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INFORMED CONSENT FOR MENTAL HEALTH SERVICE

MENTAL HEALTH COUNSELING SERVICES Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in mental health counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Mental health counseling 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 mental health counseling often requires discussing the unpleasant aspects of your life. However, mental health counseling 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. Mental health counseling 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 2-6 sessions will involve an appropriate evaluation of your needs. By the end of the evaluation, I will be able to offer you 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.

APPOINTMENTS: Appointments will ordinarily be 45-60 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 me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24-hour notice, there is a $120.00 cancellation fee that will be charged and collected prior to the next scheduled session to be paid by the client** (not the insurance company). Emergencies and sickness are two examples of when the fee will be waived as long as there is a phone call alerting me that you are not able to make the session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the cancelation fee. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

You may request a weekly standing appointment, [agreed upon same day and time a week or every other week]. In the event you decide to take some time off [three weeks, a month, or just to take a break from counseling], you may loose your requested time. This does not mean another time, once you start counseling again, will not be assigned to you.

PROFESSIONAL FEES The standard fees are within the FEE AGREEMENT FORMS. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, credit card, or cash, and any checks returned to my office are subject to an additional fee to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. In addition to weekly appointments, it is my practice to charge amount within the Fee Agreement for other professional services that you may require such as report writing, telephone conversations that are not appointment related, emails, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. 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.

INSURANCE: In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually 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.

COUPLES: If we have dependent children, we understood there might be potential limits of confidentiality regarding access to records in child custody cases]. We understand that information discussed in couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. We agree not to subpoena RS to testify for or against either party or to provide records in a court action.

We understand that while working as a couple, anything either of us might say to RS individually, whether by phone or in an individual session, will not be held as confidential. At RS'S discretion, some or all, of what we share, may be shared with the spouse/partner during a subsequent couple session. By entering into couples therapy, we accept that we both understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. We understand that the changes one or both of us makes will have an impact on our partner and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them. [This is especially true if we have dependent children.]. RS has explained that her therapeutic focus in couple's therapy is on preserving and enhancing the relationship rather than a focus on individual happiness. OR. . . If remaining together is harmful to one or both partners, the focus will be on facilitating an amicable separation.

PROFESSIONAL RECORDS: I am required to keep appropriate records of the counseling 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 a right to have my decision reviewed by another mental health professional, which I will discuss with

you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request. See special circumstances about records, if you are using your medical insurance. In some cases, this office does keep a separate psychotherapy file that is not part of your medical record file. If you'd like limited [also called lean records] note taking on my part, please let me know.

CONFIDENTIALITY: My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Privacy Practice Forms. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

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 12 unless she/he agrees that I can share whatever information I consider necessary with a parent. For children 13 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised. [See sample Adolescent Consent Form, to be signed by both adolescent and parent(s).]

COURT/LEGAL RELATED APPEARENCES: If part of the reason you are seeking therapy has to do with any court/family/mediation mandates and/or known up coming court appearances, you will supply Ruthie Steinberg with all known related documents (from other therapists, testing reports, court reports, police reports, etc.). It is important that this office has all known information to best help in any process; it could negatively impact you if something comes out that Ruthie Steinberg doesn't know and is not prepared for. In the event that RS becomes aware of documentation that you knowingly didn't supply this office, Ruthie Steinberg will end the therapeutic relationship. She will assist you in finding another appropriate therapist. As a result, it is imperative that you supply this office with all known related documents to any pending family and/or court/mediation related cases.

CONTACTING ME: My office hours are from Monday through Friday. I will return voicemail phone messages within my office hours, usually within a 24-hour period, unless other arrangements are written, signed, and agreed upon. 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 voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of 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 if you feel unable to keep yourself safe, contact Community Mental Health Services by calling 211, go to your Local Hospital Emergency Room, or call 911 and ask to speak to the mental health worker on call.

Emergent: In an emergent situation, you will be seen within twenty four(24) hours of a request for an appointment or referred to appropriate emergency service providers. Urgent: In an urgent situation, you will be offered the opportunity to be seen (face to face or telephone) within forty-eight (48) hours of a request for an appointment. Routine: In a routine situation, you will be offered the opportunity as soon as possible. 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.

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.
CONSENT for MENTAL HEALTH COUNSELING Your signature below indicates that you have read this Agreement, Fee Agreement, Privacy Practice Forms, and FACT SHEETS, and that you agree to their terms. By signing below, you will consent to an understanding of the purposes of this setting, the service approaches and methods used, and the qualifications of RS.

FEE AGREEMENT:

Responsibility of the Client:

☐☐Payment is due at the time services are rendered, unless other arrangements, in writing, are made. Insurance, victim's compensation, cash, check, or credit cards are accepted payment methods. Checks payable toRuthie Steinberg, LMHC.

☐☐Any reduced fees do not apply to conferences, testing, and/or reports. Copies of any reports that are not part of the initial herein referenced forms. Forms will be charged at a dollar a page.

☐☐The fee is $127.00 for a 50-55 minute session.

☐☐If using insurance, your copay and/or co-insurance is due on the date service is rendered. (Insurance information must be presented on or before the date service is rendered. This office will not bill insurance retroactively.)

☐☐All phone sessions and calls that are not appointment oriented, will be pro-rated at $2.11 per minute.

☐☐Cancellation of a session must be made at least 24 hours prior to the scheduled time, or you will be billed $120.00

☐☐Clients who have cancellation fees will not be rescheduled until no-show or late cancellation fees are paid.

☐☐Clients with weekly stand in appointments, who miss or reschedule two consecutive appointments, will lose their stand in time.

☐☐For returned checks, you will be charged a NSF charge (based on bank fee), in addition to the amount of the check. This office reports to the local district attorney's office for checks that are not paid within two weeks of being returned to this office.

☐☐If RS receives a witness/records subpoena, the client will be notified so that his/her attorney can take whatever action is deemed necessary. If the client desires the subpoena be honored, a signed release is required. Fees associated with any court proceedings are $300per hour with a four hour minimum. Cancellation charges explained above also apply to any appointments and reports surrounding court/legal.

☐☐Requests for reports and any third party conferences, other than court reports and appearances, will be charged at the hourly fee ($127 per hour).

☐☐The client is fully responsible for any charges not covered for any reason by their insurance carrier. If not paid according to terms, the client understands that this office reports to an outside collection agency. In the event that your account is turned over for collections, client agrees to pay all additional fees assessed in the collection of debt. These fees include collection agency fees and attorney fees.

☐☐A signed release is required for any record or information to be released from RS to court, another counselor, attorney, doctor, etc.

If you have any questions about the financial policy of this setting or third party coverage, please ask this office for assistance. I have discussed these conditions with RS and have had the

opportunity to ask any questions. My questions have been answered to my satisfaction. I understand and agree to meet my financial responsibilities in receiving treatment and services in this practice setting. I agree to:
I remit to RS a fee of $_____ beginning of each session. _____ I remit to RS a copayment of $_____, in keeping with the policies of my health benefits. By signing below I am indicating that I have read and agree to this fee agreement.
The client understands that: Mental health providers are required to submit psychiatric diagnosis &/or a “treatment plan” including counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, medication prescription and monitoring, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. If an Ins. Co. elects to audit its particular clients charts at the therapist’s practice they may also discover description of the presenting problem, members within the client’s household & quality of relationships, current medical information, therapeutic interventions, & other data in the medical record (e.g. medical session notes). Once this information is submitted to the Ins. Co. it becomes a part of the client’s permanent medical record & it may be computerized or entered into a national medical information data bank. Once, submitted to the Ins. Co., RS has nothing to do with how it’s used or maintained by the Ins. Co. & cannot be held liable for how the information is used thereafter .
If you have already given RS permission to bill the Ins. Co. and you no longer wish to utilize insurance benefits, you must advise RS of this in writing. RS cannot be held responsible for information or claims already submitted prior to the your written request.
SELF-PAY AGREEMENT: I attest that: ___ I do not have insurance coverage ___ I have insurance coverage but choose not to use it, and understand that in doing so I am waiving any right to reimbursement ___ I have insurance coverage, but I understand that your services are not covered by the plan or you are out of network.
AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to RS. I authorize RS to release all information necessary to communicate with personal physicians, other healthcare providers, and payers to secure the payment of benefits. I understand that I am responsible for all costs of therapy and counseling care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable. I understand and agree to allow this healthcare office to use my and/or my child’s Patient Health Information for the purposes of treatment, payment, healthcare operations, and coordination of care. I also understand that RS will submit a diagnosis of my condition and my spouse or other involved in my household matters may have access to my health records. RS wants you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. Please read the Notices of Privacy Practices information before signing this consent. If there is anyone you do not want to receive your medical records, please inform my office. By signing below I am indicating that I have read the referenced forms and understand the various practice policies.

CREDIT CARD RELEASE

You may waive this by issuing a check or cash upon services. Please complete the following information as per RS's policy. Card information will be securely stored in My Clients Plus Jituzu (HIPAA compliant secure portal) or PayPal and blacked out of client’s nonelectronic file. Only the signature will be stored in client’s non-electronic file; your information may be updated at anytime.
I, _____, am authorizing RS to use my credit card information to charge my credit card in the event that:
1. As payment after a scheduled appointment for any services rendered

2. I do not notify her of an inability to attend a scheduled therapy appointment
3. I do not cancel or reschedule an already scheduled appointment at least 24 hours in advance
4. If she encounters any check related fees (returned check) for any reason (the amount of the check will be billed to my credit card in addition to any service fees incurred as a result by my bank)
5. If there is an outstanding balance on my account anytime after 30 days of the date(s) of service(s) billed (my card will be billed the full amount unless prior arrangements have been made in writing with RS)

CREDIT CARD: ___AMEX ____VISA ____MC
CARD#_____
EXP. DATE_____CARDHOLDER'S NAME_____
BILLING ADDRESS_____
ZIP_____
THREE OR FOUR DIGIT CID NUMBER_____Send Reciepts (Email): _____

By signing below I am authorizing RS to charge for scheduled appointments as described above or for my outstanding balances anytime after 30 days of the date(s) of service(s) billed. I am also agreeing to notify RS as soon as possible of any change in my credit card information. In the event of a declined card – I will be asked for another credit card. If I have a question about a charge, I will notify RS within15 days of the charge because after 30 days the charge will be assumed to be correct. RS will keep a clear record of all payments and charges – in the rare event that I have been overcharged a credit will be issued towards my next session or if I have terminated therapy it will be applied back to my credit card. By signing below I have read and understood the Credit Card on File Agreement and authorize RS to charge my credit card as stated above.

PRIVACY PRACTICES

I have read the "Notice of Privacy Practices" above and have no specific restrictions to my contact information at this time (including home phone, cell, and address). I understand that this office will leave messages and send correspondence to information I provided on the intake form, unless I have privacy restrictions below.

**If you have privacy restrictions or other wishes, complete them below:
Please do not text me. Please do not call me at home. Please do not call me at work.
Please use this address, if different than intake, for any correspondence

_____
_____

Other requests and restrictions:

_____
_____

EFFECTIVE DATE: _____

By signing below I am indicating that I have read the referenced forms and understand the various practice policies. I also understand that RS, within these pages, is representative of Ruthie Steinberg, LMHC.

Adult Client/Guardian's Signature_____p Date _____

Adult Client/Guardian's Print_____