Informed Consent Service Agreement

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

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

I. PSYCHOLOGICAL SERVICES

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

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

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

II. APPOINTMENTS

Appointments will ordinarily be 60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone.

If you need to cancel or reschedule a session, I ask that you provide 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the full amount of your session (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. **You're also responsible for coming to your session on time; if you are late, your appointment still needs to end on time.**

III. PROFESSIONAL FEES

The standard intern/LMSW fee for the initial intake is $125 and each subsequent session is $100. You are responsible for paying at the time of your session unless prior arrangements were made. LCSW rates are $175 for biopsychosocial and $150 for subsesquent sessions. Couple rates for LCSW is $250. LCSW Group rates are $25 per person.

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

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

IV. INSURANCE

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

Due to the rising costs of healthcare, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health

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

You should also be aware that most insurance companies require your authorization to provide a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-IV. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable). Sometimes I must provide additional clinical information such as treatment plans or summaries or copies of the entire record (in rare cases). 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 database. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

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

Many policies leave a percentage of the fee (co-insurance) or a flat dollar amount (co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by credit card. Payments are processed through all major credit cards through our secure client portal via Simple Practice or in person in order to ensure the safety of all personal information. In addition, we also accept payments through both HSA (Health Savings Account) and FSA (Flexible Spending Account).

Some insurance companies may also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year.

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

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

V. PROFESSIONAL RECORDS

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

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

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

VI. CONFIDENTIALITY

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

VII. PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent.

For children 14 and older, I request an agreement between the child and parents to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication requires the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions). In this case, I will make every effort to notify the child of my intention to disclose information and handle any objections raised.

VIII. CONTACTING ME

The best way to contact me is by phone or email at marissa.collier@sgmentalhealthcounseling.com, and by phone at (850) 404-3639.

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

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

IX. OTHER RIGHTS

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

X. CONSENT TO PSYCHOTHERAPY

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

_______________________________ _______________________________

Client Name Date

Signature of Client/Guardian Date

HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

“Protected health information“ (PHI) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payment for the provision of health care.

<u>Your Rights Regarding Your PHI</u>
You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we’ve shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

<u>Our Uses and Disclosures</u>
We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with laws that may be in place now or in the future

<u>Your Rights</u>
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at **marissa.collier@sgmentalhealthcounseling.com**
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Sharing of psychotherapy notes

Our Uses and Disclosures

IF you give us permission, how would we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: Your physician and I may need to coordinate your care.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Informed Consent Service Agreement

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

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

I. PSYCHOLOGICAL SERVICES

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

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

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

II. APPOINTMENTS

Appointments will ordinarily be 60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone.

If you need to cancel or reschedule a session, I ask that you provide 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the full amount of your session (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. **You're also responsible for coming to your session on time; if you are late, your appointment still needs to end on time.**

III. PROFESSIONAL FEES

The standard intern/LMSW fee for the initial intake is $125 and each subsequent session is $100. You are responsible for paying at the time of your session unless prior arrangements were made. LCSW rates are $175 for biopsychosocial and $150 for subsesquent sessions. Couple rates for LCSW is $250. LCSW Group rates are $25 per person.

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

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

IV. INSURANCE

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

Due to the rising costs of healthcare, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health

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

You should also be aware that most insurance companies require your authorization to provide a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-IV. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable). Sometimes I must provide additional clinical information such as treatment plans or summaries or copies of the entire record (in rare cases). 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 database. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

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

Many policies leave a percentage of the fee (co-insurance) or a flat dollar amount (co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by credit card. Payments are processed through all major credit cards through our secure client portal via Simple Practice or in person in order to ensure the safety of all personal information. In addition, we also accept payments through both HSA (Health Savings Account) and FSA (Flexible Spending Account).

Some insurance companies may also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year.

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

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

V. PROFESSIONAL RECORDS

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

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

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

VI. CONFIDENTIALITY

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

VII. PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website, **www.sgmentalhealthco.com.**

Acknowledgement

I hereby acknowledge receiving a copy of this notice.

______________________________ ______________________________

Client Name Date

______________________________ ______________________________

Signature of Client/Guardian Date

Effective date of this notice is **January 1, 2021**

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website, **www.sgmentalhealthco.com.**

Acknowledgement

I hereby acknowledge receiving a copy of this notice.

______________________________	______________________________
Client Name	Date
______________________________	______________________________
Signature of Client/Guardian	Date

Effective date of this notice is **January 1, 2021**

Authorization for Electronic Communication

As a convenience to me, I authorize SG Mental Health Counseling to communicate with me regarding my treatment via electronic communications (email or text message) and to transmit my protected health information electronically as described below.

I understand there are risks inherent in the electronic transmission of information by email or text message:

- Such communication does not provide a completely secure means of communication.
- Any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted.
- Electronic transmission of information cannot be guaranteed to be secure or error-free.
- Data may be vulnerable to access by unauthorized third parties.

As such, SG Mental Health Counseling shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by SG Mental Health Counseling to me.

Text Communication: ☐Yes ☐No
Authorized phone number(s):____

Email Communication: ☐Yes ☐No
Authorized email address(es):____

Other: ☐Yes ☐No
Authorized service(s):
____

Your treatment does not depend on consent. You have the right to terminate or amend this agreement at any time. The use of more secure communication methods, such as messaging through your TherapyAppointment Patient Portal or email are alternatives

always available if you elect to not give consent to any of the forms of communication listed below.

I understand that SG Mental Health Counseling may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to SG Mental Health Counseling in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

______________________________ ______________________________

Client Name Date

______________________________ ______________________________

Signature of Client/Guardian Date

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

_______________________________ _________________

Client Name Date of Birth

I, ____, hereby authorize SG Mental Health Counseling (hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

Name:	
Address:	
City:	
State:	
Zip Code:	
Contact Person:	
Phone Number:	
Fax Number:	

I am requesting this disclosure of information and records for the following purpose:

At the request of the individual Other:

The specific uses and limitations of the types of health information to be released are as follows: (Check all that apply)

Treatment Coordination	
Diagnostic	
Refinement	

Treatment Planning	
Other:	
Other:	

Such disclosures shall be limited to the following specific types of information:

Psychiatric Diagnosis (es)	
Dates of Treatment	
Treatment Summary	
Other:	
Other:	
Other:	

This authorization shall remain valid until:

Initial Treatment Plan	
Full Treatment Record	
Other:	
Other:	

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless the Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by the Provider to be effective.

Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Florida law may protect such information.

________________________ ________________________

Client Name Date

Signature of Client/Guardian Date

Financial Agreement and Fee Schedule

Charges for individual counseling are $125 per 60 minute session. Subsequent sessions are billed at $100 per 60 minute session. These rates are subject to change with the changing market and clients will be notified of any changes in rates. Group therapy rates vary by practitioner.

Insurance

Services may be covered in full or in part by your health insurance or employee benefit plan. Please check your coverage carefully by calling your insurance provider prior to setting up counseling. It is your responsibility to know your copay and deductible at your first session. By signing this form, clients agree to allow their therapist or billing agent to release information to their insurance provider to process claims. Clients also release insurance benefits to be paid to their therapist. Clients also agree to pay any portion not covered by their insurance carrier.

Reduced Fee

Reduced fee services are available on a sliding scale. You must talk to your therapist if this is needed.

Payment

Please come prepared to pay your deductible and copay. We appreciate our clients and hope that you will be happy with your services here. We ask that you show your appreciation by paying in a timely manner. Any returning clients with a past due bill will be asked to settle this bill before resuming counseling. This is your therapeutic experience and paying for services helps you take responsibility for your change!

Cancellation Policy

If you do not show up for your scheduled therapy appointment, and you have not notified us at least 24 hours in advance, you will be required to pay the full cost of the session. If you fail to attend your intake session you will be referred to a different counseling clinic, our time is very valuable as private practitioners.

Report Fees

Research, Reports, and letter writing on your behalf are $20/hour. Records requests require a handling fee of $100 and $2 per page due to the time it takes our therapists away from other clients to copy and compile these.

Court Fees

If we are required to testify in court you will be charged $200 /hour plus travel time and expenses due to the amount of time this takes from the clinic, other clients, and for preparation.

Any court ordered counseling will be exempt to insurance and the rate for court ordered counseling is$200/session. The fee for court reports is also $100/hour. Expect to give two weeks' notice for any of the above. In order to ensure our therapists are compensated for this time we ask that you pay a $400 retainer in advance to court appearances. If your bill does not reach this amount you will receive the difference back after court services are rendered.

If you understand and agree with the above we ask that you sign this document as a statement of your understanding and agreement to comply with our financial and fee schedules. This document may be used along with your personal information to collect outstanding fees if not paid in a timely manner. If no attempt to pay for outstanding fees is made legal recourse may occur.

Thank you for valuing our services by agreeing with these terms,

______________________________	______________________________
Client Name	Date
______________________________	______________________________
Signature of Client/Guardian	Date

		TOTAL	

Thank you for your business!

INFORMED CONSENT FOR TELETHERAPY

Definition of Services:

I,____, hereby consent to engage in teletherapy with _____________________________. Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of teletherapy is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Teletherapy, however, requires technical competence on both our parts to be helpful. Although there are benefits of teletherapy, there are some differences between in-person psychotherapy and teletherapy, as well as some risks. For example:

- **Risks to confidentiality.** Because teletherapy sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- **Issues related to technology.** There are many ways that technology issues might impact teletherapy. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- **Crisis management and intervention.** Usually, I will not engage in teletherapy with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in teletherapy, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work.
- **Efficacy.** Most research shows that teletherapy is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of teletherapy service to use. You may have to have certain computer or cell phone systems to use teletherapy services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in teletherapy. For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters, and should be directed to the administrative team. This includes things like

setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our teletherapy. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for teletherapy sessions and having passwords to protect the device you use for teletherapy).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent still apply in teletherapy. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Teletherapy

I will let you know if I decide that teletherapy is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in teletherapy services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the teletherapy platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you.

Fees

The same fee rates will apply for teletherapy as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in teletherapy sessions in order to determine whether these sessions will be covered.

Records

The teletherapy sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

______________________________	______________________________
Client Name	Date
______________________________	______________________________
Signature of Client/Guardian	Date

New Client Intake

Name:

____

Birth Date:

____

Address:

____

City:

____

Zip Code:

____

Cell Phone: ________________________ (Other i.e work, home): __________________

May I leave a message?____

E-mail Address:

____

In case of emergency, contact:

____

Address:

____

Phone Number:__________________________ Relationship_______________________

Chief Concern

Please describe the main difficulty that has brought you to see me:

____

____

____

____

____

Your current employer

Employer:

____

Work phone:

____

Address:

____

Occupation:

____

Length of time with this employer:

Please indicate any restrictions on calls:

___

___

___

Present relationships

How do you get along with your spouse or partner?

___

___

___

How do you get along with your children?

___

___

___

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate:

When:

___

From Whom:

For What:

Results:

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

When:

From Whom:

For What:

Results:

List of Symptoms

Please circle any of the following that have been bothering you lately:

Abused as a child		Agoraphobia		Alcohol Use	
Ambition		Anger		Anxiety	

Appetite		Being a Parent		Bowel Trouble	
Career Choices		Children		Compulsions	
Compulsivity		Concentration		Confidence	
Depression		Divorce		Drug Use/Abuse	
Eating Challenges		Education		Energy (hi/low)	
Extreme Fatigue		Fears		Fetishes	
Finances		Friends		Guilt	
Headaches		Health Problems		Inferiority Feelings	
Insomnia		Loneliness		Making Decisions	
Marriage		Memory		My Thoughts	
Nervousness		Nightmares		Obsessive Thinking	
Painful Thoughts		Panic Attacks		Phobias	
Relationships		Sadness		Self-Esteem	
Seperation		Sexual Challenges		Short Temper	
Shyness		Sleep		Stress	
Suicidal Ideations		Suicidal Attempts		Work Stress	

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / Relationship:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Family:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Job/school performance:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Friendships:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Financial situation:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Physical health:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Anxiety level / nerves:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Mood:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Eating habits:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Sleeping habits:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Sexual functioning:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Alcohol / drug use:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Ability to concentrate:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Ability to control anger:

1 -No Effect	2 - Little Effect	3 - Some Effect	4 – Much Effect	5 – Significant Effect	Not Applicable

Substance Use

Do you currently consume alcohol? **Yes** **No**

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? **Yes** **No**

Have family members or friends expressed concern about your drinking? **Yes** **No**

Do you currently use non-prescribed drugs or street drugs? **Yes** **No**

Do you have a history of problematic use of prescription or non-prescription drugs?

Yes No

Do you have a family history of alcohol or drug problems? **Yes** **No**

If yes, please describe:

____

____

____

Reasons for seeking treatment

Please describe current challenges, stressors and reason for seeking therapy:

____

____

____

Please describe your goals and desired outcome for therapy:

____

____

____

Who referred you/ how did you find me:

____

Date completed:

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.

Assessment Completed By: Date

Adolescent Consent Form & Parent Agreement to Respect Privacy

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature ____ Date__________

* * *

Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

/__/ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

/__/ Although I know that in this state I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

/__/ I understand that I will be informed immediately about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Signature __________________________________ Date__________

Parent Signature __________________________________ Date__________

Therapist Signature ________________________________ Date__________

Adolescent Intake Form

Child's Name: ________________________________ Age: ______ DOB: ___________

Sibling: _______________________________________ Age: _________

Sibling: _______________________________________ Age: _________

Sibling: _______________________________________ Age: _________

Sibling: _______________________________________ Age: _________

Mother's Name: ____

Address (City, State and Zip):______________________________

Marital Status: __________________________________

Phone: (H)__________________ (W)___________________ (C)__________________

Email ____

Occupation____________________________ Employment status__________________

Father's Name: ____

Address (City, State and Zip): ____

Marital Status: __________________________________

Phone: (H)___________________(W)__________________ (C)__________________

Email____

Occupation____________________________ Employment status__________________

Step Parent(s)/Guardian(s): ____

Address (City, State and Zip): ____

Marital Status: ___________________________________

Phone: (H)___________________ (W)___________________(C)_________________

Email ____

Occupation___________________________ Employment status__________________

History of Problem

____

____

____

Please describe what concerns you have regarding your child.

____

____

____

How long has the problem existed?

____

____

____

What attempts have been made to resolve the difficulties?

____

____

____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, or financial problems, in the last several years?

Has your child had any trauma?

What are your child's greatest strengths?

Are you currently having trouble controlling your child's behavior ?

Please check the symptoms that the child is currently experiencing. Please indicate the duration, and severity.

Symptom	Duration	Severity
Sadness or Depression		Mild | Medium | Severe
Suicidal Thoughts		Mild | Medium | Severe
Sleep Problems		Mild | Medium | Severe
Changes in Appetite		Mild | Medium | Severe
Weight Change		Mild | Medium | Severe
Inability to Concentrate		Mild | Medium | Severe

Obsessive Thoughts		Mild | Medium | Severe
Compulsive Behaviors		Mild | Medium | Severe
Panic Attacks		Mild | Medium | Severe
Daytime Wetting		Mild | Medium | Severe
Bed Wetting		Mild | Medium | Severe

Fears or Phobias		Mild | Medium | Severe
Anxiety		Mild | Medium | Severe
Friendship Issues		Mild | Medium | Severe
Aggression		Mild | Medium | Severe
Stomach Aches		Mild | Medium | Severe
Headaches		Mild | Medium | Severe
Other (specify):		Mild | Medium | Severe

Social Media/Electronics Use

Average number of hours per week your child spends:

___

Playing computer or video games, X-box, etc.

___

Types of games played:

___

Watching TV/ Videos:

___

Other Child Information

School:

Grade:

Teacher:

Current Grades/Academic Performance:

Extracurricular Activities:

Has your child had any psychological or academic evaluations ? If yes, what were the major findings:

History of psychotherapy:

Significant medical problems:

Serious illnesses, accidents, or surgeries in the past:

Any significant prenatal history:

Medications currently prescribed

Pediatrician:

Psychiatrist:

Other Agencies/Providers Helping Your Child Currently:

Family History

For parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)

If adopted, does the child know of adoption? Yes / No. Age at adoption? __________

Mother:

Significant Medical problems:

Serious illnesses, accidents, or surgeries in the past:

Current and past psychotherapy :

Current prescribed medications:

Current alcohol/drug use (amount, how often, intoxication frequency):

History of alcohol/drug use:

Father:

Significant medical problems:

Serious illnesses, accidents, or surgeries in the past:

Current and past psychotherapy:

Currently prescribed medications:

Current alcohol/drug use (amount, how often, intoxication frequency):

History of alcohol/drug use:

Step-parent/Guardian:

Significant medical problems:

Serious illnesses, accidents, or surgeries in the past:

Current and past psychiatric treatment or counseling:

____

____

____

Currently prescribed medications:

____

____

____

Current alcohol/drug use (amount, how often, intoxication frequency):

____

____

____

History of alcohol/drug use:

____

____

____

Other vital family history:

____

____

____

_________________________ _________________________

Assessment Completed By: Date

SG Mental Health Counseling ▪ 2940 E Park Ave Unit 2-J Tallahassee, Fl 32301 ▪ (850) 405-3639

Marissa.Collier@sgmentalhealthcounseling.com ▪ www.sgmentalhealthco.com