Therapist – Client Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains your Client Rights and summary information about the Health Insurance Portability and Accountability Act (HIPPA) in the Notice of Privacy Practices. I am required by law to obtain your signature acknowledging that I have provided you with this information at the first session. Please read this document carefully and ask me any questions you may have. When you sign this document, it will represent an agreement between us. This is your informed consent.

Telehealth Modalities

I offer sessions Via Secure Video, Secure Chat, or Telephone. I Occasionally conduct face to face appointments or meetings .

Telehealth encompasses four distinct domains of applications. These are commonly known as:
Live video (synchronous): Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology. This type of service is also referred to as "real-time" and may serve as a substitute for an in-person encounter when it is not available.

Mobile health (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and PDAs. Applications can range from targeted text messages that promote healthy behavior to wide-scale alerts about disease outbreaks.

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 initial impressions of what our work will include and an initial treatment plan, if you decide to continue. You should evaluate this information along with your own sense about 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 secure an appropriate consultation with another mental health professional.

Meetings

My normal practice is to begin with a period of evaluation that will last from 2 to 4 sessions. During this time, we can both decide whether I am the best person to provide the services that you need in order to meet your treatment objectives. If we continue, I will usually schedule one 50-60 minute session per week at a mutually agreed time, although sometimes sessions will be longer or less frequent. Once this

appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advanced notice of cancellation (see cancellation policy below). If it is possible, I will try to find another time to reschedule the appointment the same week. Please call at the time of your appointment if session is being conducted via phone. Understand that it is your appointment time and will need to call or log in to begin sessions, unless otherwise informed.

Professional fees

My hourly fee ranges depending on household income and family size $40.00- $150.00 per hour. Please provide Proof of income . In addition to weekly appointments, it is my practice to charge for other professional services you may require such as: report writing, telephone conversations which last longer than 10 minutes, attending meetings or consultations with other professionals which you have authorized, preparing records or treatment summaries, or the time required to perform any other service which you may request of me. In unusual circumstances, you may become involved in a litigation, which may require my participation. If that were to happen, you would be expected to pay for the professional time required even if I am compelled to testify by another party. Because of the complexity and difficulty of legal involvement, I charge $200.00 per hour to prepare for, travel to, and attend at any legal proceeding.

Contacting me

Due to my work schedule, I am often not immediately available by telephone. I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by my voicemail that I monitor frequently. I will make every effort to return your call with in 24 hours, except on weekends and holidays. I do encourage you to contact me via email or text messaging and as above I will respond with 24 hours. If you are difficult to reach, please leave some times when you will be available. If you choose to communicate via text message understand that text messaging is not secure. If you cannot reach me, and you feel that you cannot wait for me to return your call, you should call your family physician, psychiatrist, or the emergency room at the nearest hospital and ask for the psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. Should you decide to contact me via email/text please note that this is not always a secure means of communication and you are accepting the risk associated with transmitting personal information over the internet. I will make every reasonable effort to maintain email/electronic security.

Phone 513 -371-1161 Fax 513-649-8349

P.O. Box 504

Middletown , Oh 45042

Martinpressley@inspiredthoughtscounselingservice.com

WWW.inspiredthoughtscounselingservice.com

Cancellation policy

As with any business, it costs me to stay in business. If you cancel at the last moment and I cannot fill that time slot, then my costs continue. Neither you nor I feel that it is fair to pay for a cancellation that is out of either of our control and yet my costs do not evaporate. Therefore, I will reserve the right to charge my full fee or some negotiated portion thereof for last minute cancellations. You may also lose any priority scheduling or dedicated appointment time slot . You have a 15 minute grace period if you need to be late to session. However, after 15 minutes your session will need to be rescheduled. No Shows may result in discharge or a discontinue of services.

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 at the time these services are requested. Payment will be sent via PayPal link in which I will provide by the day of the scheduled session.

If your account is more than 60 days in arrears and you have not make arrangements with me to pay your bill, I have the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, I am entitled to recover the costs of bringing that proceeding. In most cases, the only information that I release about a client's treatment would be the client's name, the nature of the service provided, and the amount due.

Insurance reimbursement In order for us to set realistic goals and priorities, it is important to evaluate what resources are available to pay for your therapy. If you have a health benefits policy, it will usually

provide some coverage for mental health treatment. I do not on any insurance panels and thus your treatment will likely be considered “out of network.” I will provide you with a receipt that includes the

information insurance companies need to process your claim for reimbursement and you can opt to file your own claims. Remember that you, not your insurance company, are responsible for full payment of my fees.

Please read carefully the section in your insurance coverage booklet, which describes mental health services. If you have questions, you should call your plan and ask the insurance representative. I will, of course, provide whatever help I can in deciphering the information you get from your carrier about your coverage.

The rising cost of health care has resulted in an increasing level of complexity about insurance benefits that sometimes makes it difficult to determine exactly how much mental health coverage is available. "Managed Health Care Plans" such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. If you are planning to use your insurance to help pay for therapy with me, you will want to ask your insurance representative if they cover my services. Many plans are oriented towards a short-term treatment approach designed to resolve specific problems that might be interfering with

one's usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. In my experience, while quite a lot can be accomplished in short-term therapy, many clients feel that more services are necessary after insurance benefits expire.

You should also be aware that most insurance agreements require you to authorize me to provide a diagnosis of mental illness. This diagnosis will become part of your permanent medical record. Sometimes additional clinical information such as a treatment plan or summary, or, in rare cases, a copy of the entire record is also required. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, I have no control over what they do with it. In some cases they may share information with a national medical information data bank. If you request it, I will provide you with a copy of any report that I submit to your insurance carrier. Please remember that you always have a choice to bypass the insurance altogether and pay a negotiated fee out of pocket. By signing this agreement you are giving me permission to release information requested by your carrier.

***Please note I am only excepting Medicare ,Medicaid and private pay at this time .**

Client Rights

1. You have the right to request information about your therapist's qualifications, credentials, experience, specialization and education.

2. You have the right to obtain from another therapist a second opinion regarding the assessment and treatment plan developed to assist with your presenting problem.

3. You have the right to ask for an alternative referral at any time.

4. You have the right to inquire about fees for therapy, billing practices, insurance reimbursement, and other methods of payment.

5. You have the right to terminate therapy when you have reached your goals or believe therapy is no longer necessary.

6. You have the right to refuse the suggested intervention or treatment strategy indicated by your therapist.

7. The frequency and duration of therapy depends on many factors. It is your right to be part of determining jointly with your therapist how long and often you will receive therapy.

8. You have the right to renegotiate therapy as often as needed.

9. You have the right to receive complete and accurate information regarding your diagnosis, treatment, risks and prognosis.

10. While exploring personal issues and making life changes you might experience emotional pain, discomfort and anxiety. You have the right to decide what to talk about and work on in and out of therapy. Nevertheless, your active participation will have the greatest positive effect on the outcome of therapy.

11. You have the right to confidentiality, unless you report to be in danger to yourself or others (Therapists must report to appropriate agencies if you are suicidal or homicidal). Limits also include misconduct of other mental health professionals, suspected abuse of children and vulnerable adults, prenatal exposure to controlled substances, court ordered reports, potential use of a collection agency, and insurance agencies. In these situations, there are limits to confidentiality .

12. If you are a minor, you have the right to request that data about you be kept from your parents. This request must be in writing. The request must include reasons for withholding information from parents.

13. If you are parent of a minor child, you have the right to access information unless a written request has been made by your child to deny access to information.

14. You have a right to see your file

15. If you are denied coverage by your insurance company, you may either continue treatment on a fee-for-service basis or terminate therapy with a referral.

I cover this in more detail below:

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 no authorized; determining the location to which location protected information disclosures are sent; having nay complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of the Agreement. I am happy to discuss these rights with you.

Professional records standards of my profession require that I keep appropriate treatment records. Except in unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless the other person is health care provider) and I believe the access is reasonably likely to cause substantial harm to such other person, you may examine or receive a copy of your Clinical record, if you request it in writing. Your Clinical record includes information about your reasons for seeking therapy, a description of the ways in which the problem impacts your life, your diagnosis, the goals that we set for treatment, your progress on those goals, your medical and social

history, your treatment history, any past treatment records that I receive from other providers, reports of professional consultations, your billing records, and any reports that have been sent to anyone,

including your insurance carrier. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason I recommend that you allow me to provide you

with a treatment summary instead, or in the case that you wish to review your entire Clinical record, that you do so in my presence or in the presence of another mental health professional, so that you can discuss the contents. I will provide a treatment summary to another mental health professional who is working with you. You should be aware that this will be treated in the same manner as any other professional service and you will be billed accordingly.

Minors If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. Normally, I will provide them only with general information on how your treatment is proceeding. If, however, I feel that there is a high risk that you will seriously harm yourself or another, I will notify them of my concern. Before giving them any information I will try to discuss the matter with you and will do the best I can to resolve any objections you might have about what I am prepared to discuss.

HIPAA Guidelines on Telemedicine

Communicating ePHI at Distance

The HIPAA guidelines on telemedicine affect any medical professional or healthcare organization that provides a remote service to patients in their homes or in community centers. Many people mistakenly believe that communicating ePHI at distance is acceptable when the communication is directly between physician and patient – and this would be what the HIPAA Privacy Rule would imply.

However, the channel of communication that is used for communicating ePHI at distance is also important if medical professionals and healthcare organizations want to comply with the HIPAA guidelines on telemedicine. This element of the HIPAA guidelines on telemedicine is contained within the HIPAA Security Rule and stipulates:

- Only authorized users should have access to ePHI.
- A system of secure communication should be implemented to protect the integrity of ePHI.
- A system of monitoring communications containing ePHI should be implemented to prevent accidental or malicious breaches.

All sessions are HIPPA compliant and administered through the Theranest and Docusign platform see website for any questions or concerns.

Confidentiality

In general, the law protects the confidentiality of all communications between a client and a psychologist and I can only release information about our work to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations

that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

I may occasionally find it helpful to consult with 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.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him/herself, I may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection.

There are some situations where I am permitted to disclose information without either you consent or Authorization:

If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided for you, such information is protected by the psychologist-patient 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 order 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 worker's compensation claim, and my services are being compensated through worker's compensation benefits, I must, upon appropriate request, provide a copy of the client's record to the client's employer or to the Bureau.

There are some situations in which I am legally required to take action to protect others from harm, even if that requires revealing confidential information about a client's treatment.

If I believe that a child, an elderly person, or a disabled person is being abused, I am required by Ohio law to report the suspected abuse to the Department of Social Services.

If I believe a client presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

These situations are very unusual in my practice, but if such a situation should occur, I will make every effort to discuss it with you fully before taking any action and I will limit any discloser about you 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 at our next meeting. As you might suspect, the laws governing these issues are quite complex and I am not an attorney. While I am happy to discuss these issues with you, should you want specific advice, formal legal consultation may be desirable.

In case you feel your rights have been violated in any way please contact the state licensing board:

Counselor, Social Worker and Marriage & Family Therapist Board
77 South High Street, 24th Floor, Room 2468 Columbus, Ohio 43215-6171
Tel: (614) 466-0912 Fax: (614) 728-7790
Email: cswmft.info@cswb.ohio.gov

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

• I have read the above information and have had my questions answered to my satisfaction.

• I consent to participate in treatment and abide by the terms set forth here.

• I certify that I am the legal guardian or custodial parent with the legal right to request and approve evaluation and treatment for my son/daughter/ward and hereby consent to their treatment.

• I understand that I may revoke this consent for treatment at any time, but terminating treatment without consulting this office is not recommended.

• I release Inspired Thoughts Counseling Service LLC from any liability resulting from early or non-recommended termination of treatment.

• I agree that for each session not covered by Insurance, including missed or late-canceled appointments, I will pay the agreed upon sliding scale fee or Insurance co-pay fee for that session and I authorize Inspired Thoughts Counseling Service LLC to release any information required for processing claims and to receive benefits due for services rendered.

- I authorize Inspired Thoughts Counseling Service to contact my Emergency Contact or receive Information from my Emergency contact.

_______________________________________ ____________________

Signature of client Date

_______________________________________ ____________________

Signature of Parent or Guardian if client is a minor Date

Please sign below to give permission for me to contact your referring physician or health care professional to send him/her a letter of appreciation.

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Signature of Client or Guardian

Please read and sign below: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to my physician on claims for which they have accepted assignment and I authorize the physician to submit a claim to Medicare for payment on my behalf. I request payment under the medical insurance program be made to my physician on any bills for services furnished me by my physician for which they have accepted assignment. I further release my physician to release medical information concerning my treatment to my Insurance carrier / insurance carriers and authorize payment of medical benefits from those carriers to be made directly to my physician on claims for which they have accepted the assignment. I also understand that I am responsible for payment for services not covered by the Medicare program or my insurance carrier.

I also authorize my physician's office to provide my medical information to other organizations or entities for the determination and payment of benefits. I authorize my physician's office to permit my insurance companies or third party payors to review / audit my medical chart if they so request. I assign benefits otherwise payable to me to my physician. I understand that I am financially responsible for the charges for any services rendered to me by my physician(s).

I have reviewed the practice's PRIVACY POLICY ______________________________ (INITIAL HERE) I

have reviewed the OFFICE FINANCIAL POLICY _____________________________ (INITIAL HERE) I have

reviewed the CONSENT for TREATMENT _____________________________ (INITIAL HERE) I understand that copies are available upon request.

Signature: ____ Date: ________________________________ If this is a worker's compensation visit or auto accident account we must have that information on an additional form. Please ask the receptionist for the appropriate paperwork. IF PRIVATE INSURANCE REQUIRES A COPAY IT IS TO BE PAID AT THE TIME OF SERVICE, if applicable.

Preferred Contact Phone #: (   ) ____________________

You may leave PHI on my answering machine /voicemail:

□Yes   □No

You may leave the following:

□ appointment information

□ detailed information

□ test or lab results

□ response to my inquiry /question Insurance Information: