RIVER CAIRN COUNSELING

Informed Consent

Welcome to my private practice. Counseling is a relationship that works, in part, because of clearly defined rights and responsibilities held by each person. This document frames those rights and responsibilities, and includes important information about my professional services and business policies. You have certain rights that are important for you to know about because this is your therapy, whose goal is your own personal well-being. There are also certain limitations to those rights that you should be aware of.

CONFIDENTIALITY STATEMENT:

1. You are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA), as outlined with further detail in the **Notice of Privacy Practices**. This means that I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without written permission. You may give written consent for me to share information with whomever you choose, and you can change your mind and revoke that permission at any time.

2. The following are the legal exceptions to your right to confidentiality:

    a. If I have reasonable belief that you are in imminent danger of harming yourself, I may legally break confidentiality and contact law enforcement. Under the provisions of the Health Care Information Act of 1992, only in emergency situations I may also legally speak to another health care provider or a member of your family about you without your prior consent. However, when possible I will explore all other options with you before taking these steps.

    b. If I have reasonable belief that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform the appropriate law enforcement or the Department of Health and Human Services within 48 hours.

    c. If I have reasonable belief that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also inform the appropriate law enforcement and ask them to protect that person.

**In any of these previous three situations, I will reveal only the information necessary to protect you or the person in danger. I will not divulge everything you have told me.

d. I may sometimes consult with another professional about your treatment. All counselors are required by law and professional ethics to keep your information confidential. These case consultations/supervision sessions are helpful to both you and me in determining that I am providing you with the best treatment possible. In addition, when I am out of town or unavailable, another counselor will be on-hand to assist my clients. I must provide him or her with information about any clients that might call.

e. A court order issued by a judge may require the release of information contained in records and/or require a counselor to testify in a court hearing. Please note that I will attempt to gain your consent before commencing communication with a third party.

3. I will always act so as to protect your privacy, even if you provide written authorization to me to share information about you. I will only ever share the minimal information necessary for the situation.

4. Whenever I transmit any of your Protected Health Information (PHI) or other information about you electronically (for example, sending bills or replying to an email from you), it will be done with special safeguards to insure confidentiality.

a. If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential.

b. A more secure patient portal is provided to you at no additional cost with which you may communicate with me as appropriate.

c. You will only receive "Session Reminders" in a manner you choose and agree to receive, either through email, text, or phone call.

FINANCIAL AGREEMENT

My fees follow established community guidelines and standards of reasonable value. For the initial 90-min session which includes a diagnostic interview, the fee is $180. Following the initial session, the fee is $140 for a 60-min individual session, $110 for a 45-min individual session, and $80 for a 30-min individual session. The fee for a 90-min group session is $35.

Your fee may be a contracted rate with your insurance provider. Please check with your insurance company as to your portion of the fee (i.e. co-pays, deductibles, percentage covered). While I will bill your insurance for you, you are responsible for knowing the limits of your insurance. If you have any questions regarding your statement, please contact me at (531) 289-8246 or through your patient portal.

In the event of an insurance denial of payment, you are financially responsible for the full fee of your sessions.

Your co-pay or fee is due at the start of the session. Payment should be made in cash and you will be provided a receipt. I do not accept any other forms of payment at this time.

Private Pay clients are required to pay for services in full before the session may begin. If services are unable to be paid, the session will be cancelled. Private Pay clients are responsible for the initial session fee of $180, after which individual-session rates will be reduced by 20% for follow-up sessions.

Your appointment time has been designated for you. If you are late for your session, we will still end on time and your regular session fee will apply. Following the second Late Cancellation a warning letter will be sent out. Following the first No Show a warning letter will be sent out. Please see Attendance Policy for definitions. After receiving the warning letter, you will be charged $50 for any Late Cancellation or No Show. Insurance companies will not cover this charge and it must be paid in full before another session will be scheduled. To cancel a session or inform me that you may be late, please call (531) 289- 8246.

For any out-of-session time exceeding 15 minutes per week that I spend responding to your non-emergent phone calls, emails, or in consultation with other providers *that you request*, a fee will be applied to your bill as follows: $40 for 20 minutes, $80 for 40 minutes, $120 for 60 minutes, and an additional $50 for every 20 minutes following the first hour. Insurance companies will not cover these charges.

Any services left unpaid for 1 month (30 days) following a session, or fees owed that total more than $150, will result in a hold for treatment. Once all services have been paid treatment will resume. If a 1 month lapse in payment occurs more than once, we will need to discuss terminating treatment and I will refer you to another provider as needed.

If your account has not been paid for more than 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. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only

information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. It is my legal right to disclose this information in the event that I need to collect overdue payment.

My rates are subject to change. You will be notified of the rate change at least 6 weeks before the change takes effect.

ATTENDANCE POLICY

Engaging and participating in regular treatment will increase the likelihood of experiencing positive results. We will work together to determine the appropriate frequency of your sessions. All clients, whether receiving individual or group services, must first have an initial session with the diagnostic interview before further services may begin.

Your appointment time has been designated for you. If you are late for your session, we will still end on time. If you are more than 20 minutes late, the session will be cancelled and will be considered a No Show. If you cannot attend your appointment, you must cancel at least 24-hours in advance. Cancellations that occur after the 24-hours will be considered Late Cancellations. Cancelling or No Showing more than 3 times in 2 months will result in the need for termination of services.

If a session has not been scheduled and I have not received contact from you in 2 months, I will mail a 2-week notice for the termination of services. After two weeks, if I still have not heard from you, I will assume you are no longer interested in services and close your file. You may return for services and re-open your file in the future if we both feel this is appropriate.

Definitions:

Cancellation: Cancellation of a session more than 24 hours in advance.

Late Cancellation: Cancellation of a session less than 24 hours in advance.

No Show: Not cancelling a session and not coming to session as scheduled, or arriving to appointment more than 20 minutes late.

TERMINATION POLICY

The termination of therapy may be necessary for various numbers of reasons. Most often, termination of services is mutually agreed upon and planned for by both parties. Both parties reserve the right to deny, delay, defer, or discontinue services for any reason.

Termination becomes necessary if I no longer possess the necessary competence to assist you (either due to your changing treatment needs or due to problems of professional competence relevant to stress, distress, burnout, illness, etc.) and/or because I believe that continued treatment would likely be harmful to you. I may also terminate services if I feel threatened or otherwise endangered, if the payment of fees is not upheld as described in the Financial Agreement, or if sessions are not scheduled or attended as agreed upon in the Attendance Policy.

If treatment is terminated for any reason and a client desires to return to services, the initial session may or may not be required by the individual's insurance company within the first 6 months. Following 6 months after termination, if the client desires to return to services a new initial session will be required.

CONTACTING ME

As I spend much of my day in sessions, I may not be immediately available. When I am unavailable, you may leave a message on my confidential voicemail. I monitor voicemail frequently and will make every effort to return your call within the same business day. If this is not possible, then I will respond within the next business day. **If you are experiencing an emergency, do not wait for my response as I cannot guarantee how quickly I will respond to voicemail or email. See below for what to do in times of emergency.** If you may be difficult to reach, please provide me with times you are available. Over extended periods of time that I am out of the office, I will provide you with contact information for a colleague that you may contact as needed. You may also contact me as appropriate and within reason through email or the patient portal that I monitor and respond to regularly. Please see above information about my electronic communication practices.

EMERGENCIES

In the event of a psychological emergency, call 911 or go to your nearest hospital ER. You may also call the National Suicide Prevention Lifeline at 1-800-273-8255. If we have an established safety plan, follow that safety plan.

STATEMENT OF UNDERSTANDING

Therapy involves sharing sensitive, personal, and private information that may at times be distressing. During the course of therapy, there may be periods of increased anxiety or confusion. This can be a natural part of the healing and change process. I am available to support you throughout this process. The outcome of counseling is generally positive; however, the level of satisfaction for any individual cannot be guaranteed.

I have read the enclosed policies and procedures, asked any questions that I needed to, and understand the terms of this consent. I understand my rights and responsibilities as a client and my counselor's responsibilities to me. I agree to these conditions and consent to treatment.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Counselor Date