A Seed of Hope Family Counseling Center, PLLC
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INFORMED CONSENT, INFORMATION AND POLICIES

Welcome to **A Seed of Hope Family Counseling Center, PLLC.** This agreement contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), the federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations.

HIPAA requires that you are provided with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operation. The notice, explains HIPAA and its application to your personal health information in greater detail. The law requires your signature acknowledging that you have been provided with this information before or at the time of your initial consultation. Any questions you might have about the procedures can be discussed at the time of your initial consultation.

Although these documents are lengthy and complex it is important that you read them carefully. The signed document will represent an agreement between you and the assigned clinician/practice. You may revoke this agreement in writing at any time. That revocation will be binding unless the clinician by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL AND COUNSELING SERVICES:

Psychotherapy/counseling is not easily described in general statements. It varies depending on the personalities of the clinician and client, and the particular problems that you hope to address. Psychotherapy/counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will need to work on those things discussed both during the sessions and at home.

Psychotherapy/counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy/counseling has also been shown to have many benefits. It can often lead to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no assurances of what you might experience.

The first few sessions will likely involve an evaluation of your needs. By the end of the evaluation, some impressions will be offered as well as a plan for treatment, if you decide to continue. You should evaluate this information along with your own opinions of whether you feel comfortable working with the clinician. Psychotherapy/counseling involves a large commitment of time, money, and energy, so you should be careful about the clinician you select. If you have any questions about procedures, they should be discussed. If your doubts persist, a meeting with another health professional for a second option can be arranged.

PATIENT'S RIGHTS

- **You have the right to refuse treatment.**
- **You have the right to change practitioners or receive referral to another practitioner.**
- **You have the right and responsibility to choose a practitioner that best suits your needs**
- **You have the right to confidentiality. These are the exceptions for the reporting abuse as required by law, dangerousness to self or others, neglect or grave disability.**
- **You have the right to raise questions about my therapeutic approach or progress at any time.**

PSYCHOLOGICAL TESTING AND ASSESSMENT:

Our psychologists/therapists will sometimes perform psychological testing at your request, on their own behalf or on the basis of a physician referral. **Testing may take place over several sessions and includes charges for administration, scoring, preparation of report and interpretation provided to you of test results**. As testing sessions may be scheduled across several hours, we ask that you be considerate of the providers time and keep all scheduled testing appointments whenever possible.

MEETINGS:

Typically, an evaluation/assessment will last from 2-4 sessions. During this time, you and the clinician will decide if they are the best person to provide the services you need in order to meet your treatment goals. Psychotherapy/counseling is usually scheduled as a 45-minute session (One appointment is equivalent to 45 minutes total with a quick additional 5 minutes for questions/scheduling/payments) once per week, bi-weekly or at an agreed upon time. However, this can vary depending upon individual needs and availability. **Once an appointment has been scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation (with exceptions being circumstances beyond your reasonable control that provides evidence of the circumstance). It is important to note that insurance companies do not provide reimbursements for cancelled appointments. A Seed of Hope charges 80.00 if cancellations occurs without providing your clinician a 24 hours in advance notice.** If it is possible, another time will be offered to reschedule the cancelled appointment. Clinicians have the right to suspend treatment if client has frequent cancellations or doesn't call.

PROFESSIONAL FEES:

Professional fees are determined by the professional licensure of the service provider rendering services and/or the nature of the clinical work. A specific list of fees is available upon request. Professionals will generally discuss fees with you at the time of the first visit. Services requiring legal involvement invoke fees for all professional time, including preparation and transportation costs, even if the clinician is called to testify for another party.

PAYMENT POLICIES AND FEES

Payment in full is due at the time of service unless other arrangements have been made with A Seed of Hope Family Counseling Center, PLLC ahead of time or if A Seed of Hope Family Counseling Center, PLLC or your clinician is contracted with your insurance company, your co-payment or co-insurance is due at the time of service as specified by you plan. If you are not contacted with your insurance company. Please pay at the time of service and A Seed of Hope Family Counseling Center, PLLC will provide you with a receipt that you may use to file a claim for re-imbursement. There is a $35.00 fee for return checks.

Our billing specialist can be contacted to answer you billing questions and concerns at (269) 743-7357. A Seed of Hope keeps regular business hours Monday – Friday; these times vary since each contractor creates their own

personal schedule. You may leave a message on the secure voice mail anytime. You may contact A Seed of Hope Family Counseling Center, PLLC to make payments at the above number or your designated clinician. If you desire for this facility to retain your credit card information it will be stored on a secure site in which you can request that information from your clinician or the staff taking your payment. I will not hold A Seed of Hopes Family Counseling Center's responsibility if these organizations that process payments or have a breach of security. If your payment is not received within 90 day's A Seed of Hope has the right to turn over your balance to a collection agencies of their choice, in which at that time can affect your credit report.

I have read and understand and have read the expectations for payment at A Seed of Hope Family Counseling Center, PLLC. ______________________Client's Initials _____________________Date

CONTACTING YOUR CLINICIAN:

Clinician are often not immediately available by telephone, as they are at most times meeting with patients. Every effort will be made to return your call on the same day you have made it. Please provide phone numbers at which you can be reached and sometimes when you will be available. **If you are unable to reach your clinician and feel like you can't wait for a return call, contact your family physician or the nearest emergency room and ask for the psychologist, psychiatrists or doctor on call. At any time you feel you have a mental health or medical emergency, please call 9-1-1.**

LIMITS ON CONFIDENTIALITY:

The law protect the privacy of all communications between a patient and a clinician. In most situations, information about your treatment can only be released 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 the activities, as follows:**

- A clinician may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, every effort is made to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. If you don't object, ***you will not*** be informed about these consultations unless it is deemed important. **All consultations will be noted in your clinical records (Which is referenced as the "PHI" in the Notice of Policies and Practices to Protect the Privacy of Your Health Information)**
- You should be aware that this practice includes other mental health professionals and administrative staff. In most cases, it is necessary to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- This practice has contract with a collection agency. As required by HIPAA, a formal business associate contract with this/these business(s), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law, has been established. If you wish you can be provided the names of these organizations and/or a blank copy of the contact.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in the agreement.

There are some situations whereby the clinician is permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the privileged communication law. <u>The clinician cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order.</u> If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order the clinician to disclose information.
- If a government agency is requesting the information for health oversight activities, the clinician may be required to provide it for them.
- If a client files a complaint or lawsuit against the clinician, that clinician may disclose relevant information regarding the client in order to defend him/herself.

There are some situations in which the clinician is legally obligated to take actions, which he/she believes are necessary to attempt to protect others from harm. In doing so, the clinician may have to reveal some information about a client's treatment.

- If the clinician knows or has reason to suspect that a child under 18 years of age, or a mentally disabled, developmentally disabled, or physically impaired individual under the age of 18 years of age, has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child/individual, the law requires that the clinician file a report with the appropriate government agency, usually the Children Protection Services Agency. Once such a report is filed, the clinician may be required to provide additional information.
- If the clinician has reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, the law services that the clinician report such belief to the county Department of Family Services. Once such a report has been filed, the clinician may be required to provide additional information.
- If the clinician knows or has reasonable cause to believe that a client has been the victim of domestic violence, he/she must note that knowledge or belief and the basis in the client's record.
- If the clinician believes that a patient presents a clear and substantial risk of imminent serious harm to him/herself or someone else, and he/she believes that disclosure of certain information may serve to protect that individual, then the clinician must disclose that information may serve to protect that individual, then the clinician must disclose that information to the appropriate public authorities, and/or the potential victim, and/or professional workers, and/or the family of the client.

If such a situation arises, the clinician will make every effort to fully discuss it with you before taking any action will limit the disclosure to what is necessary, if the clinician feels that is appropriate.

By Signing below you consent to our releasing information about your claim(s) to the Michigan Department of Insurance in connection with any insurance company's failure to properly pay a claim in the timely manner, as well as the Michigan Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.

In addition, by signing below, you are consenting to the fact that from time to time, we may have the need to consult our practice attorney regarding legal issues involving your care (this is an infrequent occurrence, but does happen from time to time.) Our practice attorney is bound by confidentiality rules also. In addition, we will reveal only the information that we need to reveal to receive appropriate legal advice in connection with those contacts.

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

PROFESSIONAL RECORDS:

The laws and standards of psychology and counseling professions require that the clinician keep Protected Health Information (PMI) about you in your clinical record. **Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your Clinical Record, if you request in writing and the request is signed by you and dated not more than 60 days from the date submitted.** Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. **For this reason, it is recommended that you initially *review them in the presence of the clinician* or have them forwarded to another mental health professional so you can discuss the contents.** If you request to access your records is refused, you have the right of review which will be discussed with you upon request and we will provide them to a psychologist or licensed mental health professional designated by you.

CLIENT RIGHTS:

HIPAA provides guidelines and policies regarding your rights to your Clinical Record and disclosures of protected health information. These rights include requesting that the clinician amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about policies and procedures recorded in your records; and the right to paper copy of this agreement, the notice form, and privacy policies and procedures. Please consult the Notice form more information on these rights.

MINORS AND PARENTS:

Clients who are under 18 years of age and who are not emancipate, along with their parents, should be aware that the law allows parents to not examine their child's treatment records absent of a court order blocking a parent's access. **No information about those sessions can be disclosed to anyone without the child's agreement. Under this option only the minor child is responsible for payments.** While the privacy in psychotherapy/counseling is often crucial to successful progress, particularly with teenagers, parental involvement can also be essential to successful treatment.

Both parents must recognize that if a minor child or children are the only client(s), that typically both parents hold the privilege on all communication involving the child while in therapy and that anything that either of them says in a session is available to the other parent, unless blocked by a court order.

LEGAL SITUATIONS:

If you become involved in legal proceedings that require our participation, you will be expected to pay for all professional time, even if one of us is called to testify by another party. **We will ask that a retainer be paid by half of the expected fees at least one week prior to providing these services, and the second half of the expected fees and any additional fees that may have been accrued be paid within one week after services delivered.** Our professional time for legal proceedings may include preparation (document review or letter preparation), phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that I wait in court prior to or after I have been called to testify. Due to the time consuming and often difficult nature of legal involvement, we charge our ordinary, customary, hourly rate, **fees lost due to client cancellations are $350 an hour portal to portal charge for testimony. You will be responsible for any legal fees that we occur in connection with the legal proceeding, which may include responding to subpoenas.**

BILLING AND PAYMENTS:

You will be expected to pay for each session at the time it is held, unless agreed to otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. Payment for services can be made in cash, check ($35.00 NSF) and credit card. We encourage you to take a receipt for all cash transactions in order to best serve you.

If your account has not been paid for more than 90 days and arrangements payments have NOT been agreed upon, A Seed of Hope Family Counseling Center, PLLC has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court while we require the clinician to disclose otherwise confidential information. In most collection situations, the only information that the clinician will release regarding a client's treatment is his/her name, the nature of services provided, dates of service and the amount due.

INSURANCE REIMBURSEMENT:

In order for **A Seed of Hope Family Counseling Center, PLLC,** 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. **It is your sole responsibility with calling your** provider to examine the benefits to which you are entitled. **However, you (not your insurance company) are responsible for full payment of the clinician's fees. It is very important that you find out exactly what mental health services your insurance policy covers.**

You should carefully read the section in your insurance coverage booklet that describes mental health services. **If you have questions about the coverage, call your plan administrator.** Due the rising costs of health care, 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 authorization before they provide reimbursement for mental health services.** These plans are often limited to a person's usual level of functioning. It may be necessary to seek approval for more psychotherapy/counseling, some clients feel that they need more services after insurance benefits end. Some managed-care plans will not allow the clinician to provide services to you once your benefits end. If this is the case, the clinician will do their best to find another provider who will help continue your psychotherapy/counseling.

You should also be aware that your contract with your health insurance company requires that the clinician provide it with information relevant to the services provided to you. The clinician is required to provide a clinical diagnosis. Sometimes the clinician is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. **In such situations, the clinician will make every effort to release only the minimum information about you that is necessary for the purpose request. 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, the clinician has no control over what they do with it once it's in their hands.** In some cases, they may share the information with a national medical information database. The clinician will provide you with a copy of any report they submit, if they request it. **By signing this agreement, you agree that the clinician can provide requested information to your insurance carrier.**

A Seed of Hope Family Counseling Center, PLLC, has all of the information about your insurance coverage, it will be possible to discuss what can be accomplished with the benefits that are available and what will happen if they run out before you feel ready to end your session. It is important to remember that **you will always have the right to pay for the clinician services to avoid the potential problems described above.**

Under changes to HIPAA in 2009, **you now have the right to elect not to use insurance when seeing a therapist and then no information will be disclosed to your insurance company.** You should be aware, however, that you have to make such an election prior to each therapy session and you must pay for those services at that time. You will be charged allowable fees under such circumstances.

EMAILING AND TEXTING:

We prefer not to use email or texting for communication. If you decide you want to utilize either form of communication, **you must acknowledge that there are risks inherent in such either form of communication, and accept those risks. If you wish to use texting or email for communication with your therapist or the office, please place your initials in the space below: We ask that no counseling is done through text or email this should wait until your next appointment.**

_____________________/Date:____________(By initialing this section, you agree that you understand the risks involved in texting and emailing and agree to accept such risks in communication from either **A Seed of Hope Family Counseling Center and** to you of from you to us that involve scheduling and/or therapy.)

SAFEGUARDS FROM IDENTITY THEFT:

In completing information on the intake form for the office, we do ask the social security number is provided. With some third-party vendors, this represents necessary information for billing purposes. The social security number has been necessary when a name change has occurred in order for us to verify insurance benefits appropriately. Record requests from insurance carries and EAP services will request this information at times. While this information is placed on the written form you complete, this private and identifying data will not be stored electronically unless it is a part of your insurance carrier's identification number. In this way, we hope to avoid any possible problems with electronic data breaches and for potential identity theft. Our billing system data is encrypted as a part of this protection policy. Similar security number for these purposes and have taken these added precautions to no longer store this information electronically. This policy became official as of October 9, 2017.

STUDENTS AS A PART OF TREATMENT:

From time to time, you may be asked to allow a student training as a social worker to sit in as a part of their training process. You should always be asked before this occurs and have the right the refuse at your discretion. Should you elect to allow a student in session, students provide you the same confidentiality as your psychologist/Mental health provider. Clinical social worker or clinical counselor and your cooperation will benefit the future generation of providers with learning opportunities by allowing these students to move forward in their educational process.

SIGNATURE REQUIRED

I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions. *If more than one adult client, each person should check and initial boxes.*

☐ Yes ☐ No I have received a copy of the HIPAA Privacy Notice.

☐ Yes ☐ No I authorize the release of any medical information necessary to process my insurance claims and I authorize benefits to be paid directly to A Seed of Hope Family Counseling Center, PLLC.

☐ Yes ☐ No I consent to the exchange of treatment information between ASOH and my primary care physician.

Client(s) Physician's Name/Office and Phone Number ___________________________

YOUR SIGNATURE BELOW INDICATES THAT YOU READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM AS DESCRIBED ABOVE.

____ ___________________________

Client or Guardian Signature Date

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Witness/Date

Revised 1/2022