CLIENT INFORMATION AND POLICY STATEMENT

Version 9, 2017

NEW CLIENTS The following is important information about treatment, confidentiality, and office policy. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). Please read it carefully and if you have questions, your therapist will discuss them with you. HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice is this Agreement, which explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. You and your counselor can discuss any questions you have about these procedures in your first or second session. When you sign this document, it will represent an agreement between you, your counselor, and Arbor Counseling LLC. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless: we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have to us.

CONFIDENTIALITY AND EXCEPTIONS TO CONFIDENTIALITY Federal and Ohio law require that issues discussed with a therapist be confidential. The information you reveal will not be discussed by the therapist with anyone, other than the exceptions listed below, without a signed authorization from you.

Supervision If your therapist is under formal supervision due to state licensing status, process or requirements, they will meet regularly for consultation and direction and, therefore, the supervisor will be familiar with you, your concerns and the content of sessions. You can request a meeting with this supervisor at any time or for any reason, including to discuss treatment or diagnosis issues.

☐ Your therapist, does not require supervision.

☐ Your therapist is not in network for your insurance provider but will bill in network under the practice or supervisor name.

☐ Your therapist, _____ requires supervision and is supervised by Darlene Herron, LPCC-S, Ohio License #E3064 or _____ License #_____.

Legal Requirements The release of confidential materials may be legally required of your therapist in the following situations: 1) If you therapist believes you present a clear and substantial risk of imminent serious harm to yourself (suicide) or others (homicide); 2) Suspected child or elder abuse or neglect; 3) Instances where the court subpoenas records; and 4) If you file a complaint or lawsuit against your counselor or Arbor Counseling LLC.

Staff Your counselor practices with other mental health professionals and an administrative staff. Protected information may be shared with these individuals for both clinical and administrative purposes, such as consulting, scheduling, billing and quality assurance. All of the mental health professionals and the administrative staff members are bound by the same laws of confidentiality.
If you learn at any time during your therapy that information may be requested from your therapist by a third party, e.g., parents, lawyer, schools, or other mental health professionals, you need to inform your therapist as soon as possible. In such cases, you can waive your privilege of confidentiality by signing an authorization form.

If at any point the therapist believes it would be useful to confer with other professionals, you will be asked to grant permission and to sign an authorization form.

APPOINTMENTS usually are scheduled weekly or bi-weekly. Because ongoing therapy is a negotiated process between you and your therapist, you will not be automatically rescheduled. Both you and your therapist need to evaluate the progress of your therapy periodically to determine the need for further appointments. It is your right to discontinue treatment any time you feel it is in your best interest to do so. It is the therapist's ethical responsibility to end therapy when it is reasonably clear that you are not benefiting from treatment.

CANCELLATIONS If you find it necessary to cancel a scheduled appointment, 24 hrs. notice is required. When less than 24 hrs. notice is given, you will be responsible for a missed appointment fee. Missed appointment fees are not covered under any insurance. We reserve the right to charge the full amount of the therapeutic session in some circumstances. However, the standard missed appointment fee will be $25. In case of a serious emergency, if you notify us immediately, we will reschedule your appointment without additional charge. **We reserve the right to not reschedule after 3 missed appointments without early or prior notice.**

EMERGENCIES & AFTER HOURS CARE If known ahead of time you must discuss any expectations you have for emergency treatment with your therapist and agree to develop and follow a written step-by-step crisis plan. You should also be aware that you will be charged for after-hours care, whether on the phone or in person. If the need for crisis care arises unexpectedly you may call and leave your therapist a voicemail message which is accessed daily. If your crisis needs immediate attention, please proceed to the nearest hospital emergency room or call **Netcare at (614) 276-2273; the Suicide Prevention line at (614) 221-5445; Dublin Springs at 614-344-7486 or Riverside Crisis Line at (614) 566-5056. In Pickaway or Ross County- SPVMHC at 740-773-4357**

Our general philosophy regarding emergencies is that clients are assumed to be self-responsible (i.e. autonomous, functioning, not in need of day to day supervision). In addition, as private practice clinicians we cannot assume responsibility for our client's day to day functioning as can an institution nor can we be available for 24-hour per day crisis care.

PROTECTED HEALTH INFORMATION RECORDS

You should be aware that, pursuant to HIPAA, your therapist will keep Protected Health Information (PHI) about you in two sets of professional records. One set constitutes your Medical Record, the other is the therapist's Psychotherapy Notes.

Your Medical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that are set for treatment, your progress towards those goals, your medical and social history, any psychological testing, your treatment history, any past treatment records that are received from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself or others, you may examine and/or receive a copy of your Medical Record if you request it in writing and the request is signed by you and dated not more that 60 days from the date it is submitted. If we refuse your request for access to your Medical Record, you have a right of review, which we will explain at that time. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. You will be assessed a copying fee of $1 per page for the first 10 pages, $.50 per page for pages 11-50, and $.20 per page for pages in excess of 50 pages, as well as a records search fee of $15 plus postage.

Your therapist's Psychotherapy Notes are for the therapists own use and are designed to assist them in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of conversations, analysis of those conversations, and their impact on your therapy. They also contain particularly sensitive information that you may reveal that is not required to be

included in your Medical Record. These Psychotherapy Notes are kept separate from your Medical Record. While insurance companies can request and receive a copy of your Medical Record, they cannot receive a copy of your Psychotherapy Notes nor require your authorization to release them as a condition of coverage. Your insurance company cannot penalize you in any way for your refusal.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Medical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Medical Record is disclosed to others; requesting an accounting of disclosures of PHI; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement and our privacy policies and procedures. Your therapist will be happy to discuss any of these rights with you. A full list of your rights is listed on our website and posted in the office.

FEES

- Individual, marital or family therapy is $115 for a 45 minute session (clinical hour), $143.75 for a 60 minute session, and $172.50 for a 75 minute session, $201.25 for a 90 minute session and $287.50 for a 120 minute session. Please note that most initial counseling sessions are 90 minutes or $201.25. A standard session will last 45 minutes.
- Group Therapy is $75 for a 2 hour group session, $60 for a 90 minute group session and $45 for a 60 minute group session.
- The following professional activities are billed for at $115 per hour and prorated to 15 minutes increments ($28.75): 1) unscheduled phone consultations; 2) report preparation, letters on your behalf, completing disability papers; 3) consultation with third parties (i.e. school guidance counselor, psychiatrist, medical doctors); 4) for work outside the office, such as attending a deposition, or on-site school visit, we charge from door to door - that is from the time we left the office until we return; 5) significant reading of materials submitted by you or third parties regarding your care, and 6) appearances in court.
- Psychological testing. There will be a charge for the administration of the test as well as scoring and interpretation. This fee will be based upon the complexity of the test administered and time involved in scoring and interpreting. Your counselor will advise you of any fees prior to the administration of the testing. Additional time involved in interpreting or sharing test results with third parties will be pro-rated to our standard fee.

PAYMENTS Payment at each session is expected. As a general rule, health insurance does pay a portion of fees submitted. Until we have written documentation from your insurance company that your insurance deductible is met, we ask that you pay the full fee, based on personal insurance mandates, at each visit. After your deductible has been met, we ask that you pay the amount not covered by your insurance at the time of each session. If necessary, special payment arrangements can be made with your therapist. We offer Mastercard, Visa, and Discover for your convenience. We do require a $30.00 returned check fee.

The billing cycle ends with the third Saturday of each month. Statements are mailed for your payment during the last week of each month. Any payments made after the third Saturday of each month may not appear until the following month's statement. You are responsible for paying the "Your Portion Due" category on the statement. If payment is not received within 30 days, you will be charged a finance charge on the following statement. If you do not pay by the following month (net 60 days), you will receive another finance charge. If you have not paid by the final month (net 90 days) you will receive another finance charge and a final notice for collections from the billing office.

After your last visit with your therapist, we expect you to be current in having paid your co-payments, deductibles and missed appointment fees. After reasonable efforts to collect from you have been made, we do reserve the right to turn your account over to a collection agency. This is a measure of last resort on our part and is made only when we think a client has not made a good faith effort to pay on their account. If you are having difficulty paying, please contact our office to make arrangements so we can work with you.

PRIVATE PAY It may be to your benefit to not use any insurance benefits, due to the following reasons: 1) PRIVACY**.** Many insurance companies ask for your complete medical record and this is kept in their computer database. We have no control over how this information is used or who has access to it. Therefore, we cannot guarantee confidentiality on any information released to your insurance company. 2) You have complete CONTROL (*except the standard confidentiality exceptions)* over all information about you, who has it and what is done with that information. 3) You receive NO psychological DIAGNOSIS that anyone else is aware of (when you use insurance a diagnosis has to be submitted to them). 4) You have CONTROL over the frequency of your sessions and how long you feel you need to come.

INSURANCE If you have health insurance, part of your therapy expenses may be covered. ***You should contact your insurance company to understand your benefits. All EAP services require pre-authorization! It is your responsibility to obtain the initial authorization in a timely manner.*** If an EAP authorization is not obtained, we will bill your health insurance or bill your directly for services used. Your health insurance policy is a contract between you and your insurance company. We are obligated to comply with terms of your coverage. When you call them please ask the following questions about your outpatient mental health care coverage:
1) Is Arbor Counseling, my specific therapist or his/her supervisor a provider on your plan?
2) If no, how much do you pay for out-of-network visits?
3) What is my copay?
4) What is my deductible and has any of it been met?
It is very important that you understand that the total bill is your responsibility. Any dispute over payments received from the insurance company will be your responsibility to resolve with them. Any amount disputed by the insurance company will need to be paid by you and if the insurance problem is resolved later and a payment is sent to us, we will return it to you. You should also be aware that your contract with your health insurance company requires that we provide them with information relevant to the service provided to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional information such as treatment plans or summaries, or copies of your entire medical 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, we 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. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

SESSION ETIQUETTE We make our best efforts to begin and end each session on time. When you arrive, it is not necessary to sign in. Please have a seat in the waiting area and your therapist will come out to meet you. A restroom is located directly down the hallway. We ask that you not bring additional children to the office without consulting with your counselor.
Please note for the Circleville/Arbor South location: We share this space with a school and child care center. To comply with government and safety regulations, we ask that you only use the restroom set aside for Arbor Counseling and do not walk around the building unescorted during school hours. **A violation of this policy will result in a necessity to transfer your services to a different location.**
You will enter the building through the door by the café. This is located to the right of the main entrance doors if you are looking at the building. To comply with the above mentioned regulations, you may not be able to access the building during school hours. If the building is locked, you may be asked to wait in the courtyard or your vehicle until your counselor can let you in the building. If you can access the building, we ask that you enter our suite and just have a seat in the waiting area until your counselor is available. We appreciate your understanding in this arrangement.

SATELLITE OFFICES We use space in local churches/facilities for our satellite offices. Arbor Counseling LLC is a distinct and separate entity from these facilities. The church/satellite facility is no way responsible for the actions of Arbor Counseling LLC. Likewise, Arbor Counseling LLC is not liable or responsible for the actions of the church/satellite facility.

DIVORCED/DIVORCING PARENTS We require a copy of the final or most recent divorce decree indicating medical rights for children that enter treatment. In order to continue treatment, this form needs to be given to your therapist on or before your child's second session.

**Please note that only a legal parent or guardian can sign the consent form. A step parent cannot give consent unless granted this privilege as evidenced by the court order or other binding legal document.

Unless otherwise indicated in the court order, we are required to inform both parents of the child(ren)'s involvement in counseling. You will be asked to give contact information for the other parent regardless of their agreement with the counseling. If you refuse, you will be asked to sign a form indicating your refusal which will be included in the child(ren)'s medical record.

As a policy, we will not become involved between divorced or divorcing parties regarding payments. We will follow your court order regarding payments. However, in cases where one party does not pay their portion of the bill, we look only to the custodial parent or legal guardian who signs this policy statement and intake/consent forms for full payment (regardless of any court ordered arrangements) unless the non-custodial parent has made payment arrangements with Arbor Counseling. If it is helpful, we can send duplicate statements to both parties.

For custody related matters, as a policy, we do **NOT** make recommendations related to custody or become involved in custody disputes as this interferes with the therapeutic relationship with the child(ren). We will be happy to offer contact information to someone who specializes in such matters. We can, on a case by case basis, make statements based on the therapeutic observations, diagnosis and treatment of the child and information presented in sessions to professional parties such as a guardian ad litem as long as it does not interfere with the therapeutic relationship of the child(ren) involved.

NOTICE

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SIGNATURE PAGE

☐ **Yes** ☐ **No** I have received a copy of the Arbor Counseling LLC Client Information and Policy Statement including summary information from the Health Insurance Portability and Accountability Act (HIPAA).

☐ **Yes** ☐ **No** I agree that Arbor Counseling LLC can provide the requested information to my health insurance carrier.

In addition, I understand that I am solely responsible for all financial charges regardless of potential reimbursement by an insurance company or any other third party. I agree to be treated at Arbor Counseling LLC under the terms of the Arbor Counseling LLC Client Information and Policy Statement, Version 9, 2017 including the Health Insurance Portability and Accountability Act policies. For children: I agree that I am the legal parent/guardian and give my consent that my child can be treated at Arbor Counseling LLC under the same terms and conditions listed above.

CLIENT PRINTED NAME _____

CLIENT/PARENT/GUARDIAN SIGNATURE _____ **DATE** _____