Ethics: Money and the Therapeutic Relationship

Part 1: An Interview with Kathleen Murphy, PhD

ALEXANDER: Welcome. I'm Barbara Alexander, LCSW, BCD, of On Good Authority. In these interviews, we are concentrating on the topic of money and the therapeutic relationship, specifically fees, billing, gifts, missed sessions, and collections.

Ethical behavior in the money department is not always easy, especially as bookkeeping requirements increase and the reimbursement system becomes ever more parsimonious, sometimes unfair, and frequently cold-hearted. Dueling interests can put our principles to the test, especially when it is so easy to rationalize business judgments that compromise our moral standards. Grown-up ethical behavior requires that, sometimes, we must be willing to sacrifice, and so, our ethical positions may have a financial cost to us, which we must be willing to incur. To help us with this is Kathleen Murphy, PhD, who is going to talk to us about the principles of ethical decision-making. It is important to have these concepts in mind; otherwise we are just memorizing a cookbook of instructions. I think you will be impressed with the heightened sensitivity and professionalism she brings to the topic, and the seriousness with which she takes her ethical thinking.

Dr. Murphy is a licensed clinical social worker in private practice in Glenview, Illinois, where she specializes in working with children with chronic disease, disability, and terminal illness. She has served on the NASW Committee on Inquiry in Illinois since 1985, and she a former chair of the National Committee of Ethics and Adjudication. She is a frequent speaker on the topic of ethical issues in mental health and social work practice. Dr. Murphy is on the faculty of the Institute for Clinical Social Work in Chicago, as well as being a visiting lecturer for Loyola University School of Social Work and the Jane Addams College of Social Work, University of Illinois at Chicago. In addition to her private practice and her workshops on ethical issues, she has published on the topics of home care with families and on addictions.

ALEXANDER: Dr. Murphy, so many times in practice we find ourselves in a position where our decision-making has both clinical and ethical components, and this is what I would like to talk to you about today: How those decisions get made; if there is a priority; and how we reason these things out.

MURPHY: That is a very good question, Barbara. Some of the fee questions that are asked by mental health professionals in individual practice as well as in group practice, by agency administrators, and by independent consultants, include things like: How do we set our fees? How much of a sliding scale should we offer? Do we have to offer pro bono service?

While the setting of fees is basically a business decision at its core, it is also a decision that has both clinical and ethical implications. So, it is a good topic to use to talk about how to apply clinical standards and ethical standards.
I hope the participants know, at this juncture, that there are both clinical and ethical aspects to any practice. The clinical aspects of practice include our theories, our methods, our models of mental health practice for social service. That can include different intervention strategies, different management techniques, a variety of different methods of assessment or supervision or consultation, issues of record keeping, confidentiality, and so on and so forth, all of which are essentially what we call professional practice decisions, or clinical decisions. In and of themselves, these aspects of practice require the acquisition of knowledge about the theory and practice of whatever one's profession is and the development of a variety of skills and techniques to be used for applying that theory, whether it is with clients or in supervision, or consultation, or in administrative tasks. We certainly look at money as an administrative function, but essentially, the clinical aspects of mental health service provide an array of what we can do in any given situation.

What I consider to be on a higher plain than what we do is what we should do. That is what we call the ethical aspects of practice. The ethical aspects of practice are about our moral obligations and our moral duty as mental health providers to do the right thing in any given clinical situation.

Now, ethical practice is not just about having knowledge and skill. In fact, we presume that mental health practitioners have the knowledge and the skill to do whatever it is that they do. But ethics is about doing what is the right or doing what is wrong in any given situation. So, ethical practice is doing what we should do from among the array of things that we can do. I think it is important to keep in mind that while all aspects of practice are essentially clinical or professional issues, many aspects also have ethical implications.

ALEXANDER: In terms of what we should do, that "should" has to be set in a universe. It has to be grounded in something. It can't be what we should do according to "me." It shouldn't be entirely personal, should it?

MURPHY: No, it is not entirely personal. That is where our profession standards and professional codes of ethics come into play. That is where we also interface to some degree with the law in terms of what we should do. The legal aspects of practice are also the codifications of social ethics or social morals in terms of our obligations. So, there are a variety of things that tell us what we should do. But, at center, what we should do is an individual decision of the individual professional, meaning that reasonable professionals can, given the same facts, come to different conclusions about what is the right thing to do.

There is no singular inherently right thing to do as a matter of course. Now you can say, sex with clients -- yes, that is a wrong thing to do. It is wrong to have sex with clients. But most of what we talk about in terms of ethical decision-making, certainly in the mental health field, is not that definitive.

Now, if you want to get into deontological thinking versus utilitarian thinking in terms of moral philosophy, we can certainly do that. But, that is a huge other issue. Basically, there are different moral philosophies that inform our moral decision-making. I happen to be utilitarian in my moral philosophy and what I use to guide my ethical decision-making. Others might use a deontological, moral philosophy or moral perspective to do their ethical thinking.

ALEXANDER: Would you be able, in a very short phrase or two, to define those various components - the utilitarian, the deontological?

MURPHY: It is not a short issue. The deontologists basically feel that there is a "universal right," meaning, for example, if we use confidentiality as a value that is consistent across mental health professions, we all agree with the value of upholding confidentiality. The deontologist would say
that no matter what, we uphold confidentiality so that confidentiality is a principle that comes down in essence from on high, and it is something that can not be violated.

A utilitarian would think more along the lines of "the means justify the ends," meaning that, while a utilitarian would uphold the principle of confidentiality, a utilitarian could also envision times when confidentiality would not be in the best interest of the client. You might realistically see this played out with particularly vulnerable clients, an elder client, or a disenfranchised client, or a psychotic client, where you are trying to find a safe place for this individual to be very quickly, and you don't have time to get a release of information, or you don't have the person with you who is able to sign the informed consent, or you are talking with a referral source over the phone and asking that person whether or not it is a possibility. So there are times when we might realistically and ethically breach confidentiality in the best interest of the client. A utilitarian would say, "That's okay." A deontologist would say, "No, that is a violation of the principles of confidentiality."

In a court of law, is talking to a referral source about a vulnerable client a violation of confidentiality? Absolutely! The question, though, is whether or not it is a permissible violation. So, you can go back and forth in terms of what is deontological and what is utilitarian. The Social Work Code of Ethics is essentially written from a utilitarian perspective, meaning that it essentially gives a fair amount of decision-making freedom and power to social workers (and by the way, so do the two APA Codes of Ethics) with the exception of sexual relationships with clients. Interestingly enough, that is a singular example across codes of ethics where there is the absolute prohibition against that. In that sense, the Social Work Code of Ethics is an essentially utilitarian document -- one written from a deontological perspective.

ALEXANDER: Okay.

MURPHY: If that helps.

ALEXANDER: It does, it does. Now, back to the topic of fees, and irreverently I say that sex with clients is, of course, always wrong. And, it is equally wrong for the therapist to be charging in those situations!

MURPHY: Yes, that compounds the absolute violation. No question about it. It is fascinating as one who has worked in adjudication for fifteen years, looking at ethic complaints against social workers. Because I am a social worker, it is astounding to me how many people who are having sex with their clients are, in fact, charging fees.

That said, most mental health professionals are not having sex with clients. Most mental health professionals are having to contend with ethical decision-making and ethical dilemmas which are more of the routine variety, in which we would say, basically, that the main bodies of mental health professionals do take a utilitarian perspective. That means it is up to individuals using their best judgment, which includes using the literature on ethical decision-making, their own respective standards of practice, their own respective codes of ethics, and consultation with colleagues to arrive at decisions that are ethical.

If I can go back to how we set fees, using both clinical and the ethical considerations, that might help to illustrate what I am talking about.

The NASW Code of Ethics says that when setting fees, social workers should insure that the fees are fair, reasonable, and commensurate with the service performed. Consideration should be given to the client's ability to pay. The principle is the same in the American Psychological Association Code of Ethics. I believe that it is the same or similar to the code that psychiatrists
use. Anyway, this ethical standard is intended to be open enough to allow the individual practitioner or the individual agency, or group practice some latitude to consider a variety of different factors which affect the setting of fees.

Now, we in social work further define the factors that would help define fair and reasonable fees to include reasonable income goals, expenses, such as overhead, the professional's expertise and experience, and the market forces which are driven by both competition and clientele, and we are also able to consider payers in the formula that helps us establish what a fee is. What this means is that agencies and family service organizations, group practices, or individual practitioners, can rightfully, both clinically and ethically, consider a variety of different factors when figuring out what their fee is going to be.

ALEXANDER: Dr. Murphy, I am very glad that you have listed these factors because it takes fee setting out of the area of the self-worth of the practitioner, or the competitive, "Well, so and so charges X, and I have been in practice longer, or I am smarter, and I should charge Y." It is good to hear that things like overhead make a difference.

MURPHY: What is important about this is that it does take it out of the realm of being whim or whimsy. It takes it out of the realm of the "neener, neener" third grade competition with your neighbor. I think that based on these guidelines, every mental health professional who charges a fee for service should be able to articulate to colleagues, to employers, and to clients, in some very specific terms, (although, I don't think we would articulate in specific terms to clients what our overhead might be or that sort of thing), why our fee is what it is, based on just those factors, because those are the factors involved with the cost of doing business. We should then, after going through that deliberative process, be able to state why our given fee, or range of fees, is, in fact, the ethical thing to do, meaning, that it is the right thing to do. When we have thought through what the factors are that we need to consider when establishing a fee, then we can say that this is the fee that I can charge and that I should charge.

Now certainly we can, in certain circumstances, charge more or charge less. No question about that. But, I think when we think about what we should charge, that helps narrow that decision. To simply charge what somebody else charges or to charge what you think the market will bear, or to simply charge what insurance will pay -- these are clinical options, but, I think, in the absence of the deliberative process, the practitioner is practicing by whim rather than based on professional values, which makes it much more difficult to support the decision-making down the road. It is only through the deliberative process of considering what we can do and what we should do that mental health professionals can say with confidence that a fee is clinically appropriate and ethically determined.

Now, that said, with any established fee, there are a number of additional considerations regarding, for example, charging for a missed or a cancelled session, and how and when to increase and decrease a fee, and so on. Charging fees for missed sessions is relatively routine. I think clinically we can, and, as far as I know, all mental health professionals and social service agencies do establish a policy regarding charging a fee for missed or cancelled sessions. Some policies require payment of the full fee; other policies require cancellation notice within twenty-four hours, or forty-eight hours, or seventy-two hours. There are different policies, and the policy can be whatever it is. Given a missed or cancelled session that is covered by that policy, the mental health professional or the agency can adhere to that policy. No matter what, clinically they can.

However, ethically there may be times when the right thing to do is to forego the application of that cancellation policy. For example, I work with children and adults, some of whom have severe disabilities and some of whom are terminally ill. Realistically, there are times when a client of mine
is unable, on very short notice, to come to an appointment, due to either exacerbation of their own illness or a need to go to another medical appointment, or even in some situations due to inclement weather - something which would not necessarily stop somebody else, but for somebody in a wheelchair, it becomes a deterrent. I can, in these situations, apply my cancellation policy because a session has been missed, but sometimes I don't, because morally, or ethically, I do not feel that the policy is the right thing to do. Sometimes the ethical thing to do is not to adhere to one's own clinically derived cancellation policy.

On the flip side of that, I work with adolescents who sometimes will blow me off just because they have a concert to go to or they have a better offer. (Sometimes it doesn't take much to have a better offer to blow me off.) I do not generally accept that being blown off is a moral challenge to my cancellation policy, and I will charge accordingly. My point is that in each instance, I think it is important that we consider why we are applying a policy or why we are choosing not to apply the policy for ethical reasons. Ethically, we have an obligation to make sure that we are not discriminating against one client or a category of clients when there is an exception to the policy. So again, it is in the deliberative process that we do the ethical decision-making in terms of charging for a fee for a missed session. I can do it, but I don't ethically have to do it, or I ethically may have to do it. My point is that we need to kick it up a notch to our ethical standards when we think about the application of a policy. That's certainly clinically appropriate and reasonably derived.

Another issue is that of pro bono work. I get a lot of questions such as, "Do I have to provide pro bono service?" This is typically coupled with, "Do I have to provide, or how much of a sliding scale do I have to offer?" So, let me talk about pro bono service for just a minute.

Pro bono service is a core value of all the mental health professions and, in particular, social work. It is stated clearly and explicitly in the core values in the NASW Code of Ethics. It is a core value of the respective APAs, the marriage and family folks, the professional counselor folks. Everybody agrees that pro bono service is a value for each of our respective professions. However, to the best of my knowledge, none of the codes require it. Now, I do believe there is a moral imperative to provide pro bono service. I don't know how anyone can be a social worker, a psychologist, or a counselor, or other mental health professional, and not look for opportunities to serve in that way, but there is no ethical standard that requires it that I am aware of. So, the answer to the pro bono question generally is that certainly clinically we can do it, ethically we should do it, but nobody is going to fault us if we don't do it.

The sliding scale, on the other hand, is an interesting fee related issue. It is one that engenders a fair amount of discussion because of my perspective, but I want to say that this is my perspective and not necessarily your perspective, Barbara, or the NASW's perspective.

Clinically, social workers and social service agencies and most mental professionals know that they are expected to offer a sliding scale, and people use that terminology. But as one who spends an inordinate amount of time - maybe too much time - thinking about ethics, I actually object to that way of thinking for the following reasons. From an ethical perspective under our respective codes of ethics, we establish fees with consideration given to the client's ability to pay. We do not have to see every client who seeks service from us, but, certainly, consideration of the client's ability to pay is one of the factors that gets air time in our thinking about any individual client. I have no official sliding scale in my own practice, although I certainly have a low end fee in my head. I know myself well enough to know that if I go below that, I will tend to get cranky and resentful of what is being required of me. But, I don't have a sliding fee because the figure in my head at which I will probably get cranky and resentful is by no means the lowest fee that I will
accept. A homeless kid who is paying me $1.00 out of his own pocket from his work at a fast food restaurant is just as valued by me as a client as somebody who is paying the full fee.

I think that social workers and other mental professionals, clinically, all need to decide whom we are willing and able to see based on our skill and our training and our professional interests and for what amount of money. Then ethically we need to do that same sort of thinking on a case by case basis. So, we set our standard fee, whatever that may be, based on good solid ethical thinking, and then we make exceptions to that policy based on good ethical thinking on a case by case basis, which is why I object to the notion of a sliding scale. I think that does a disservice to the notion of thinking about the ethical standards or the ethical requirements according to each client's needs.

Now, we also have to know our own tolerance and our limits. Many could argue differently, but for me, clients should not drive up to my office in a BMW, sit there in designer clothes, and ask me for a reduced fee. Whether or not I could do it clinically, whether I could do it ethically, is a moot point from my perspective. I am just not willing to do it. Ethically, I believe I can decide not to do that. Yes, I do know about all of the massive debt of the rich and famous. I do know about women and men going through divorce situations who have a lot of belongings and no actual cash and all of that kind of stuff - so you know that I am making this somewhat simplistic, but I do know myself well enough, and I respect myself well enough to know that I would be less able to exercise my own professional judgment if I start getting resentful about money. And I work very hard to make sure that I don't set myself up to get resentful about money as a conflict of interest. This segues nicely into one of my final points about ethical thinking related to money in the therapeutic relationship.

One of the reasons it is so critically important to be careful about one's deliberation in terms of what fee to charge, is because money can, in fact, create a conflict of interest. For example, being reluctant at times to terminate somebody who is a full paying client or jumping through a whole bunch of different hoops providing above and beyond the call of duty so one doesn't lose a full paying client, and on the flip side of that, being more casual about service to or even resentful of the professional demands of a low pay or pro bono client.

Mental health professionals are ethically required to do that which is in the best interest of the client to our maximum application of skill and professional service unrelated to a fee. No code of ethics says we can give half service to half paying clients or lip service to pro bono clients. We have an ethical obligation to provide maximum clinical skill to all clients irrespective of the fee. So, we have to know ourselves as clinicians well enough to know when we start to lose our professional objectivity due to money. There are many other factors related to this in terms of burn-out and a variety of different things relative to the meaning of money in the therapeutic relationship. But, I really do caution professionals about setting a fee so high that they can't walk away from it if it's clinically warranted, or so low that they do walk away from it when it's not clinically warranted. The best interest of the client always has to take priority and that is both a clinical and an ethical issue.

ALEXANDER: Dr. Murphy, I can't tell you how refreshing those words are.

MURPHY: Well, thank you. This next thought I have may not be as refreshing. When we first talked, Barb, you asked me about accepting money obtained through gambling or through other questionable means, and I sort of laughed. I thought, "What does that have to do with the price of eggs?" But then I thought, "Okay, that is a serious question. Let me think about it in a serious way." Let me take you through my thinking just a little bit.
Ethically, as far as I know, there is no prohibition in any code of ethics, or any other prohibition that I can think of, from accepting money gained from casinos or drug trafficking, or prostitution, or the mafia, any more than there is any prohibition from accepting money obtained by not paying child support, or by being forty and living at home and having your mom pay the therapy bill, or being kept on the side by a paramour, or money that is gained by inheritance from a random relative. I know for myself and my practice, I pretty much don't know, nor do I particularly care, where my fee comes from, unless (and this is a pretty big unless) it is blatantly illegal, such as robbing a bank, or embezzling, and I know that it is obtained illegally.

Another concern would be if the reason for the therapy in the first place is related to the money behavior. What I mean by that is if I am working with a gambler who wants to stop gambling but feels compelled to try to make my fee by gambling, then we have a clinical issue that impacts on the ethical decision-making, or has some ethical implications anyway with regard to the fee. I need to think it through that way, and I need to think it through with the client in terms of what is in the best interest of client relative to the presenting problem - gambling and the fee. As mental health professionals, though, generally we are not in the business of judging the morality per se of a client's life, so ipso facto to refuse money because it was obtained by means of what we do not agree with, would, I think, be ethically questionable at best. I don't know that it would be clinically appropriate either in many cases, but I think ethically it would be problematic.

That said, I am pretty sure that I would have a problem ethically and that would probably be a clinical problem for other reasons. But, I would have a problem accepting cash from somebody whom I know just robbed a bank and was showing up in my office. Whether or not that was the reason for treatment, I do think or I would hope that I would have my limits regarding somebody's lifestyle in that regard. I do think that we do make some judgments. But, I remember years ago when I was working with female juvenile delinquents, many of them were prostitutes, which is blatantly illegal behavior, but in terms of their trying to get out of prostitution, it took awhile for them to be able to stop that.

There are a variety of clinical and ethical implications in continuing to work with somebody who is knowingly engaging in illegal behavior while we are continuing the work. You know, there is a counter-balance between ethical decision-making and the clinical importance of being able to develop a relationship and work with a person to get them on a different track.

My bottom line is that in all areas of practice we have an obligation to consider our clinical options. Then, we need to decide what the right thing to do is. Money is absolutely no different. We need to use reasonable clinical thinking about the place of money in mental health, social work, and other mental health services. We don't have to squirm or be uncomfortable about it. Money is the price of doing business. My business happens to be in the mental health and human service realm. I can charge a reasonable fee for my service and expertise and feel comfortable about it clinically and ethically. In that regard, when we do that, when we apply that kind of thinking to fees, we don't end up having to acquiesce to managed care or other third party payers quite so blatantly as many have.

ALEXANDER: Dr. Murphy, what if somebody pays you a lump sum in advance? Let's say that the client is going to pay you for three months or six months worth of counseling/therapy sessions. He/she wants to pay you in advance. What might that do in terms of the notation of missed sessions?

MURPHY: I would not accept and never have accepted advance payment. The ethics code says "commensurate with the service provided." So, I charge people for the service that I have provided, and I would not, from my ethical perspective, accept an up front lump sum payment.
would encourage therapists not to because I think it can become a conflict of interest. I don't know if anybody does accept advance payment. I don't know who other people see, but I have not had somebody offer that. I have had clients, on a couple of occasions where my practice has been closed and I was not taking on new clients, offer me money to fit them in. And, again, that would be a conflict of interest in terms of my professional responsibility to the clients that I serve.

I limit my practice, meaning that I have X number of service hours that I provide during the week. I do a certain amount of pro bono service as well as direct clinical practice because I work with terminally ill children and adults. I have a certain level of that category because it is very stressful. I decide who I see based upon a multitude of clinical and ethical processes. You cannot buy your way in to see me. I am not going to accept money to squish somebody in because I know what my limits are. I know what I can do; I know what I should do; and it is important, too, for me to maintain that balance.

**ALEXANDER:** You are in control of your practice.

**MURPHY:** Yes.

**ALEXANDER:** You know yourself. You set boundaries for yourself, and I think that is so crucial. I would say most people -- whether they are self-employed or in an agency practice -- their practice is reactive. They take who comes to them. They take who is assigned to them. They take who calls and asks for an appointment. There may be some kind of screening that goes on, but by and large most people are reactive. To hear you describe the way you know yourself and the way you set your boundaries is really exemplary, and I congratulate you for that.

**MURPHY:** Well, thank you. I don't know if it is so exemplary. I worked in an agency when I was a younger mental health professional. I worked in a family service agency, and I worked in child abuse and neglect, in foster care, and in residential care, and then I was a medical social worker for a period of time. I knew very early on that in order for me to do what I felt I could do and what I should do, I was pretty confident that I needed not to be in an agency setting. So I put myself on a track to be able to control my own practice.

That said, I do a fair amount of consulting for agencies and for departments of social work in medical settings, and I talk stridently and strenuously about the importance of ethics for everybody from the top to the bottom - for administrators to think about the clinical, ethical, and the legal implications of what they are doing and what their people are doing. I ask social workers and psychologists and nurses and teachers and a variety of different people to think about what they can do and what they should do and then to link together in a unified grouping in an agency or a secondary setting so that everybody is working toward the same end -- and that is, to do the right thing. I think that is what we all want to do. When people are in isolation, it's hard to do. Also, people in a group setting feel that they don't have any say over the overall organization. I think that it is harder in an organization, but I think that it's all the more important for people to work together.

I think money becomes an unfortunate conflict of interest across settings. I know private practitioners who will see ten, twelve, thirteen clients a day for the money, and I find that very ethically questionable. It would probably be clinically questionable, but I suppose clinically one could do it.

**ALEXANDER:** You mean in terms of fatigue?
MURPHY: Fatigue, mental alertness, knowing which client is sitting in front of you at any given time and being available. Part of my fee and what is built into part of my fee is the fact that I am as available as I am supposed to be clinically, legally, and ethically, twenty-four/seven - so that's part of my fee, and I cannot be available twenty-four/seven if I am seeing sixty clients a week. So that is one of the reasons I set a limit on the number of people that I see.

But, that said, we have to, I think, enjoy what we do. I love what I do more than I can even begin to say. Doing it right, the way it should be done makes that all the more pleasurable for me, but I certainly believe that we have to enjoy the work that we do. Otherwise there is no point. For people in agencies, or even in independent practice, who feel that they are getting burned out because of policies and procedures that they can't keep up with or don't want to keep up with, I do encourage them to think about what it is that they need and want out of life. As I have said before, I work with terminally ill people, and I have not yet heard one person on his/her death bed say, "I wish I would have spent more time at the office."

ALEXANDER: So, Dr. Murphy, is there anything else you want to say before we close?

MURPHY: My bottom line is we need to know what the right thing is in order to be able to do it. That's where the deliberative process is so critically important.

ALEXANDER: Dr. Murphy, thank you very much for your time.

MURPHY: It's my pleasure.

ALEXANDER: Dr. Murphy can be contacted at

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I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of On Good Authority. Thank you for reading this interview.

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Part 2: An Interview with Robert Galatzer-Levy, MD

ALEXANDER: Welcome. I'm Barbara Alexander, LCSW, BCD, of On Good Authority. Talking about money with our clients or patients is difficult, and we often avoid the topic. In practice, this can lead to misdiagnosis, premature termination, unresolved transference and countertransference, inconsistencies in payment practices, and undue anxiety. To guide us, we turn to someone who will be a familiar speaker to our frequent participants, Dr. Robert Galatzer-Levy.

Dr. Galatzer-Levy is a psychiatrist and psychoanalyst of children, adolescents, and adults. His practice includes extensive work in custody evaluations and in the treatment of children of divorce. He is co-author of The Essential Other: A Developmental Psychology of the Self; Problems, Findings and Methods; and The Scientific Basis of Child Custody Decisions. I have found Dr. Galatzer-Levy to be a wonderfully clear thinker and teacher. In this interview he will
share with us some of his thoughts on the psychological meaning of money in the therapeutic relationship. I think you will be pleased with his very practical, sensible advice.

ALEXANDER: Dr. Galatzer-Levy, we are here to talk about money, finances, and fees, as they impact our work.

GALATZER-LEVY: You mean the biggest taboo in psychotherapy?

ALEXANDER: Yes, the biggest taboo. Why is that so?

GALATZER-LEVY: Well, I think it's because most of us haven't worked through our attitudes about money. In our society it has become sort of normative to talk about sexual matters of all kinds, but talking about money in this society remains, in general, something we are quite secretive about.

ALEXANDER: I think part of the taboo is that mental health professionals, who are there to help, sometimes feel uncomfortable about setting or charging a fee.

GALATZER-LEVY: Yes, I think it comes to this. Most of us believe that we chose this profession in order to help other people, which is true, but we also chose it in order to make a living. Sometimes that comes into conflict. When mental health professionals own up to the idea that they are also earning a living as well as helping people, it tends to take some of the edge off, or some of the glamour off of the idea that, "I'm such a wonderful person that I'm helping those in need," which isn't what most of us are doing most of the time.

ALEXANDER: What about self-esteem issues as they impact fee setting? I think that it is not only true in private practice, but it is also true in agencies as we work out sliding fee scales. How do we decide what our services are really worth? It's like saying how much we are worth.

GALATZER-LEVY: That's right. I was going to say that if you talk about people informally, people will often say, "How much is he worth?" And, what they mean literally is "How much money does the person have?" So, even in our language, the idea of how much a person is worth overall and how much he/she is worth financially tend to get mixed up.

I think this can move us in two different directions. One is the idea that the more we charge, the better we are. "I can get so many dollars per session; I must be terrific." The other side of it is going along with this idea that we are doing it out of love for patients. "If I charge less, then I am really a much nobler person." So, a number of very irrational factors get mixed into the fee. Now, if you are working in an agency setting, this comes across in a slightly different way because if you don't set your own fees, someone else is setting them. And, in a sense, they are saying how much you are worth. The result is that a person may be told in effect, "Your time is worth ten dollars an hour," and the clinician may feel very diminished by that. So, thinking through what the fee means tends to get pretty complex.

ALEXANDER: I suppose that when clients go through the agency front office that is going to be setting the fee on a sliding scale, they are also asked, in a sense, what they are worth. It seems that the whole thing can get very muddy.

GALATZER-LEVY: Yes, they are essentially asked two questions: "What are you worth? And, how much is it worth to relieve your depression or anxiety?" Also, patients are asked to put some estimate on how much they value the therapy even before they start treatment. So, if a therapist
or an agency sets a fee that seems out of line in one direction or another, the patient is likely to feel, "Oh, that's what these folks think of me and what they think of themselves."

Let me give you an example. A clinic that I am familiar with wanted very much to get a certain group of patients to come into the clinic, so they set a very low fee, a much lower fee than the patient population was accustomed to paying for professional services. Indeed, they did manage to round up a few patients this way. However, a recurring theme in the treatment of these patients was, "I must be getting second-rate services because they are charging so little. I must not have very serious problems because, after all, I am only being asked to spend a small proportion of my income on this treatment." The end result was that most of the treatment got mired down in the presumption that the treatment wasn't worth very much because no one was paying very much for it or even asking very much for it.

ALEXANDER: What about situations where treatment is free? For instance, let's take a school social worker seeing a group of kids from divorced families. There's not a charge for that -- I suppose our taxes pay for it -- but are fees and money, or the lack thereof, an issue in a situation like this?

GALATZER-LEVY: Yes, I think the lack of fees or money is an issue because there are some things being communicated by the lack of fees. Again, there is the theme that the service itself may not be worth very much. Also, clients who feel entitled to the service may feel they get to set their own parameters regarding it. There is an awful lot of very good work done by school social workers, in my view, but they are very commonly depreciated as "merely" school social workers. I think part of the reason for that is the lack of fees, but also sometimes in terms of the setup within a school where their services are treated as if they are not very important or aren't worth very much.

ALEXANDER: Do you think if patients have to dig deep into their pockets to pay for treatment that it will be worth more to them?

GALATZER-LEVY: It depends on how deep you mean. Patients have to dig deep enough so that they get a sense that, at bottom, they are paying a reasonable price for a reasonable service.

ALEXANDER: My next question has to do with the sliding fee scale. What if you are seeing one client and charging this person a certain fee - let's say that this client is paying the full fee, and the client has a friend who is also seeing you, or seeing someone else in the agency, perhaps, and the client finds out that the friend is paying a lesser fee? So, the first person decides that he or she doesn't want to pay so much - "Why should my friend get to pay so little?" Conversely, of course, the person who is paying less would say, "Well, gee, how come I am not paying as much? I must either be 'lucky' or I am valuable because the therapist is willing to cut his/her rate to see me." I suppose in a way my question is, should practitioners have a sliding fee at all or should they charge a flat fee for everybody?

GALATZER-LEVY: I would like to step away from the question for a minute and introduce a concept from psychoanalytic psychotherapy that I think may be very useful in talking about this. This is the concept of transference. Now, everybody has heard the term, and the term is used in a variety of ways, but I tend to think of transference in this way. When we perceive something in the world, there are two sources for what we perceive. One source is, in some sense, what is out there, what's external, and the other part of our perception is, what we bring to it - whether it be from our past or from our personal psychodynamics. Whatever it is that we bring to it, I call "the transference."
Now, what you are describing here is a wonderful situation for exploring the transference because each of these patients is confronted with a piece of information, that is, Mrs. Jones is being charged less than Mr. Smith. What does that mean?

What will be useful and what we want to help the patient understand is what they themselves bring to the situation. Separating this out is much simpler if we, in the first place, have a good idea about why the fees are different. We have to have a clear idea why we are charging different fees, and it has to make sense. Then we can say to either Mrs. Jones or Mr. Smith, "Okay, now, you have this information. What are you making of it?" It may be, for example, that Mrs. Jones is being seen at a reduced fee because the clinic policy includes making sure to serve victims of domestic violence. Well, that is going to mean a lot to Mr. Smith. He is going to say, "Oh, you are prejudiced against men." We can begin to examine how he feels about it, why he feels this way about it, what his fantasies are.

Having the sliding scale is not the problem. The problem is where the therapist, himself/herself, can't recognize the meaning of money. In that case the therapist can't figure out how the patient can take the information and use it in terms of his/her own psychology.

ALEXANDER: Could you explain that a little more, please?

GALATZER-LEVY: Sure. Maybe if I give you an example, it would be helpful. A patient came to see a psychoanalyst and said that she could only afford to pay $10.00 a session. The analyst said, "Okay, because treating you is part of my training, I will be willing to see you at that fee," and they began the analysis. Now, in a sense, this had a sensible basis; that is, the analyst was getting much less per session than he ordinarily did, but he was doing that because he wanted to advance his own development in training. The patient was aware that the analyst was in training and thought to herself, not necessarily completely consciously, "Since I am getting such a low fee, I need to pay the analyst in some other way. What he really wants is for me to be a 'good' analytic patient." So, the patient, instead of paying the analyst with money that she didn't have, attempted to pay him by talking like someone who believed in the analyst's theories. At that point in history, oedipal theories were very popular. So, she talked a lot about her Oedipus complex, which unfortunately had very little to do with what really troubled her. It wasn't until the analyst and the patient were able to understand that the patient thought she had to pay for her treatment in some other way than money that they were able to overcome this impasse where the patient was compliantly telling the analyst what she thought the analyst wanted to hear. It wasn't until they could be very open and talk about money and the reduced fee that this became possible.

ALEXANDER: All right, let's say that the patient either gets a better job or a big raise. Now we get to the topic of raising the fee. What about that?

GALATZER-LEVY: Again, the useful, right way to think about this is what might be described as an "ordinary reality." If a therapist is seeing someone at a much reduced fee because that person doesn't have enough money, and then the person has enough money, or has more money, well, then it would make perfect sense to raise the fee, if it is clear to the patient from the beginning that this is the nature of the agreement. Then, if the patient says, "You are exploiting me. You are using me. I managed (as a result of this therapy, incidentally) to get a better job, and now all you are interested in is money." Well, the therapist is in a position to say, "Well, you seem to be making kind of an elaborate interpretation of my actions. What actually went on was I stuck to an agreement we had, or an implicit agreement that we had." That's how one would address that situation. Again, it is very, very helpful for the therapist to have a very clear and honest idea of what he/she is doing with regard to money, or else the therapist will get caught up in, "Maybe I
really am exploiting the patient," and not be able to help the patient see what the patient brings to the situation.

**ALEXANDER:** What if the patient starts to bring little presents -- maybe cookies, or maybe it's Valentine's Day and the patient brings a valentine, or maybe it's Christmas, and he/she brings a book or a present or something. What about little gifts?

**GALATZER-LEVY:** Little gifts are complicated, because if the patient brings them, it may be a way of expressing gratitude, and it may be deeply humiliating to the patient if you turn them down. However, the therapist needs to ask what this little gift really means. For example, is the little gift a bribe? Is the little gift some sort of additional payment by the patient, especially in a reduced fee situation. It is worth being very careful and trying to get pretty explicit about what the patient's idea is about the little gift. Now, with some patients, of course, this is the beginning of a slippery slope because little gifts can often turn into big gifts, or little gifts can be regarded as payment for services other than psychotherapy. Here, I am not talking in the legal sense. The patient says, "Oh, I brought you cookies because I know you like cookies. Now, doesn't that really mean we are friends rather than therapist and patient?" The boundaries of the therapeutic situation can become blurred and complicated around supposedly little gifts.

**ALEXANDER:** I know of a situation where a client collected stamps and liked to bring and show the stamps to the therapist, and the therapist would say, "Oh, these are beautiful." Then the client started giving the therapist stamps. The client knew that it was something that the therapist was interested in, like you say, cookies. Maybe the therapist accepted one or two stamps, but finally it got to be more stamps every week. Now, how do you really say, "I can't accept this gift."

Or let's say the gift is something more major. I was asked a question from one of our listeners about rather substantial gifts. Let's say the patient is wealthy and has a vacation home in a ski resort and says to the therapist, "I would like to make this vacation home available to you," so that's a different kind of gift.

**GALATZER-LEVY:** At some point the therapist does have to say, "No, I can't accept that gift. It's contrary to the ethics of my profession, but I do understand that it was important to you to give it to me." So, we want to understand what the offer of the gift is about.

**ALEXANDER:** Would you take that stance instead of saying, "My code of ethics says that I am not allowed to take gifts"?

**GALATZER-LEVY:** Yes, I would take that stance because I think what it means is that you don't want to berate the patient for doing something in relationship to you. You want to create a situation where the patient, on the one hand, doesn't involve you in unethical behavior, but at the same time, is free to talk about what they are trying to do through the proposed unethical behavior. Treating the offer with what I call ordinary courtesy, I think, is part of giving the patient the opportunity to explore why they are choosing to do such a thing.

**ALEXANDER:** What about missed sessions?

**GALATZER-LEVY:** This is controversial in some ways. Freud was very clear about missed sessions. He said that you charge for them, and he had two reasons for this which were not closely related. One was simply practical. If you are seeing a patient five times a week, and the patient starts missing sessions, it's not as if you can fill in with another five times a week patient. So, analysts and other therapists who see people very frequently may, as a practical matter, not want to be stuck with missed sessions that aren't paid for. The other reason was that it was a way
of twisting the patient's arm. Freud assumed, and I hope he is right, that the patient was better off talking to the analyst than staying at home and that at times the patient would be reluctant to talk to the analyst. This was a kind of manipulation almost: "If you don't come to see me, you will charge so many dollars for absolutely nothing." I want you to notice, though, that that kind of manipulation isn't really the kind of thing we approve of very much in doing psychotherapy any longer. It doesn't fit terribly well.

There are a variety of solutions to this. One is to simply say, "Since I didn't provide services, I won't charge for them." That's a kind of ordinary business-like transaction, and if that is clear, it is a useful beginning point. If the patient begins to abuse that position, then it should be brought into the therapy.

Another possibility, which is the one I follow, is that if I am seeing a patient on a regular basis, or if I have an appointment with the patient, then I charge for the time unless I fill it with some other activity that earns an equivalent amount of money. So, I will tell patients that we have an agreement to meet at 10:45 on Mondays. If you let me know you won't be here on a particular Monday, I will try to fill the time, but if I don't, you will charged. Most patients find that fairly reasonable. However, it can lead to not very useful debates, such as, "How seriously did you try to fill the time, doctor?" or "I know that since I took Christmas week off and many of your other patients took Christmas week off, how did you choose to fill one patient's time rather than another?" You can get into a kind of obsessional tangle with that.

But, again, it's close to an ordinary business practice. You are basically renting your time out, and if the person chooses not to use that rented time, well then, of course, they still pay for it. Some therapists continue to follow the simple rule that if patients miss a session, they pay for it. That has the advantage that it doesn't lead to as tangled conversations about how or whether the time was filled. It can sometimes lead to annoying situations because most of us, even though we are being paid, don't want to sit doing nothing, and the patient may vengefully say, "Okay, I am paying for it. I won't let you know that I am not coming in. You can just sit there." And, that tends to make a therapist pretty mad, or least it would make me pretty mad. So there are a variety of possible solutions to the missed appointment.

ALEXANDER: If it's psychotherapy or a counseling situation, where you are not seeing the person every day or four times a week - maybe it's once a week, and your policy is that you need twenty-four hours notice and the person doesn't give you that twenty-four hours notice, what kind of an excuse would be an legitimate excuse?

GALATZER-LEVY: Well, I don't like to work with excuses because then I get into the position of judging what is legitimate and not legitimate. I don't think that's where a therapist wants to be. If you have a policy that is based on twenty-four hours notice, I would charge the patient who failed to give that notice, and when the person comes in and says, "Well, that's unreasonable or unfair. There was three feet of snow on the ground and I couldn't get to your office," I would say, "You are right. It's understandable that you would feel that being charged for something you didn't get isn't fair. But, on the other hand, it isn't fair that I should have been left sitting here and not be paid, so we are going to stick to our agreement, but we are going to talk about how you understand and feel about it."

You see, the alternative is a situation that is a very bad one for a therapist to be in which is that of making judgments about the validity of a patient's statements. Continuing with your snow example, I have patients who, if there's a quarter of an inch of snow in Chicago, which is nothing, would say, "It's snowing. It's dangerous to go out." Now, I don't want to spend a huge amount of time discussing the statistics about traffic accidents in the snow with a patient. I don't think that
does the patient very much good. So, if I have made it clear that I don't make a judgment about
that; that it is simply the business practice that they get charged. Then I have a much better
opportunity to discuss with them questions of what their opinion or views are about how
dangerous or not dangerous things are. And, that's often a very fruitful discussion.

ALEXANDER: I don't know if you have seen the television program, "The Sopranos," but there
was one episode where Tony Soprano tells his psychiatrist that he is going to miss the next
week's session, and she says, "Well, you know that I will have to charge you," and he flies into a
rage and says that she is nothing but a whore and throws the cash on the floor at her. I thought it
was a terrific episode and interesting to think about.

GALATZER-LEVY: Yes, I think it is a terrific example because what she succeeded in doing, by
sort of flat-footedly sticking to the rules, was to get him to be very explicit about some fantasies
that he has about her, that is, that anyone who would charge to talk to him must be a whore --
probably women, in general, are whores. And, he brings it right into the room with plenty of affect.

Now, I don't know whether the program indicated whether or not they were able to understand
why he would react that way to an ordinary business dealing, but it certainly does bring it into
sharp focus. Notice how sharp that focus is compared to the situation in which she had said,
"Well, let's try to decide together whether it is reasonable for me to charge or not." We could
imagine Tony Soprano getting into a long discussion of what constitutes something reasonable
and how her practice is compared to his and what-not. The intense, clear, emotional response
that you described would certainly be lost.

ALEXANDER: Would that have been good? Bad?

GALATZER-LEVY: That would have been bad because assuming that the patient can come
back to it and look at it and understand it, he/she can learn a huge amount from such an
experience. Now, of course, if the patient says, "You are a whore, and I am never coming back
here again," and means it, then one has to decide whether you want to introduce some
parameters into the situation that will allow the patient to stay.

ALEXANDER: Do you have any opinions about giving patients or clients a written policy
statement at the first session, or having the front office give them a written policy statement,
saying to the effect, "This is what your fee is going to be. It must be paid by the fifteenth of the
month or you will be charged this, that, or the other." And, in fact, sometimes it maybe even goes
into, "I won't testify," or "I might have to release your records if they're subpoenaed." -- you know,
a written policy statement can really go on and on about what is allowed and what is not allowed.
What do you think about things like that?

GALATZER-LEVY: I have mixed feelings about it. I generally don't do it essentially because I
think it puts such a strong emphasis on what is, after all, just one aspect of the situation between
the therapist and the patient, and it communicates a certain amount of legalism toward the whole
situation that might be an interference. On the other hand, I can see where it might be a very good
idea, especially in a situation where the function of collecting the money and doing the therapy are
separated because then one has very clear ground work from which to proceed and from which to
talk about things. I think that the clearer that ground work is, the easier it is to understand
problems that come up with it, so I wouldn't be opposed to it by any means.

ALEXANDER: I have one last question to ask you. Let's say as the therapist or counselor, you
have made a major mistake with your patient. Let's say you have forgotten something that they
have told you, and they are crushed by it, and they are terribly upset by it. Do you charge for that session?

**GALATZER-LEVY:** Yes, and I do it for two reasons. But first let me say, of course, the first thing you do is apologize. However, if the patient is crushed by it, there is probably something more going on than simply what you did wrong. That is, you have done something wrong, but the patient has made out of that what they will. For example, "You forgot it was my birthday. You don't care about me at all. You just see me as patient #247." Well, that is the patient's interpretation, which hopefully is inaccurate, and the therapist might think to him/herself, "I don't remember anybody's birthday." So, the fact that the patient is very upset by the behavior doesn't mean you have necessarily done something terribly wrong. But dealing with it by the money confuses the issue. If you say, "I will not charge for this because I did such a crummy job," you really help to deflect from the patient's central emotional concern which usually has to do with how interested and involved the therapist is with the patient. You have introduced another layer of confusion. Now we are talking about money, as well as the emotional impact. So I wouldn't do it.

**ALEXANDER:** We have only scratched the surface here. I really wish we could go on because one question does lead to another and another.

**GALATZER-LEVY:** It is a fascinating topic, and it is something that therapists should be thinking about over and over again. As we said at the beginning, money is the major taboo in our society, and thinking about it straight is hard, so just as in this program we have to stop at a certain point, and we have left a lot unresolved, so, too, people in thinking about this should come back to it over and over and review their policies, review how they are working, think through the meaning of money for both themselves and their patients.

**ALEXANDER:** Wonderful summary. Dr. Galatzer-Levy, it is always a great pleasure to talk with you, and I thank you once again for sharing your thoughts with us.

**GALATZER-LEVY:** Thank you so much for having me.

**ALEXANDER:** Dr. Galatzer-Levy's book, *The Scientific Basis of Child Custody Decisions*, is available through John Wylie and Sons or amazon.com.

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I must say here that the opinions expressed by our speakers are theirs alone and do not necessarily reflect the opinion of On Good Authority. Thank you for reading this interview.

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Part 3: Ethics Codes, Laws, and Regulations

Athealth.com Editor’s Note:

Practitioners are governed by state laws and regulations and by codes of ethics. All major organizations in the mental health professions have adopted a code of ethics. Readers are encouraged to examine their state laws and regulations as well as provisions of the ethics codes related to the topics in this program. Below are links to the ethics codes and examples of some of the ethical issues and state laws and regulations in California and Florida that are related to the material discussed in this program.

Ethics Codes

APA: Ethical Principles of Psychologists and Code of Conduct

Code of Ethics of the National Association of Social Workers
http://www.socialworkers.org/pubs/code/code.asp

California Association of Marriage and Family Therapists (CAMFT)
http://www.camft.org/CamftBenefits/whatiscamft_ethnic1.html

American Association for Marriage and Family Therapy Code of Ethics
http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx

American Counseling Association Code of Ethics and Standards of Practice

Code of Ethics of the American Mental Health Counselors Association
http://www.amhca.org/assets/content/CodeofEthics1.pdf

National Board for Certified Counselors Code of Ethics
http://www.nbcc.org/assets/ethics/nbcc-codeofethics.pdf

The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry
http://www.psychiatry.org/practice/ethics

California Law and Ethical Standards

The following ethical standards and laws relate to the issue of billings and fees.

Consumer Protection

Consumer Protection is one of the highest priorities for the California Board of Psychology as stated in Section 2920.1 of the California Business and Professions Code.

2920.1. Protection of the public shall be the highest priority for the Board of Psychology in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.
Accepted Ethical Standard for Psychologists

Pursuant to Section 2936 of the California Business and Professions Code, the American Psychological Association's, Ethical Principles of Psychologists and Code of Conduct, is the accepted ethical standard applicable to the practice of psychology in California.

Section 2936 states as follows:

2936. The board shall adopt a program of consumer and professional education in matters relevant to the ethical practice of psychology. The board shall establish as its standards of ethical conduct relating to the practice of psychology, the "Ethical Principles and Code of Conduct" published by the American Psychological Association (APA). Those standards shall be applied by the board as the accepted standard of care in all licensing examination development and in all board enforcement policies and disciplinary case evaluations.

To facilitate consumers in receiving appropriate psychological services, all licensees and registrants shall be required to post, in a conspicuous location in their principal psychological business office, a notice which reads as follows:

NOTICE TO CONSUMERS:
The Department of Consumer Affair's Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints, you may contact the board on the Internet at www.psychboard.ca.gov, by calling 1-866-503-3221, or by writing to the following address:

    Board of Psychology
    1422 Howe Avenue, Suite 22
    Sacramento, California 95825-3236

Psychologists are encouraged to review the Ethical Principles and Code of Conduct (APA, 2002), which can be found at http://www.apa.org/ethics/code/index.aspx

Beware of Fraudulent Billing

In California, grounds for disciplinary action include the commission of any dishonest, corrupt, or fraudulent act.

Section 2960 provides, in part, as follows:

2960. The board may refuse to issue any registration or license, or may issue a registration or license with terms and conditions, or may suspend or revoke the registration or license of any registrant or licensee if the applicant, registrant, or licensee has been guilty of unprofessional conduct. Unprofessional conduct shall include, but not be limited to:

    . . .

    (n) The commission of any dishonest, corrupt, or fraudulent act.

Fees for services should accurately reflect the services provided. Practitioners should not provide an insurance company with incorrect information. For example, if insurance pays for individual therapy but not for couples' therapy, couples' therapy should not be billed as an individual session.
The APA Ethics Code addresses the issue of fees and billing, in part, as follows:

6.04 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements. (b) Psychologists' fee practices are consistent with law. (c) Psychologists do not misrepresent their fees. (d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.) (e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.06 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

Florida Clinical, Counseling, and Psychotherapy Services

Grounds for Disciplinary Action

Pursuant to Chapter 490, Florida Statutes: Psychology, s. 490.009, and Chapter 491, Florida Statutes: Clinical, Counseling, and Psychotherapy Services, s. 491.009, grounds for disciplinary action against a licensed psychologist, clinical social worker, marriage and family therapist, and/or mental health counselor related to fees include, but are not limited to, the following:

490.009 Discipline.

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s.456.072(2):

   . . .

(c) Being convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession. A plea of nolo contendere creates a rebuttable presumption of guilt of the underlying criminal charges. However, the board shall allow the person who is the subject of the disciplinary proceeding to present any evidence relevant to the underlying charges and circumstances surrounding the plea.
(d) False, deceptive, or misleading advertising or obtaining a fee or other thing of value on the representation that beneficial results from any treatment will be guaranteed.

... .

(h) Failing to perform any statutory or legal obligation placed upon a person licensed under this chapter.

(i) Willfully making or filing a false report or record; failing to file a report or record required by state or federal law; willfully impeding or obstructing the filing of a report or record; or inducing another person to make or file a false report or record or to impede or obstruct the filing of a report or record. Such report or record includes only a report or record which requires the signature of a person licensed under this chapter.

(j) Paying a kickback, rebate, bonus, or other remuneration for receiving a patient or client, or receiving a kickback, rebate, bonus, or other remuneration for referring a patient or client to another provider of mental health care services or to a provider of health care services or goods; referring a patient or client to oneself for services on a fee-paid basis when those services are already being paid for by some other public or private entity; or entering into a reciprocal referral agreement.

(k) Committing any act upon a patient or client which would constitute sexual battery or which would constitute sexual misconduct as defined in s. 490.0111.

(l) Making misleading, deceptive, untrue, or fraudulent representations in the practice of any profession licensed under this chapter.

... .

(t) Violating a rule relating to the regulation of the profession or a lawful order of the department previously entered in a disciplinary hearing.

(w) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto. (2) The department, or in the case of psychologists, the board, may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).