



# Blissful Path Therapy

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## THERAPY CONSENT, POLICIES, & AGREEMENT

### PART I: THERAPEUTIC PROCESS

**BENEFITS/OUTCOMES:** The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

**EXPECTATIONS:** In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

**RISKS:** In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

### **STRUCTURE OF THERAPY:**

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaboratively identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

**LENGTH OF THERAPY:** Therapy sessions are typically weekly or biweekly for 53 minutes depending upon the nature of the presenting challenges and insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

**APPOINTMENTS AND CANCELLATIONS:** You are responsible for attending each appointment and agree to adhere to the following policy: *If you cannot keep the scheduled appointment, you MUST notify our office to cancel or*

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*reschedule the appointment in advance of 48 hours of the scheduled appointment time. If you cancel or reschedule more than once, we may re-evaluate your needs, desires, and motivations for treatment at this time. Each insurance panel has a different policy on whether clinicians can charge for missed appointment/s. Check your provider's policies regarding cancellations and/or no shows.*

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment.

**FEES:** The fee for each 53-minute therapy session is \$120.00 or your insurance copay is \$120.00. Payment is due at the time of service. Acceptable forms of payment are: exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus \$35.00 for any returned check), or credit/debit card. In the event that a scheduled appointment time is missed or cancelled less than 48 hours, please refer to the "Appointments and Cancellations" policy above.

The clinician reserves the right to terminate the counseling relationship if more than 3 sessions are missed without proper notification.

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed. **\*\*\*EACH CLIENT WILL SIGN CONSENT FOR CREDIT CARD AUTHORIZATION FOR CHARGING COPAY AFTER EACH SESSION AND CREDIT CARD WILL BE KEPT ON FILE IN HIPAA COMPLIANT PATIENT PORTAL FOR THIS CHARGE; OTHER PAYMENT OPTIONS ARE AVAILABLE ON A CASE BY CASE BASIS AND AGREED UPON BY CLINICIAN AND CLIENT PRIOR TO SERVICES/SESSIONS\*\*\***

**TRIAL, COURT ORDERED APPEARANCES, LITIGATION:** Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged a fee of \$250.00 to include travel time, court time, preparing documents, etc.

**COPIES OF MEDICAL RECORDS:** Should you request a copy of your medical records, the cost is \$1.00 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 10 BUSINESS DAYS to prepare medical records.

**PHONE CONTACTS AND EMERGENCIES:** Office hours are from 12 PM TO 9 PM, Tuesday, Wednesday, Thursday; and 8AM to 8PM Saturdays. If you need to contact the clinician for any reason, please call 561-849-4071, leave a voicemail, and a return call will be made 24 Hours or as soon as possible. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255, or call/text/message 988. If either you or someone else is in danger of being harmed, dial 911, or go to your nearest emergency room. Local services include: MOBILE CRISIS ([561\) 383-5777](tel:5613835777), TEXT NAMI 741-741, SOUTH COUNTY MENTAL HEALTH CENTER (561) 637-2102, OR text PALM BEACH COUNTY RESOURCES 211.

## PART II: CONFIDENTIALITY:

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, *except* for the following limitations:

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- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Law Enforcement and Public health**: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.
- **Governmental Oversight Activities**: To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when a your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- **Upon Your Death**: To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes", except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & "No Secret" Policy**: When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.

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- **Dual Relationships & Public:** Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (ie: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **Social Media:** No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical records.
- **Electronic Communication: If you need to contact me outside of our sessions, please do so via phone.**
  - **Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship.** Texting is not a substitute for sessions. **Texting is not confidential.** Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client’s phone.
  - **Do not use e-mail for emergencies.** In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment. **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.
- **Sessions Outside the Office:** From time to time, clients like to meet in an alternate location (i.e. their home, in public, or somewhere more conducive for them). We are NOT able to accommodate this request, as this can put your confidentiality at risk.

## PART III: HEALTH INSURANCE

**YOUR INSURANCE COMPANY:** By using insurance, I am required to give a mental health disorder diagnosis that goes in your medical record. The clinical diagnosis is based on your current symptoms even though you may have been previously diagnosed. We will discuss your diagnosis during the session. Your insurance company will know the times and dates of services provided. They may request further information to authorize additional services regarding treatment.

**IMPORTANT:** Some psychiatric diagnoses are not eligible for reimbursement (ie: marriage/couples therapy). In the event of non-coverage or denial of payment, you will be responsible to pay for services provided. **KARIE BLISS, LMHC of BLISSFUL PATH THERAPY SERVICES, LLC** reserves the right to seek payment of unpaid balances by collection agency or legal recourse after reasonable notice to the client.

**PRE-AUTHORIZATION & REDUCED CONFIDENTIALITY:** When visits are authorized, usually only a few sessions are granted at a time. When these sessions are complete, we may need to justify the need for continued service, potentially causing a delay in treatment. If insurance is requesting information for continued services, confidentiality cannot be guaranteed. Sometimes, additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not met.

**POTENTIAL NEGATIVE IMPACTS OF A DIAGNOSIS:** Insurance companies require clinicians to give a mental health diagnosis (i.e., “major depression” or “obsessive-compulsive disorder”) for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;

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3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to: applying for a job, financial aid, and/or concealed weapons permits.
5. A psychiatric diagnosis can be brought into a court case (ie: divorce court, family law, criminal, etc.).

It is important that you're an informed consumer. This allows you to take charge regarding your health and medical record. At times, having a diagnosis can be helpful (ie: child needing extra services in the school system or a person being able to receive disability).

### EMERGENCY CONTACT:

It is necessary that **KARIE BLISS, LMHC** of **BLISSFUL PATH THERAPY SERVICES, LLC** has someone to contact on your behalf. In case of an emergency who should we contact?

Full Name	Relationship	Phone Number(s)
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Please check here that you agree and sign below. Thank-you.

I agree to allow **BLISSFUL PATH THERAPY SERVICES, LLC** to contact my emergency contact on my behalf in the case of emergency

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **PART IV: CONSENT**

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **KARIE BLISS, LMHC**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **KARIE BLISS, LMHC** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to **KARIE BLISS, LMHC** of **BLISSFUL PATH THERAPY SERVICES, LLC**. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **KARIE BLISS, LMHC** of **BLISSFUL PATH THERAPY SERVICES, LLC** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to KARIE BLISS, LMHC to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **KARIE BLISS, LMHC** prior to or

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at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

*Your signature signifies that you have received a copy of the “Therapy Agreement, Policies and Consent” for your records.*

Printed Name of Minor Child	DOB	Date

Witness – **KARIE BLISS, LMHC**

Date

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## CLIENT COPY

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2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to **KARIE BLISS, LMHC** of **BLISSFUL PATH THERAPY SERVICES, LLC**. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **KARIE BLISS, LMHC** of **BLISSFUL PATH THERAPY SERVICES, LLC** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

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Printed Name	Signature	Date

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Witness – **KARIE BLISS, LMHC**

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