COUNSELING FOR
GROWTH & CHANGE, LC

Child Registration Intake Packet

Counseling for Growth and Change, L.C.

Registration Information – Minor

Name of Minor: _____ Today's Date: _____

MINOR (CLIENT):

Home Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Soc. Sec. #: _____

Date of Birth: _____ Age: _____ Grade level: _____

School: _____ Favorite Activity: _____

Who does the minor live with? (Biological parent, foster family, other family member?)

_____

PCP Name: _____ Medications: _____

_____

Physical Illnesses: _____ Allergies: _____

BIOLOGICAL/ADOPTIVE PARENTS:

Mother's Name: _____ Social Security #: _____

Home Address (*if different from above*): _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone _____

Date of Birth: _____ Age: _____ Occupation: _____

Employer: _____ Emp. Address: _____

Father's Name: _____ Social Security #: _____

Home Address (*if different from above*): _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone _____

Date of Birth: _____ Age: _____ Occupation: _____

Employer: _____ Emp. Address: _____

BIOLOGICAL/ADOPTIVE SIBLINGS:

Name: _____ Age: _____ DOB: _____ Sex: _____

Name: _____ Age: _____ DOB: _____ Sex: _____

Name: _____ Age: _____ DOB: _____ Sex: _____

Name: _____ Age: _____ DOB: _____ Sex: _____

Name: _____ Age: _____ DOB: _____ Sex: _____

Name: _____ Age: _____ DOB: _____ Sex: _____

(Next page please)

Counseling for Growth and Change, L.C.

PAYMENT INFORMATION

___ I will be personally responsible and privately paying for charges of therapeutic services.
___ I will be paying for therapeutic services with my insurance. (Please complete following information on insurance.).

INSURANCE (a copy of your card is required, please)

Primary Insurance Company Name:	Secondary Insurance Company Name (if any):
_____	_____
Subscriber Name: _____	Subscriber Name: _____
Subscriber Birthdate: _____	Subscriber Birthdate: _____
Subscriber #: _____	Subscriber #: _____
Group #: _____	Group#: _____
Co-payment: $_____	Co-payment: $_____

INSURANCE PAYMENT AUTHORIZATION

I hereby direct my insurer to pay directly to Counseling for Growth & Change, LC., and/or my therapist all benefits due them as a result of claims for my therapeutic services. Although covered by insurance, I am aware that I am personally responsible for all charges. A photo static copy of this authorization will be valid as the original.

Signature of Parent/Legal Guardian: _____ Date: _____

INSURANCE RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize Counseling for Growth & Change, LC., and/or my therapist to release information concerning my present illness to insurance carrier for the purpose of processing my claims. A photo static copy of this authorization will be valid as the original.

Signature of Parent/Legal Guardian: _____ Date: _____

CANCELLATION POLICY

My therapist has reserved time to work with me, so I agree to contact this office 24 hours in advance of any necessary rescheduling or cancellation. Failure to provide such notice will result in a cancellation fee, and I understand I am responsible for payment of that fee.

Signature of Parent/Legal Guardian: _____ Date: _____

(Next page please)

Counseling for Growth and Change, L.C.

Assessment Information - Minor

Minor's Name: _____ Today's Date:_____
Minor's Date of Birth: _____ Age: _____ Grade in School: _____

Who referred you to this office? _____

Please place an "X" by the answer that is closest to describing your situation and/or fill in the blanks where necessary. Thank you.

1. What are your current concerns related to the minor today?

_____
_____
_____

2. What is the quality of your family relationships at this time?

_____
_____

3. Are there school issues that you are concerned about? If so, please describe.

_____
_____

4. Are there drug/alcohol issues related to the minor? If so, what are they?

_____
_____

5. Is your family involved with the Department of Human Services or Juvenile Court? If so, how and why? _____
_____

6. What problem(s) bring(s) the minor to counseling?

_____ Depression
_____ Family
_____ School
_____ Sexual Abuse
_____ Physical Abuse
_____ Divorce/Separation
_____ Anxiety
_____ Adjustment
_____ Grief
_____ Criminal charges
_____ Other issues (please describe in as much detail as possible): _____
_____
_____

(Next page please)

7. Are the minor experiencing any of the following?

_____ Guilt	_____ Poor appetite	_____ Fatigue
_____ Panic/Anxiety	_____ Loss of interest	_____ Irritability
_____ Sexual issues	_____ Trouble concentrating	_____ Worry
_____ Trouble sleeping	_____ Feelings of hopelessness	_____ Aggression
_____ Wetting/Soiling	_____ Tantrum behavior	_____ Poor memory
_____ Touching others inappropriately		_____ Poor boundaries with others

Other significant problems/behaviors, please explain: _____
_____
_____

8. Has the minor participated in counseling before? If so, with whom, and for how long? _____. When? _____
For what issues? _____

9. Have others in the minor's family received counseling services before today? If so, where and when? _____ What other family members were involved in the counseling sessions? _____
_____

10. Is the minor taking any medications currently? _____ Yes _____ No
If yes, what kind (please include name & dose of medication)? _____
_____
_____
Who is prescribes this medication? _____

11. Do anyone in the minor's family have issues with drugs/alcohol? If so, please describe:
_____
_____

12. Is there a family history of mental health issues, drug and alcohol use, domestic violence or criminal activity? If so, please describe: _____
_____
_____

13. Is there anything else about your child and your family that might be helpful to the counseling process? If so, please describe: _____
_____
_____

_____ _____ _____
Parent/Legal Guardian's signature Date Relationship to child

Counseling for Growth & Change, LC

1248 8th Street, Suite 201
West Des Moines, IA 50265
Phone: 515.243.1020
Fax: 515.883.1946

915 8th Street, Suite109
Boone, IA 50036
Phone & Fax: 515.432.8687

Client Rights & Responsibilities

- Clients have the right to be treated with personal dignity and respect.
- Clients have the right to care that is considerate and respects members' personal values and belief system.
- Clients have the right to personal privacy and confidentiality of information.
- Clients have the right to receive information about managed care company's services, practitioners, clinical guidelines, and client rights and responsibilities.
- Clients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Clients have the right to participate in an informed way in the decision making process regarding their treatment planning.
- Clients have the right to discuss with their providers the necessary treatment options for their condition.
- Clients have the responsibility to follow their agreed upon treatment plan and instructions for care.
- Clients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with their provider mutually agreed upon treatment goals.
- Clients have the right of members' families to participate in treatment planning as well as the right of members over 12 years old to participate in such planning.
- Clients have the right to individualized treatment, including
    - Adequate and humane services,
    - An individualized treatment or program plan,
    - Periodic review of the treatment or program plan, and
    - Competent, qualified, and experienced professional clinicians to supervise and carry out the treatment plan.
- Clients have the right to participate in the consideration of ethical issues that arise in the provision of care and services, including
    - Resolving conflict.
- Clients have the right to designate a surrogate decision-maker if the member is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
- Clients and their families have the right to be informed of their rights in a language they understand.
- Clients have the right to voice complaints or appeals regarding managed care company or the care provider.
- Clients have the right to make recommendations regarding managed care company rights and responsibilities policies.
- Clients have the responsibility to give their provider and managed care company information needed in order to receive care.

Client Signature:_____ Date: _____

Counseling for Growth & Change, L.C.
1248 8th Street,
Suite 201
West Des Moines, IA 50265
515.243.1020

Notice of Psychotherapist's Policies & Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE VIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Questions

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
  - *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health professional.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.
- *"Authorization"* is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided

each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may release PHI to a third-party payor or peer review organization with the prior written consent of you or your legal representative. I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse - If I reasonably believe a child, whom I am treating, has been abused, I must report this belief to the appropriate authorities as required by law.
- Adult and Domestic Abuse - If I suspect that a dependent adult has been abused, I must report this suspicion to the appropriate authorities as required by law.
- Health Oversight Activities - If I receive a subpoena from my licensing board (such as the Iowa Board of Psychology Examiners) for protected health information regarding you, I must comply with that subpoena and disclose that information to the Board.
- Judicial and Administrative Proceedings - If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- ***Serious Threat to Health or Safety*** - If I believe you present a clear, imminent risk to another, I may disclose information necessary to seek hospitalization or otherwise protect that individual. If I believe there is a clear and imminent risk that you will harm yourself, I may disclose information necessary to seek hospitalization for you or to alert family members or others who have the ability to protect you.
- Worker's Compensation - I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Client's Right's and Psychotherapist's Duties

Client's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will post the revisions and will provide you with a copy upon request.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact:

Greg Febbraro, PhD. who is the HIPAA Privacy Officer for Counseling for Growth & Change, L.C. He can be reached at 515.243.1020. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice went into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. Whenever the Notice is revised it will be available upon request and all posted Notices will be replaced with the new Notice.

6/15/10

Counseling for Growth & Change, LC

1248 8th Street, Suite 201
West Des Moines, IA 50265
Phone: 515.243.1020
Fax: 515.883.1946

915 8th Street, Suite109
Boone, IA 50036
Phone & Fax: 515.432.8687

Acknowledgement of Receipt of Provider's Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of Counseling for Growth & Change, LC's Notice of Privacy Practices which summarizes the ways my identifiable health information may be used and disclosed by this Provider and states my rights with respect to my medical information. I understand this Provider has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event this Provider revises its information practices, a revised Notice will be posted at 6959 University Avenue, Windsor Heights, IA 50324 and that I may obtain a current Notice of Privacy Practices at any time from Counseling for Growth and Change, LC.

_____ _____
Signature of Patient or Guardian/Representative Date Signed

_____
If Guardian/Representative- State Relationship to Patient

_____ _____
Signature of Witness Date Signed

8/1/11

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THERAPIST - CLIENT SERVICE AGREEMENT

This document contains important information about the professional services and business policies for Counseling for Growth & Change, L.C. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), which is a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) that is used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time.

When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me 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 incurred.

PSYCHOTHERAPY SERVICES

Psychotherapy varies depending on the personalities of the psychotherapist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life. You may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. 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.

MEETINGS

I normally conduct an evaluation that will last from two to four sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule a session of one appointment hour of 45 minutes duration at a time we agree on. The frequency and duration of these sessions will be discussed with your input. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. Please refer to the Cancellation Policy. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee is $198 for the initial session, $88 for a 30 minute individual session, $165 for a 45 minute individual session, and $248 for 60 minute individual session. In addition to weekly appointments, I charge $75 per hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than ten minutes, consulting with other professionals with your permission, preparation of records or treatment

summaries, and the time spent performing any other service you may request of me (e.g., attending meetings or school staffings). If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $195 per hour for preparation and attendance at any legal proceeding. If you cancel an appointment with less than 24 hours notice or do not show for an appointment, I may charge you a late cancellation fee of $55. As previously mentioned, insurance companies do not provide reimbursement for cancelled sessions.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 8 AM and 5 PM, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by a receptionist or voice mail. I will make an effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, the nearest emergency room, and/or the crisis telephone numbers you have been provided. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

EMAIL

You should be aware that while email can be a quick and convenient medium of communication, we cannot guarantee that information emailed to us is secure or confidential. In addition, emails sent or received between us will be printed and kept in your clinical records. Furthermore, any communication by email with other individuals or agencies (e.g., your family physician, school, your attorney) involved in your case will also be printed and kept in your clinical records. By signing this document you indicated your understanding of the above.

SOCIAL/BUSINESS NETWORKING SITES

Your psychotherapist will not accept “friend” or “contact” requests on any social or business networking sites. Adding clients as “friends” or “contacts” can compromise your confidentiality and our privacy. If you have concerns or questions, please bring them up with your psychotherapist.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a mental health professional. In most situations, I can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA and/or Iowa law. However, in the following situations, no authorization is required:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- I also have contracts with bookkeeping and typing services. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided, such information is protected by the psychotherapist-client privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, I must, upon appropriate request, provide any information concerning the employee's physical or mental condition relative to the claim.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I have reasonable cause to believe that a child I have provided professional services to has been abused or if I suspect that a dependent adult has been abused, the law requires that I file a report with the appropriate government agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- If a client communicates an imminent threat of serious physical harm to an identifiable victim, I may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- If a client communicates an imminent threat of serious physical harm to him/herself, I may be required to disclose information in order to take protective actions. These actions may include initiating hospitalization or contacting family members or others who can assist in providing protection.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I may keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It 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 we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive 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 and others or makes reference to another person (unless-such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me by others confidentially, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $1.00 per page (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Records, you have a right of review except for information supplied to me confidentially by others, which I will discuss with you upon request.

In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. They also may include information from others provided to me confidentially. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; 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, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of your treatment when it is complete. Any other communication will require your Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify your parents of my concern. Before giving your parents any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If the client is under 18 years of age and not emancipated, the same expectations for billing and payments as indicated above apply with the added stipulation that the parent who brings the child to the appointment is responsible for payment or co-payment. In the case of separated or divorced parents where one parent is court-ordered to pay for services, a copy of this document (in its entirety) is required before this information can be used for billing purposes.

If your account has not been paid for more than sixty (60) days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

It is important to remember that you always have the right to pay for my services yourself to avoid the problems described below. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administrator.

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 authorization before they 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 clients 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 your contract with your health insurance company requires that you authorize me to provide it with information relevant to the services that I provide to you. If you are seeking reimbursement for services under your health insurance policy, you will be required to sign an authorization form that allows me to provide such information. I am required to provide a clinical diagnosis. Sometimes, I will be requested to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. This may require an additional authorization. (If you refuse such authorization, the insurance company can deny your claims and you will be responsible for paying for services yourself.) In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Signature of Client/Guardian/Representative Date Signed

_____

If Guardian/Representative-State Relationship to Client

3/18/15