



Psychotherapeutic Privacy & Practice Policies

Informed Consent For Treatment

Welcome to Awareness Counseling, LLC. This document (the Agreement) contains important information about our professional psychotherapeutic services and business policies. What is attached to this package are the following:

- Patient Acknowledgement of Receipt of Notice of Privacy Practice
- HIPAA Notice of Privacy Practices
- HIPAA Patient Consent and Authorization for Release of Information
- Acknowledgement and Consent for Treatment at the end of this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time.

Summary information about the Health Insurance Portability and Accountability Act (HIPAA). This is a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice). The Notice is attached to this Agreement and explains the application of HIPAA to your PHI in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Please take time to read our Privacy & Practice Policies agreement carefully and let us know if you have any questions or need more information.

PSYCHOTHERAPY

Taking initial steps into starting psychotherapy is a brave act. Despite an advancement in minimizing the stigma in modern time it may still be a difficult decision for some to make. You as a client are taking steps to address areas of your life that are causing distress through psychotherapeutic process. Psychotherapy is a dynamic form of treatment that requires both parties to work hard. In order for psychotherapy to be effective, you will likely be asked to think about and practice topics discussed during and outside of your sessions. Psychotherapy often involves discussing and exploring aspects of your life you wish to change. Psychotherapy can have risks and benefits. Some of the risks are you may experience strong or uncomfortable emotions such sadness, anxiety, guilt, shame, anger, etc. However, psychotherapy has also been shown to have many benefits. Psychotherapy can lead to reduction in distressing psychological symptoms, greater understanding and insight of self and others, improvements in relationships, solutions to specific problems, and enhanced quality of life. There are no guarantees of what you will experience, or how quickly your condition may improve. Even though certain patterns may be recognized everyone's situation is unique and everyone is interpreting the same situations in a unique fashion. By the end of your initial intake evaluation (psychosocial assessment), the therapist will be able to share initial clinical impressions with you. At your subsequent session, your therapeutic goals will be discussed and an Individual Treatment Plan (ITP) will be formed collaboratively with the clinician.



Please keep in mind that our clinical staff may not be equipped to help everyone. Someone's needs may not be our specialty; however, we will do our best to refer you to other professionals that may be better able to help you and match your needs.

You may also decide that our psychotherapist is not the appropriate match for you at any time. Should this occur we encourage everyone you to inform us as we will be happy to assist you in locating another therapist.

CONFIDENTIALITY

We take confidentiality of the personal information of our patients very seriously. This agreement was prepared to clarify our legal and ethical responsibilities regarding this important matter. Personal information that you share with our therapist may be entered into your records in a written form. We make every effort to protect the confidentiality of your records including locking paper records in a locked file cabinet in a locked office and storing electronic files on a password protected computer and are uploaded via a password protected internet connected to a password protected database. Individuals from outside our office are not allowed access to your clinical records. The only way we share your personal information is if you give us a written permission to do so via *HIPAA Patient Consent and Authorization for Release of Information* form.

EXCEPTIONS TO CONFIDENTIALITY

There are several important exceptions to the above policy regarding your confidentiality in which disclosure is required by law. The following are the exceptions and limits to confidentiality and represent instances in which confidential information may be released to others without your expressed written permission:

- a. When our clinician believes you present a serious, imminent danger to harm yourself
- b. When our clinician believes you present a serious, imminent danger of violence to others. In this case the same clinician is also obligated by law to warn identified others.
- c. When there is *reasonable* suspicion of child, elder or a dependent adult abuse (physical, emotional/psychological, sexual), or neglect
- d. Pursuant to a lawfully issued subpoena
- e. When a clinician is defending him/herself against a claim, or subject to investigation, review, or audit
- f. When minors (under 18 years of age) are seen in therapy, the parent or legal guardian holds the legal privilege regarding releasing their clinical records. If you have any questions about confidentiality, please discuss them with us.



A note regarding working with minor population

The therapeutic relationship is relationship based on trust. Children and adolescents sometimes disclose information that they expect a professional to keep in confidence just as an adult would. By consenting to psychotherapeutic services with us, you are agreeing that our therapist may hold your child's therapy disclosures confidential. Out of respect for our minor client population and their privacy, in general, the therapist would only disclose information to parents/guardians without a minor patient's consent if it's believed the minor is engaging in activities which could put him/her in danger. Our therapist is not permitted to disclose any information about adult (18 years or older) client to their parents without client's permission even if the client is living with their parent(s) and even if their parent(s) are paying for their treatment. We do not provide custody evaluations. We do not testify in court as a witness and do not provide court testimony for marital or custody disputes.

RELEASE OF INFORMATION TO OTHERS

By law, the sharing of information in your record is done only with your written, expressed permission. If you would like us to share your information, we will provide you with a *HIPAA Patient Consent and Authorization for Release of Information* form. This release form specifies what information you are consenting us to release, to whom, and for what time period. You can revoke your permission at any time by providing us with a written notice.

COMMUNICATION

We believe communication is a vital segment for a quality service and progress. We have three forms of communication means with our clients; phone, email and fax.

Phone, electronic messages and Email

Please feel free to contact your provider regarding your appointment time and general inquiries. We believe that using a phone, electronic messages (e.g. text messages) and email communication are for administrative purposes only (such as making appointments, cancellations, rescheduling etc.) and it is preferable to be used as least as necessary. Please do not email us the content related to our psychotherapy sessions, as emails and electronic messages are not 100% secure or confidential. You should also know that any emails and/or electronic messages we receive and send to you become a part of your treatment record. Please do not contact us via e-mail for emergencies. In case of an emergency, patients should call the National Suicide Prevention Lifeline (800) 273-8255, call 911, or visit their local emergency department.



Social Media

We recognize the importance of Social Media in modern world. However, for the psychotherapeutic services we do not accept friend or contact requests from any current or former clients or their immediate family members on any social networking site (Facebook, LinkedIn, etc). Our strong belief is that adding client's as friends or contacts on these social media sites can compromise a client's confidentiality and our respective privacy. It may also blur the boundaries of our psychotherapeutic relationship.

CANCELLATIONS, RESCHEDULING, LATENESS, NO-SHOWS

Scheduling of an appointment involves the reservation of time allocated specifically for you. For that reason, a minimum of 24-hour notice is required for re-scheduling or canceling your appointment. The normal psychotherapeutic session fee will be charged for sessions missed without such notification. Understandably, occasional exceptions occur if it is agreed that a late cancellation was unavoidable.

If you are running late for your appointment, please contact us as soon as possible to let us know you will be late. If you arrive late for your psychotherapy appointment, please understand that your session will need to end on already predetermined time, as other clients may be waiting for their appointment.

If you are requesting an invoice from us that you could submit to your health insurance company, be aware that insurance companies do not reimburse for missed sessions.

If you cancel or no-show for 3 scheduled psychotherapy sessions within 3-month period, we will likely make a decision to refer you to another professional that may better match to your needs.

PAYMENT & FEES

Psychotherapy with us is considered an "out of network". This means that our provider does not submit directly to insurance companies for payment. This was a conscious business decision on our behalf. We believe that by being "out of network" allows for greater freedom in treatment for our clients while protecting their confidentiality.

Payment is due at the time of service. Generally, payment is collected prior to our session beginning. Payment is accepted in the form of cash, check, or credit card and we also offer financing options. We keep your payment information secure in your file for convenience and easier processing.

Statement and/or invoices that are used to submit to insurance companies for reimbursement are created upon request. Please allow us some time to create an invoice for you. A fee of \$35 will be charged for returned (overdrawn) checks and this payment option will no longer be accepted. If you fail to pay, your account may be referred for collection. In that event you will be responsible for all costs and expenses of collection, including reasonable attorneys' fees. Fees are evaluated annually, and if warranted, fee increases generally take effect on January 1st. Those currently in treatment will be notified of any increases 30 days in advance of the effective date.



Fees:

Initial Phone Consultation (15 minutes) - Free

Initial sessions/evaluations (up to 90 minutes) - \$175

Individual or family therapy sessions (45-50 minutes) - \$115

Attendance at meetings, professional consultation, personal services - \$115/hr

Clinical supervision for Licensed Graduate Professional Counselors (LGPC) - \$115

Please initial each item and sign below to acknowledge your understanding of the practice payment policies.

_____ I understand that payment is due at the time of service.

_____ I understand that this practice does not accept payment from insurance companies.

_____ I understand that I may be charged the full session fee for a missed session not cancelled at least 24 hours in advance.

_____ I understand that multiple late cancellations may result in termination from the practice.

Note:

Pages 1-5 are provided to the client, parent(s), or guardian(s).

Page 6 is kept within our office and becomes a part of the client's medical record.

Welcome to Awareness Counseling, LLC





INSURANCE INFORMATION

If you would like to be given monthly invoices which you can submit to your insurance company for potential reimbursement, please complete the following section. Your insurance carrier determines whether and how much they will reimburse. Please call your member services department for information on "out of network" benefits.

Insurance Carrier: _____ Member ID: _____

Policy Holder Name: _____ Policy Holder DOB: ___/___/_____

ACKNOWLEDGEMENT & CONSENT FOR TREATMENT

Your signature below indicates that you have read the above agreement and agree to its terms. Your signature also serves as an acknowledgement that you have been provided a copy of the Notice of Privacy Practices. Finally, your signature indicates you have been given the opportunity to ask questions about any of the above.

For minors in which parents are in the process of separating, are separated, or have joint legal custody, both parents must consent to treatment.

Pages 1-5 are provided to the client, parent(s), or guardian(s).

Page 6 is kept within out office and becomes a part of the client's medical record.

_____/_____/_____
Client Name (print) Client Signature Date

_____/_____/_____
Parent/Guardian Name (print) Parent/Guardian Name Signature Date

_____/_____/_____
Parent/Guardian Name (print) Parent/Guardian Name Signature Date

_____/_____/_____
Clinician Name (print) Clinician Signature Date

- Copy of Psychotherapeutic Privacy & Practice Policies and Informed Consent for Treatment provided to the client.
- Original Psychotherapeutic Privacy & Practice Policies and Informed Consent for Treatment placed in the client's medical record.