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# Client Information and Acknowledgment of Informed Consent to Treatment

I am an Ohio Licensed Independent Social Worker with a Supervision designation and am engaged in private practice providing mental health services to the public.

*Mental Health Services*

The purpose of mental health services is to help you better understand your situation, change your behavior, or move toward resolving your difficulties. Using my knowledge of human development and behavior, I will make observations about situations and help you to develop new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur.

The services offered can have risks as well as benefits. Treatment often involves discussing unpleasant issues, and you might experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health care may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

*Appointments*

Appointments are made by calling (513) 310-6755. **Please call to cancel or reschedule at least 24 hours in advance, or you will be charged $50.00 for the missed appointment unless I determine an emergency was involved.** Third party payers will not cover or reimburse for missed appointments. Appointments are 45 minutes in length, but session length may vary for clinical reasons. The number of appointments depends on many factors and we will discuss this as part of your treatment planning. Since there is no way a therapist can see another client when they have a late arrival, no reductions are provided when a client arrives late for an appointment. Some insurance companies will only pay for the actual time during which services are rendered. In that case you, the client, will be billed for the portion of the appointment time when no services could be rendered. In some cases governmental insurance or employee assistance programs do not allow billing for missed or partially missed appointments and if that is the case you will be billed in accordance with those programs' rules.

*Relationship*

My relationship with clients is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Please do not attempt to "friend" me on Facebook or on any other social media site.

*Goals, Purposes and Techniques*

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment I recommend and to have input into setting the goals of your therapy. As therapy progresses these goals may change. You and I will jointly determine how to effect the changes you are seeking to make for yourself. You always have the opportunity to seek either another opinion or a different therapist. I will let you know if I feel that we are not a good fit or if you might obtain better help elsewhere. I will always retain the right to terminate my therapy with you in the event that I feel you would be better served elsewhere, if I feel you are not complying with treatment requests, or if payments due to me remain unpaid. In the event that I terminate services with you I will offer you referrals.

*Confidentiality*

Laws protect the privacy of all communications between a client and a therapist. In most situations I can only release information about your treatment to others if you sign a written authorization. There are some situations where I am permitted or required to disclose information either with or without your consent or authorization. For example:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, I cannot provide such information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order me as your therapist to disclose information;
- If a government agency is requesting the information, I may be required to provide it;
- If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend myself;
- If you file a worker's compensation claim, I may be required, upon appropriate request, to provide a copy of your records, or a report of your treatment.

There are some situations in which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm, and in such cases I might have to reveal some information about your treatment. If such a situation arises, I will make every effort to fully discuss it with you before taking any action, if I deem that to be appropriate under the circumstances, and will limit disclosure to what is necessary. For instance:

- If I have reason to believe that a child, a developmentally or physically disabled or elderly adult is being neglected or abused, the law may require me to report that information to the appropriate state or local agency;
- If I believe you present a clear and substantial danger of harm to yourself and/or others, I may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and/or notifying the police.

You agree that I may release information about your claim(s) to the Ohio Department of Insurance in connection with any insurance company's failure to properly pay a claim in a timely manner as well as to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.

You agree that from time to time I may have the need to consult with my practice attorney regarding legal issues involving your care (this is an infrequent occurrence, but does happen from time to time). My practice attorney is bound by confidentiality rules also. In addition, I will reveal only the information that I need to reveal to receive appropriate legal advice in connection with those contacts.

You should be aware that I may practice with other health professionals and that I may employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as typing, scheduling, billing, and quality assurance and you agree that I may do that. If I do that I will only release the information necessary in order for me to provide help to you, the client. All of the health professions will be bound by the same rules of confidentiality. All staff members will have been given training about protecting your privacy and will have agreed not to release any information outside of the practice without the permission of a professional staff member.

Also, I may have a contract with a collection agency. I will have a formal business contract with this business, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed or is required by law.

In addition, I may have a contract with a billing service. I will have a formal HIPAA business associate contract with this business, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed or is required by law.

This summary is designed to provide an overview of confidentiality and its limits. It is important that you read the Notice of Privacy Practices form that has been provided to you for more detailed explanations, and that you discuss with me any questions or concerns that you have.

*Legal Situations*

If you or the client becomes involved in legal proceedings that require my participation you will be expected to pay for all of my professional time, even if I am called to testify by another party. I will ask that a retainer be paid of half of the expected fees at least one week prior to providing these services, and the second half of expected fees and any additional fees that may have been accrued be paid within one week after services are delivered. Any unused amounts will be refunded. My professional time for legal proceedings may include preparation (document review or letter preparation), phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that I wait in court prior to or after I may be called to testify). Due to the time-consuming and often difficult nature of legal involvement, I charge $200.00 per hour for these services. You will also be responsible for any legal fees that I may incur in connection with the legal proceeding, which may include responding to subpoenas.

Please be advised that as a treating therapist I cannot ethically provide any recommendations on guardianship, custody, visitation, parenting capacity or abilities or what is in the best interest of the child(ren) if you or your child(ren) are involved in custody/divorce/guardianship proceedings. You will need to hire an independent mental health professional for any evaluation or testimony you require. Being a witness or expert legal proceedings can have many risks to the therapeutic relationship. It is my policy to avoid being involved in legal proceedings if at all possible to protect the integrity and confidentiality of the therapist/client relationship and to avoid dual roles.

*Professional Records*

The laws and standards of my profession require that I keep Protected Health Information about you in your client file. Your client file may include information about your reasons for seeking therapy, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of all of your records that I have prepared in connection with your treatment if you request them in writing, unless I determine for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, and in that event I may exercise the option of turning the records over to another mental health therapist designated by you. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, I therefore recommend that you initially review them with me, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so I will let you know what the charge is at the time that a records request is made. If you desire to have the information sent to you electronically, if I maintain the information in an electronic format, I will provide the information in that format if you agree to accept the potential risks involved in sending the information that way.

As your therapist, I may also keep a set of psychotherapy notes which are for my own use and which are designed to assist me in providing you with the best treatment. These notes are kept separate from the rest of your records. In order for psychotherapy notes to be released to third parties, you must sign a separate authorization in addition to one for the rest of your records. I will discuss with you whether or not I am maintaining psychotherapy notes on you.

*Fees, Payments, and Billing*

Payment for services is an important part of any professional relationship. This is even more true in therapy; one treatment goal is to make relationships and the duties and obligations they involve clear. You are responsible for seeing that my services are paid for. Meeting this responsibility shows your commitment and maturity.

My current regular fees are as follows. You will be given advance notice if my fees should change. Regular therapy services are $150.00 for the first diagnostic session, with following sessions at $140.00 for each 50 minute session. Longer sessions will incur higher costs. Please pay for each session before or at its end. I have found that this arrangement helps us stay focused on our goals, and so it works best. It also allows me to keep my fees as low as possible because it cuts down on my bookkeeping costs. I suggest you make out your check before each session begins, so that our time will be used best. Other payment or fee arrangements must be worked out before the end of our first meeting.

Telephone consultations: I believe that telephone consultations may be suitable or even needed at times in our therapy. If so, I will charge you my regular fee, prorated for the time needed. If I need to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about this, please be sure to discuss it with me in advance so we can set a policy that is comfortable for both of us. Of course, there is no charge for calls about appointments or similar business issues. Insurance companies will typically not provide reimbursement for telephone consultations.

Extended sessions: Occasionally it may be better to go on with a session, rather than stop or postpone work on a particular issue. When this extension is more than 10 minutes I will tell you, because sessions that are extended beyond 10 minutes will be charged on a prorated basis. Insurance may not pay for the extended portion of a session.

Reports: I will not charge you for my time spent making routine reports to your insurance company.

If you think you may have trouble paying your bills on time, please discuss this with me. I will also raise the matter with you so we can arrive at a solution. If your unpaid balance reaches $300.00, I will notify you by mail. If it then remains unpaid, I may stop therapy with you if we cannot agree on a payment plan. Fees that continue unpaid after this may be turned over to small-claims court or a collection service and you agree to allow me to do that. If I choose to do that I will report only enough information to collect fees due to me.

A late payment fee of $25.00 will be charged each month that a balance remains unpaid, since I will incur costs to rebill and other accounting costs. A returned check fee of $35.00 will be charged if your check bounces.

Because I am a licensed mental health therapist, many health insurance plans will help you pay for therapy and other services I offer. Because health insurance is written by many different companies, I cannot tell you what your plan covers. Please read your plan's booklet under coverage for "Outpatient Psychotherapy" or under "Treatment of Mental and Nervous Conditions." Or call your employer's benefits office to find out what you need to know.

If your health insurance will pay part of my fee, I will help you with your insurance claim forms. However, please keep two things in mind: 1. I had no role in deciding what your insurance covers. Your employer or you (if you have individual coverage) decided which, if any, services will be covered and how much you have to pay. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth.

Your insurance contract is between you and your insurance company; it is not between me and the insurance company unless I have signed a separate agreement with that particular company. You are responsible for paying the fees we agree upon. If you ask me to bill a separated spouse, a relative, or an insurance company and I do not receive payment on time, I will then expect this payment from you and you agree to pay amounts due. In addition, the plan may have rules, limits, and procedures that we should discuss and I may not be on one of their panels. Please bring your health insurance plan's description of services to one of our early meetings, so that we can talk about it and decide what to do.

I will provide information about you to your insurance company with your consent, and by signing below you agree that I may do that. If I have a contract with your insurance company then billing will be sent in accordance with the contract I have with that company. If I am not contracted with that insurance company then I will supply you with an invoice for my services with the standard diagnostic and procedure codes for billing purposes, the times we met, my charges, and your payments. You can use this to apply for reimbursement. By signing this form you agree to assign any reimbursement you receive from your insurance company to me.

If you choose to not have me send information to your insurance company, you must select this option before each session and then pay for the session in full. I will then not report any information to your insurance company about that session. Although insurance companies say that they maintain confidentiality, oftentimes they report information to a national data bank that may later affect your ability to obtain other types of insurance.

*Minors*

If you are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order or if I feel that the release of your records to your parents might have an adverse effect on you, in which case they can name another mental health therapist that I will have to turn them over to. Before giving parents any information I will discuss the matter with you, if possible, and do my best to handle any objections you may have. Except in unusual circumstances, I like to make both parents aware of and involved in the treatment. In addition, if one parent brings in a child and the therapy only involves the child, under Ohio law since generally both parents have access to the child's records unless that access is blocked by a court order, anything that either parent says in the sessions is available to both parents. Legal documents need to be provided in cases where custody, visitation, shared parenting, guardianship or other matters which are covered by court documents are involved before I see a minor for treatment. Minors 14 years of age and older should be aware that they have an option to see me on a limited basis without their parents' knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of my intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option.

*Emergencies and After-Hours Care*

I may be reached at (513) 310-6755. I will make every effort to return messages within 24 hours; however, I may not always be able to do that. Current clients will be notified during

sessions of upcoming travel or vacation. If you have an emergency you should go directly to a hospital emergency department or call 911. Emergencies are urgent situations and require your immediate action.

*Incapacity or Death of Therapist*

In the event that I am incapacitated or die, it will be necessary for another therapist to take possession of your file and records. By signing this form you consent to allow another licensed mental health professional whom I designate to take possession of your file and records, provide you with copies upon request, or to deliver them to a therapist of your choice.

*Disclosing Information to Family Members, Relatives, or Close Friends*

_____By initialing this section you agree to allow me, if you are incapacitated, in an emergency situation, or are not available, to contact a family member, a relative, a close friend or any other person you identify, and disclose your personal health information that directly relates to that person's involvement in your healthcare, This information will be disclosed as necessary only if I determine that it is your best interest based on my professional judgment.

*Email, Texting, and Electronic Communications*

I do not like to use e-mail, texting, or electronic communications unless we both agree that is appropriate. If you decide you want to utilize any form of electronic communication you acknowledge that there are confidentiality risks inherent in such communications if they are unencrypted and you agree to accept those risks. If you wish to use unencrypted electronic communications, please place your initials in the space below:

_____By initializing this section you agree that you understand the risks involved in unencrypted electronic communications and agree to accept such risks in communications from either me to you or you to me that involve scheduling and/or therapy.

*Acknowledgment of Informed Consent to Treatment*

**I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize you to provide such care, treatment or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company, third party payer, to obtain reimbursement unless I direct otherwise.**

**I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through you at any time. I also understand that there are no guarantees that treatment will be successful.**

**By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything**

unclear to me. If a minor is the client I am signing on behalf of the minor as the authorized parent/guardian. (Information on Minor rights will be shared with the minor)

I also acknowledge that I have received a copy of the Notice of Privacy Practices for the mental health therapist listed at the top of this form.

Client Name(s) (please print)

_____

_____

Client(s) Signature

_____ _____ Date

_____ _____ Date

Parent(s) or Guardian Signature (for minor child or children or disabled adults)