Lauren Johnson, MMFT
Living Water 2670 Memorial Blvd. B *Murfreesboro, TN 37129
615.390.3713 * lauren@livingwatermft.com

STATEMENT OF POLICIES AND PROCEDURES

SERVICE FEES

My professional service fee is **$70** per **50-minute** session. I also desire for everyone to have the opportunity therapy can offer. Please complete the **scholarship application** if you need to apply for a partial scholarship. **Payment is due at the time of service.** You may pay either by cash or by a check made payable to "Lauren Johnson." Returned checks will be charged a $30 service fee. *Additional fees: court depositions, testimony & copying documents.

$375 Pre-Engaged/Marital Package

(Partial-Scholarship Available)
Included:

- Online assessment, Prepare/Enrich.

Why Prepare/Enrich? Because you have been an individual longer than a couple, it is my desire to look at your family history, your compatibility, and areas that could cause complications.

- Results of Prepare/Enrich
- 6 sessions
- 1 year anniversary check-up

*Not included in package:
Book: *Hold Me Tight,* by Dr. Sue Johnson. Please purchase and begin reading (preferably before the first session). Highlight "your own stuff." If sharing a book, each person should use a designated color.

OFFICE HOURS

Office hours are by appointment. Should you need to contact me, I can be reached via email or phone. Extensive phone calls (outside of scheduling) will constitute a session and payment will be expected at your next appointment.

INSURANCE

I do not accept insurance. However, I can provide you with a receipt that you may submit to your insurance company.

CANCELLATIONS

If you must cancel your appointment, please notify at least **24 hours** in advance of your scheduled time. You may call any time, day or night, and leave a confidential voice mail message. **Failure to cancel** will result in you being charged the full professional service fee, payable on your next visit. Should an emergency arise, call to discuss waiver.

NO SHOWS

If you fail to show up for an appointment and have not made notification at least 24 hours in advance, you will be considered to have been a "no-show." It is your responsibility to contact me before your next session to confirm the appointment. You will be expected to pay for the "no show" session.

CONTACT INFORMATION

You may leave a confidential voice mail or email message:
*** ELECTRONIC MESSAGING IS NOT 100% SAFE**
Phone/voicemail: **615.390.3713**
Email: lauren@livingwatermft.com
Credentials: Please see the full listing at
www.livingwatermft.com

- **Masters in Marriage and Family Therapy, Trevecca University**
- **Certified with Prepare/Enrich**
- **Trained in Emotionally Focused Therapy (EFT)**

Under Supervision of:
Kenneth Sanderfer, LMFT (#547) 615.500.2849
Susan Lahey, Ph.D.,LMFT(#634) 615.491.6114

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EMERGENCIES

Living Water, MFT is not equipped to handle mental-health crises. If you experience a psychiatric emergency or find that you cannot guarantee your safety or the safety of others please immediately contact:

- **The Crisis Center (615) 244-7444**
- **National Suicide Prevention hotline at 800-273-TALK (8255)**
- **911** or go to your nearest **Emergency Room**

BENEFITS AND RISKS

It is not unusual for significant changes to parallel the therapeutic process. Some clients may experience uncomfortable feelings (i.e. sadness, guilt or anger). The internal changes of an individual may "pour out" into their relationships, employment, or lifestyle. The biggest factor in therapy is you. You are responsible for you and the benefits and risks that derive from your growth. I cannot guarantee outcomes.

*******NOTICE OF PRIVACY PRACTICES*******

CLIENT RIGHTS

Effective April 14, 2003, the **Health Insurance Portability and Accountability Act (HIPAA)** is a federal law that provides new privacy protections and client rights with regard to the use and disclosure of your **Protected Health Information (PHI).**
HIPAA gives you the right to:

- request amendments of incorrect information to your record
- request restrictions on what information is disclosed to others
- request an accounting of non-authorized disclosures of your PHI
- determine the location to which protected information disclosures have been sent
- have any complaints you make re: policies/procedures recorded in your records
- a paper copy of this agreement and other notices/information
- a right to end therapy (does not include payment for services rendered or cancelation fees)

http://health.state.tn.us/HIPAA/index.htm

LIMITS ON CONFIDENTIALITY * ELECTRONIC MESSAGING IS NOT 100% SAFE

The law protects the privacy of all communications conducted in therapy. In most situations, I can only release information about your treatment to others if you sign a written *Authorization* form that specifies disclosure of the information to whom and under what circumstances. There are a few exceptions to this rule:

1. If for any reason I believe you are at risk of hurting yourself/another person
2. All child abuse *MUST* be reported to the Department of Human Services
3. If you are referred through the courts, or another professional, it is common practice to discuss your file. This may be done unless you specifically request otherwise.
4. Court order
5. It is customary to seek advice/guidance among peers or supervisors regarding specific scenarios referred to as case studies. Names and personal qualifiers are not discussed.

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PRINT

CONSENT TO TREATMENT/AUTHORIZATION FORM

I agree to all Policies and Procedures of *Living Water, Mft* and have been given a copy for my records. (initial) ___/__

I agree to pay Lauren Johnson, dba *Living Water, Mft.* the amount of $____ financial consideration for a therapy session . (initial) ___/__

I agree to the cancellation and "no show" policy. (initial) ___/__

In accordance with HIPPA regulations, a copy of the "Notice of Privacy Practices" has been made available to me. (initial) ___/__

If I checked YES to receive email or text, in accordance with HIPPA, I am aware electronic messaging is not 100% safe. (initial) ___/__

I consent to participate in evaluation and treatment and I understand that I may end therapy at any time. (initial) ___/__

I am aware that there is a possibility of consultations with peers/supervisors regarding my file. Topics or scenarios may be presented, but no discernable references or personal data will be divulged. (initial) ___/__

My signature below affirms my informed and voluntary consent to therapy.
Signature _____**Date** _____

Signature _____**Date** _____

****If under 18, signature of a parent or guardian is required:**
If you are requesting therapy as the guardian or parent, the same general principles as above will apply. However, it is important that your child/dependent adult be able to completely trust me. As such, I keep confidentiality guarded the same way. As the parent or guardian you have the right and responsibility to question and understand the nature of our progress, and I must use my discretion as to what is an appropriate disclosure. In general, I will not release specific information that is provided to me; however, I feel it is appropriate to discuss your child's/dependent adult's progress in broader terms and value your participation in the therapeutic process. Your signature below indicates your consent to therapy on their behalf:
Signature _____ **Date** _____