will breach confidentiality:

- 1) When I have cause to suspect the child or elderly or disabled individual has been or may be abused.
- 2) **Domestic violence or (high conflict of any kind) within ANY range of minor children is now considered child abuse and a mandatory reportable offense.**
- 3) When I have reasonable cause to believe that you pose a risk of imminent harm to yourself.
- 4) When I have reasonable cause to believe you pose a risk of imminent harm to another individual.



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- 5) When I am compelled to testify pursuant to a valid court order. (In this latter circumstance, I will assert that communication is privileged and will only testify after you have had an opportunity to obtain a court order protecting the confidential information.)

LIMITED RELEASE OF INFORMATION

Clients generally wish to establish certain limited waivers of confidentiality. Unless otherwise specified in writing, you agree to the following limited waivers:

- 1) To the referral source. You agree that I may contact the individual or agency who referred you and may convey the following limited information:
 - a. The fact that you have been seen for a clinical interview;
 - b. The number of sessions you have attended or missed;
 - c. Anticipated length of treatment; and
 - d. General comments regarding your prognosis, and participation in treatment.
- 2) For medical consultations. You agree that I may consult with your physician or physicians. You authorize the release of information from your physician to me and vice versa to facilitate such consultation.
- 3) For consultation with professional peers. From time to time, I may consult with my professional peers regarding a clinical matter. My professional peers are likewise bound by confidentiality. You authorize the release of information reasonably necessary to such a consultation. It is understood that your name will not be released to the consulting clinician in such cases.
- 4) Third party payers. You agree that I may release information to the extent necessary for you to obtain payment from third-party payers. (i.e., your insurance carrier).



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CHILD AND ADOLESCENT TREATMENT

Both parents have the right to be informed about their child's treatment. I will, however, respect the confidences of your child or adolescent when, in my opinion, it is in their best interest to do so. Absent such a guarantee of confidentiality, your child or adolescent may not trust me enough to establish a therapeutic relationship and treatment may be less effective.

When children and adolescents are seen in treatment, it may be desirable to consult with their teachers. You agree that confidentiality is waived to the extent necessary to effect such a consultation.

Child and adolescent therapy frequently requires the active involvement of the significant individuals in a child's life. If necessary, you agree to participate in your child or adolescent's treatment and agree to assist in getting other significant individuals in the child's life to participate as well.

FAMILY, GROUP, AND COUPLES THERAPY

When multiple individuals are seen in therapy or for consultation, each of the individuals present has the power to waive confidentiality even though they may not have the right to do so. I do not take responsibility for the actions of others.

Unless otherwise specified, when multiple individuals with a common bond or relationship are seen in therapy, the "client" is the relationship that binds individuals together (i.e., the marriage in marital therapy, the group in group therapy) Individual therapy/consultation for any of the participants in the relationship is available as requested. When a referral is deemed appropriate, or desired, it will be discussed.

REFERRALS

You and I may deem it appropriate to make a referral to another practitioner for specific services. I know many professional in my field and in related fields and will gladly make any necessary arrangements. My knowledge as to their



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competence comes in part from reports other clients, and thus, I cannot take personal responsibility for their competence.

VACATION AND ILLNESS

I will, from time to time, take time off for vacation, to attend seminars or because I am ill. Psychotherapy/consultation is a uniquely personal service, and therefore, therapy may be briefly interrupted. I will attempt to give you adequate advance notice and will arrange coverage for any emergencies by a peer or crisis center.

PAYMENT

Payment is expected at each visit. If special circumstances exist that render it difficult for you to make payment as expected, please discuss it with me. My general practice is to require full payment from all clients and to assist them in obtaining reimbursement from their insurer when appropriate.

CANCELLATION

As a clinician, **what I sell to my clients is my time and expertise.** It is generally impossible to fill a time slot that I had reserved for a client on short notice. It is therefore necessary to charge for missed appointment and short notice cancellations. Forty-eight (48) hour notice cancellation is required or you will be billed and required to pay my hourly fee.

TELEPHONE AVAILABILITY/OUT OF SESSION COMMUNICATION

When necessary, due to unusual circumstance, I will try to make myself available for telephone psychotherapy/consultation appointments. Such sessions are generally less desirable than face-to-face sessions and are therefore reserved for unusual circumstances and my standard fee applies.

Please do not expect an immediate response via text or e-mail. Text messaging is highly discouraged. Be aware that cell phone, text or e-mail is not a guaranteed secure method of communication and your confidentiality could be compromised. If you utilize these methods of communication you are agreeing to potentially waive your confidentiality



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FEE AGREEMENT

You have requested counseling/consultation services from Randy Heller, PhD, LMHC, LMFT. This outline sets forth the financial agreement concerning this agreement.

- 1) Unless otherwise specified a fee of \$195.00 will be charged for counseling/consulting sessions, as well as an hourly fee of \$195.00 for cross-professional consultations, conferences, phone conversations and other therapeutic services rendered by your therapist.
- 2) Clients are charged usual and customary fees for service and are expected to pay for such services at the time they are rendered. Many insurance companies will reimburse for psychotherapy services that are out of their network. In such instances, full payment is due at the time of service and insurance reimbursement will be sent directly to you from your insurance company. You are responsible for the bill, not the insurance company. We will do everything possible to assist you in obtaining insurance reimbursement.
- 3) As your scheduled appointment time is reserved exclusively for you, a 48-hour cancellation policy will be in effect. If you must cancel an appointment less than 48 hours before the scheduled time, you will be billed the full fee. This fee cannot be billed to your insurance company and this policy would not apply if a true emergency came up. Emergency situations will be considered at the discretion of The Family Network, Inc. and Randy Heller.
- 4) Unless otherwise arranged for in advance with this office, accounts past due for more than 90 days will be turned over for collection. In the event this account becomes delinquent and past due, you agree to **waive confidentiality** and pay all costs of collection including, but not limited to, interest, court costs, sheriff fees, court fees, collection fees and attorney fees as may be necessary.

Note: any payments made by check or credit card may compromise your confidentiality



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NOTICE OF PRIVACY PRACTICES – BRIEF VERSION

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

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP. However, we can't cover all possible situations so please talk to our Privacy Officer about any questions or problems.

We will use the information about your health and other circumstances which we get from you or from others mainly to provide you with services, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information if necessary. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it. For example: When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization which is able to help prevent or reduce the threat.

- 1) Some lawsuits and legal or court proceedings.
- 2) If a law enforcement official requires to do so.
- 3) For Workers Compensation and similar benefit programs.



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YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- 1) You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
- 2) You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you or keep you safe.
- 3) You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records.
- 4) If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
- 5) You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP form from the Privacy Officer.
- 6) You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.



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**RECEIPT OF THE FAMILY NETWORK NOTICE OF
PRIVACY PRACTICES**

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is Randy Heller and can be reached by phone at 954-236-4490 or by e-mail at THEFAMILYNETWK@AOL.COM.

I, _____ have read and received a copy
Client Name
of The Family Network's Privacy Practices.

Signature of Client or
Parent or Legal Guardian

Date



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CLIENT INFORMATION FORM

Today's Date: _____ Name of person filling out this form: _____
Name of Client _____

Age: _____ Date of Birth: _____ Referred by: _____

Home Address _____

City: _____ State: _____ Zip: _____

Home Phone: _____ ok to call do not call ok to leave message

Work Phone: _____ ok to call do not call ok to leave message

Cell Phone: _____ ok to call do not call ok to leave message

E Mail Address: _____ ok to use do not use ok to send message

Occupation: _____

Place of Employment: _____

Work Address: _____ City: _____ State _____ Zip _____

Current marital status: Married: _____ Divorced: _____ Single: _____ Separated: _____

Married Spouses/Partner Information: Name: _____

Age: _____ Date of Birth: _____ Spouses SS#: _____

Home Address, if different _____

City: _____ State: _____ Zip: _____

Occupation: _____

Place of Employment: _____

Work Address: _____ City: _____ State _____ Zip _____



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Primary Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip _____

What brings you in for therapy/consultation/therapy?

How long has situation been present? _____

Have you consulted with other professionals regarding this matter? _____

What was the outcome? _____

Are there times when this situation is not a problem for you? _____

Do you know of any possible medical or genetic causes of this problem? _____

Is there any special family, work, legal, medical or stressors of which I should be aware?

Do you have children? _____

If yes, what are their ages? _____

Who lives in your home? _____

Who is in your support system? _____

Are you taking medication? If so, what and prescribed by whom? _____

Have you ever had any suicidal/homicidal thoughts? If yes, please

explain _____



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How will you know when/if this process has been useful for you? What do you hope will be different? _____

Are there any other circumstances that I have not asked about that you would like me to know about? _____



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HANDBOOK SIGNATURE PAGE

EMERGENCIES PROCEDURES

If you have an emergency, you can call me and leave a message at 954.236.4490 which will be returned as promptly as possible. However, if you cannot reach me, you should call 211 or 911 immediately for crisis assistance or go to your local emergency room.

I have read, understand, and agree to the conditions outlined in this handbook as well as emergency procedures. I received a copy of this handbook to retain for my records.

Client Name: _____

Client Signature: _____

Date: _____



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THE FAMILY NETWORK, INC.

THERAPY AGREEMENT:

I hereby apply and consent to psychotherapy and consultation with Randy Heller, PhD, LMFT, LMHC. Signature: _____ Date: _____.

I hereby apply and consent to psychotherapy and consultation with Randy Heller, PhD, LMFT, LMHC, for my minor child(ren) _____ DOB _____.

I understand that I as the client am responsible for payment for services rendered in my office.

All follow up with the insurance company is the responsibility of the client.

Signature: _____ Date: _____.

Charges for services are due and payable at the time services are rendered, unless prior arrangements have been made. If you have health insurance, it should be understood that this is an arrangement between you and your insurance company. You are responsible for the payment of your bill, regardless of the status of your insurance claim. Insurance companies have a schedule of fees which they will pay. Your fees may be more or less than this actual schedule. If you fail to meet financial responsibilities, your account may be turned over to collection agency or the appropriate court. I hereby give my consent to release necessary information taking such action. The client will be responsible for any fees or expenses incurred because of collection or court actions.

Signature: _____ Date: _____

Because time has been reserved exclusively for me and/or my family member(s), I understand that I am required to provide at least 48 hour's notice prior to canceling. I am financially responsible for the appointment. I hereby assume financial responsibility for all charges that may be incurred for the services rendered to myself and/or my family member(s). I understand these responsibilities.

Signature: _____ Date: _____