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Client Information and Acknowledgment of Informed Consent to Treatment

Bluestone Counseling LLC is a business that employs professionals who are licensed in the state of Ohio to diagnose and treat mental and emotional disorders and related services in a private practice setting to people residing in the state of Ohio.

Mental Health Services

The purpose of mental health services is to help you better understand your situation, change your behavior, or move toward resolving your difficulties. Using my knowledge of human development and behavior, I will make observations about situations and help you to develop new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur.

The services offered can have risks as well as benefits. Treatment often involves discussing unpleasant issues, and you might experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health and substance abuse care may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Appointments

Appointments are made by calling **(614) 406-0299**. **Please call to cancel or reschedule at least 24 hours in advance, or you will be charged $75.00 for the missed appointment unless I determine an emergency was involved.** Third party payers will not cover or reimburse for missed appointments. Appointments are 60 minutes in length, but session length may vary for clinical reasons. The number of appointments depends on many factors and we will discuss this as part of your treatment planning. Since there is no way a therapist can see another client when they have a late arrival, no reductions are provided when a client arrives late for an appointment. Some insurance companies will only pay for the actual time during which services are rendered. In that case you, the client, will be billed for the portion of the appointment time when no services could be rendered. In some cases governmental insurance or employee assistance programs do not allow billing for missed or partially missed appointments and if that is the case you will be billed in accordance with those programs' rules.

Relationship

My relationship with clients is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Please do not attempt to "friend" me on Facebook or on any other social media site. You always have the right to terminate services with me at any time and for any reason.

Goals, Purposes and Techniques

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment I recommend and to have input into setting the

goals of your therapy. As therapy progresses these goals may change. You and I will jointly determine how to effect the changes you are seeking to make for yourself. You always have the opportunity to seek either another opinion or a different therapist. I will let you know if I feel that we are not a good fit or if you might obtain better help elsewhere. I will always retain the right to terminate my therapy with you in the event that I feel you would be better served elsewhere, if I feel you are not complying with treatment requests, or if payments due to me remain unpaid. In the event that I terminate services with you I will offer you referrals.

Confidentiality

Laws protect the privacy of all communications between a client and a therapist. In most situations I can only release information about your treatment to others if you sign a written authorization. There are some situations where I am permitted or required to disclose information either with or without your consent or authorization. For example:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, I cannot provide such information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order me as your therapist to disclose information.
- If a government agency is requesting the information, I may be required to provide it;
- If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend myself.
- If you file a worker's compensation claim, I may be required, upon appropriate request, to provide a copy of your records, or a report of your treatment.

There are some situations in which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm, and in such cases I might have to reveal some information about your treatment. If such a situation arises, I will make every effort to fully discuss it with you before taking any action, if I deem that to be appropriate under the circumstances and will limit disclosure to what is necessary. For instance:

- If I have reason to believe that a child, a developmentally or physically disabled or elderly adult is being neglected or abused, the law may require me to report that information to the appropriate state or local agency.
- If I believe you present a clear and substantial danger of harm to yourself and/or others, I may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and/or notifying the police.

You agree that I may release information about your claim(s) to the Ohio Department of Insurance in connection with any insurance company's failure to properly pay a claim in a timely manner as well as to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.

You agree that from time to time I may have the need to consult with my practice attorney regarding legal issues involving your care (this is an infrequent occurrence but does happen from time to time). My practice attorney is bound by confidentiality rules also. In addition, I will reveal only the information that I need to reveal to receive appropriate legal advice in connection with those contacts.

You should be aware that I may practice with other health professionals and that I may employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as typing, scheduling, billing, and quality assurance and you agree that I may do that. If I do that I will only release the information necessary in order for me to provide help to you, the client. All of the health professions will be bound by the same rules of confidentiality. All staff members will have been given training about protecting your privacy and will have agreed not to release any information outside of the practice without the permission of a professional staff member.

Also, I may have a contract with a collection agency. I will have a formal business contract with this business, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed or is required by law.

In addition, I may have a contract with a billing service. I will have a formal HIPAA business associate contract with this business, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed or is required by law.

This summary is designed to provide an overview of confidentiality and its limits. It is important that you read the Notice of Privacy Practices form that has been provided to you for more detailed explanations, and that you discuss with me any questions or concerns that you have.

Fees, Payments, and Billing:

Payment for services is an important part of any professional relationship. This is even more true in therapy; one treatment goal is to make relationships and the duties and obligations they involve clear. You are responsible for seeing that my services are paid for. Meeting this responsibility shows your commitment and maturity.

My current regular fees are as follows. You will be given advance notice if my fees should change. Regular therapy services are $150.00 for the first diagnostic session, with subsequent 60-minute sessions billed at $100.00- and 45-minute sessions billed at $75.00. Please pay for each session before or at its end. I have found that this arrangement helps us stay focused on our goals, and so it works best. It also allows me to keep my fees as low as possible because it cuts down on my bookkeeping costs. I suggest you pay by credit card before each session begins, so that our time will be used best. I accept most credit cards and also Health Savings Account payments. Other payment or fee arrangements must be worked out before the end of our first meeting.

Students will have a discounted rate of $140 for the first diagnostic session, and subsequent 60- minute sessions billed at $90 and 45-minute sessions billed at $65 per session. A valid student ID must be presented at first session to receive this discount.

Reports: I will not charge you for my time spent making routine reports to your insurance company.

If you think you may have trouble paying your bills on time, please discuss this with me. I will also raise the matter with you so we can arrive at a solution. If your unpaid balance reaches $100.00, I reserve the right to not schedule additional sessions with you. If it then remains unpaid, I may stop therapy with you if we cannot agree on a payment plan. If therapy services are delayed or discontinued, I am happy to provide referral resources to you, or you can call your insurance carrier to find out if they have providers available to treat you. Fees that continue unpaid after this may be turned over to small-claims court or a collection service and you agree to allow me to do that. If I choose to do that I will report only enough information to collect fees due to me. Please note that in the event that your account goes into collections, there will be a 35% collection fee added to your account balance.

A late payment fee of $25.00 will be charged each month that a balance remains unpaid, since I will incur costs to rebill and other accounting costs. A returned check fee of $35.00 will be charged if you pay by check and it bounces.

Because I am a licensed mental health therapist, many health insurance plans will help you pay for therapy and other services I offer. Because health insurance is written by many different companies, I cannot tell you what your plan covers. Please read your plan's booklet under coverage for "Outpatient Psychotherapy" or under "Treatment of Mental and Nervous Conditions." Or call your employer's benefits office to find out what you need to know.

If your health insurance will pay part of my fee, I will help you with your insurance claim forms. However,

please keep two things in mind: 1. I had no role in deciding what your insurance covers. Your employer or you (if you have individual coverage) decided which, if any, services will be covered and how much you have to pay. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth. Your insurance contract is between you and your insurance company; it is not between me and the insurance company unless I have signed a separate agreement with that particular company. You are responsible for paying the fees we agree upon. In addition, the plan may have rules, limits, and procedures that we should discuss and I may not be on one of their panels. Please bring your health insurance plan's description of services to one of our early meetings, so that we can talk about it and decide what to do.

I will provide information about you to your insurance company with your consent, and by signing below you agree that I may do that. If I have a contract with your insurance company, then billing will be sent in accordance with the contract I have with that company. If I am not contracted with that insurance company then I will supply you with an invoice for my services with the standard diagnostic and procedure codes for billing purposes, the times we met, my charges, and your payments. You can use this to apply for reimbursement. By signing this form you agree to assign any reimbursement you receive from your insurance company to me.

If you choose to not have me send information to your insurance company, you must select this option before each session and then pay for the session in full. I will then not report any information to your insurance company about that session. Although insurance companies say that they maintain confidentiality, oftentimes they report information to a national data bank that may later affect your ability to obtain other types of insurance.

Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance companies. Please be aware that not all issues/problems/conditions dealt with in therapy are covered by insurance. It is your responsibility to verify the specifics of your coverage. If you are using insurance, I will submit claims for you. You are responsible for any applicable deductibles and co-pays at the beginning of each session. You understand that insurance is billed as a courtesy to you and that you are responsible for full payment if the insurance company denies the claim.

Phone and Emergency Contact

If you need to contact your counselor by phone, please do so at the phone number provided to you by your counselor. If your counselor is not available, please leave a message and your call will usually be returned within 24 hours. If you have an emergency you should go directly to a hospital emergency department, call 911, or Netcare Access at 614-276-2273. You can also call the National Suicide Prevention Lifeline number at 1-800-273-8255. Emergencies are urgent situations and require your immediate reaction.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information about you in your client file. Your client file may include information about your reasons for seeking therapy, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of all of your records that I have prepared in connection with your treatment if you request them in writing, unless I determine for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, and in that event under Ohio law I may exercise the option of turning the records over to another mental health therapist designated by you, unless otherwise required by federal law. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, I therefore recommend that you initially review them with me or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so I will let you know what the charge is at the time that a records request is made. If you desire to have the information sent

to you electronically, if I maintain the information in an electronic format, I will provide the information in that format if you agree to accept the potential risks involved in sending the information that way.

Minors

If you are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order or if I feel that the release of your records to your parents might have an adverse effect on you, in which case under Ohio law they can name another mental health therapist that I will have to turn them over to, unless otherwise required by federal law. Before giving parents any information I will discuss the matter with you, if possible, and do my best to handle any objections you may have. Except in unusual circumstances, I like to make both parents aware of and involved in the treatment. In addition, if one parent brings in a child and the therapy only involves the child, under Ohio law since generally both parents have access to the child's records unless that access is blocked by a court order, anything that either parent says in the sessions is available to both parents. Legal documents need to be provided in cases where custody, visitation, shared parenting, guardianship or other matters which are covered by court documents are involved before I see a minor for treatment. Minors 14 years of age and older should be aware that they have an option to see me on a limited basis without their parents' knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of my intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option.

Acknowledgment of Informed Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize you to provide such care, treatment or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company or third party payer, to obtain reimbursement unless I direct otherwise.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through you at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor is the client I am signing on behalf of the minor as the authorized parent/guardian. (Information on Minor rights will be shared with the minor)

I also acknowledge that I have received a copy of the Notice of Privacy Practices for the mental health therapist listed at the top of this form.

Client Name(s) (please print)

_____

Client(s) Signature

_____ _____ Date

_____ _____ Date

Parent(s) or Guardian Signature (for minor child or children or disabled adults)