

## Informed Consent Service Agreement

Welcome to **CLB Counseling, LLC**. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations.

Although these documents are long and sometimes complex, it is very important that you understand them. Signing this document represents an agreement between us. We can discuss any questions you have when you sign or at any point in the future.

### I. PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each party. As a client in psychotherapy, you have certain rights and responsibilities. There are also legal limitations to those rights you should be aware of. As your therapist, I have responsibilities to you, as well. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems; however, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first two sessions will involve a comprehensive evaluation of your needs, including a review of the intake paperwork you completed. By the end of the evaluation, I will be able to offer some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

### II. APPOINTMENTS AND CANCELLATIONS

Appointments will ordinarily be **45 minutes** in duration, every other week, at a time we agree on. As symptoms improve, we may space out sessions as needed. Similarly, if symptoms become more acute, we may meet more frequently as needed. The time scheduled for your appointment is assigned to you and you alone.

If you need to cancel or reschedule a session, I ask that you provide **24-hour** notice. If you no-show or late-cancel two appointments, my policy is to **charge half the amount of the session** (unless we both agree that you were unable to attend due to circumstances beyond your control). If you no-show or late-cancel three or more appointments, my policy is to **charge full the amount of the session**. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment.

You're also responsible for coming to your session on time; if you are late, your appointment still needs to end on time.

### **III. PROFESSIONAL FEES**

The standard fee for the initial intake is \$200 and each subsequent session is \$150 for sessions 53+ minutes, \$120 for sessions 38-52 minutes, and \$75 for sessions 16-37 minutes (time ranges are based on reimbursement standards of insurance companies). You are responsible for paying at the time of your session unless prior arrangements were made.

A \$10.00 service charge will be charged for any checks returned for any reason for special handling. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to scheduled appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

### **IV. INSURANCE**

To set realistic treatment goals and priorities, it is important to evaluate your resources available to pay for your treatment. If you have a health insurance policy, it may provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of healthcare, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require your authorization to provide a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM 5. There is a copy in my office, and I will be glad to let you see it to learn more about your diagnosis, if applicable). Sometimes I must provide additional clinical information such as treatment plans or summaries or, in rare cases, copies of the entire record. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

If you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee.

Many policies leave a percentage of the fee (co-insurance) or a flat dollar amount (co-payment) to be covered by the patient. Either amount will be invoiced to you through the Simple Practice Client Portal. Some insurance companies may also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year.

Once we have all the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will provide information to help you find those services.

#### **V. PROFESSIONAL RECORDS**

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records.

Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me or have them forwarded to another mental health professional to discuss the contents.

If I refuse your request for access to your records, you have the right to have my decision reviewed by another mental health professional. We can discuss upon your request. You also have the right to request that a copy of your file be made available to other health care providers.

#### **VI. CONFIDENTIALITY**

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices provided to you. Please remember that you may reopen the conversation at any time during our work together.

#### **VII. PARENTS & MINORS**

Parents may also be legally entitled to some information about a child's therapy. While privacy in therapy is crucial to successful progress, parental involvement can also be essential. I do not provide therapy for children 13 and younger. For children 14 and older, I request an agreement between the child and parents to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication requires the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions). In this case, I will make every effort to notify the child of my intention to disclose information and handle any objections raised.

#### **VIII. CONTACTING ME**

The best way to contact me is through the Simple Practice Client Portal.

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I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voicemail and your call will be returned as soon as possible. It may take a day or two for non-urgent matters.

If, for unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or feel unable to keep yourself safe, please go to your local hospital Emergency Room or call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my practice.

## **IX. SOCIAL MEDIA AND TELECOMMUNICAION**

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.)

## **X. ELECTRONIC COMMUNICATION**

I cannot ensure the confidentiality of any form of communication through electronic media. If you prefer to communicate via email for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. I

## **XI. OTHER RIGHTS**

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or former clients.

## **XII. CONSENT TO PSYCHOTHERAPY**

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date