Seaside Counseling Services

P.O. Box 4097 Plymouth, MA 02361

Consent to Treatment

You have decided to embark on a powerful journey known as psychotherapy, a decision of strength and courage. At Seaside Counseling Services, know that we consider the psychotherapeutic relationship to be one of sacred trust. This letter serves to inform you about the therapeutic process, give you some information and answer questions about the professional relationship between therapist and clients.

Psychotherapy cannot insure the successful resolution of the issues you bring to it. Human beings are far too complex and life is too uncertain. However, it is our experience as therapists that most people can gain some value from the therapeutic process. Know that as we journey together new, often unforeseen destinations may appear. The therapeutic process may not only affect you, but also relationships, work and other areas of life. There are alternatives and many adjuncts to psychotherapy. These include, but are not limited to, medications, support groups and complimentary modalities. I will be happy to discuss any alternatives you want to consider at any time.

We have a number of client expectations about the professional relationship we embark on with each client. We expect you to keep your appointments. Please remember that someone else may want this time. Please give our other clients, their obligations, relations and your therapist the courtesy of a 24 hour notice if you must cancel an appointment; otherwise, you will be charged for this time. We always consider broken appointments individually and understand that emergencies do arise. Insurance will not pay for broken appointments.

Our current fee is $125-150 per session. Payment for your session is due at the time of service. We accept cash, personal checks, and credit cards. We work with a number of insurance companies via managed care contracts and we are responsible for filing claims for our services; you must pay your co pay at the time services are rendered. There are no exceptions. Other insurance plans (out of network) are accepted but you may be required to pay the difference. Payment arrangements are discussed during your initial session.

We also charge for our time when you require written correspondence. This is billed according to the amount of time utilized with a minimum fee of $20. This would include correspondence such as letters to other practitioners, disability applications, etc. Insurance will not pay for correspondence. We do not charge for customary insurance filing. Telephone/email consults are also billed at regular rates. The first 5 minutes we consider a professional courtesy to our relationship; thereafter, the time is billed at regular rates to the nearest quarter hour. Sessions are 45 to 50 minutes in length. Our therapist take a several minutes of an hour between clients to relax, let go of the last session and prepare for the next one.

Our appointment times are generally on the hour from 8 AM to 8 PM depending on the day of the week. Your therapist will schedule your next appointment at the end of each session. We are in the office Monday through Saturday. You may reach us via telephone/voicemail/email during regular office hours. As our therapists are in session most of the day, they do often check voice mail and return messages several times a day. If your call is non-urgent, we will respond as soon as possible. Calls left for me after 7 PM will be returned the following business day.

If you are in a life and death emergency situation dial 911 for assistance or go immediately to your local emergency department.

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Your sessions should focus on your concerns exclusively. You will learn a great deal about your therapist the longer you work together; our therapist may occasionally share experiences and struggles with some regularity as models for clients. Nonetheless, you will still be experiencing the therapist in a professional role solely. Our therapist will keep confidential anything you say with the following exceptions: a) you direct the therapist to speak about you with someone, b) The therapist determines that you are a danger to yourself or others, or c) there is evidence of child or elder abuse. In the event of the latter two exceptions, the therapist will contact family, friends, DCF and/or law enforcement authorities to attempt to prevent harm from coming to anyone.

Our therapists use an eclectic approach to therapy, meaning that they utilize a variety of therapeutic models. Our therapist work diligently to use what is most helpful for each individual rather than take any one approach exclusively. We hope this information is helpful to you. If at any time during your relationship your therapist, you have any questions please feel free to ask.

I do hereby seek and consent to take part in the treatment provided by Compassion Counseling Services, PC. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I (or my child) may stop treatment with this therapist at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I am aware that an agent of my insurance company or other third-party may be given information about the type (s), cost (s), and providers of any services I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment. My signature below shows that I understand and agree with all of these statements. I have been given the opportunity to ask questions regarding this information.

_____ _____

Signature of Client (or person acting for client) Date

_____

Relationship to Client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Therapist Date

Client Name _____ C.I.D.#_____

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Credit Card Payments Agreement

Seaside Counseling Services, uses a highly secure online credit card payment system. We can accept all major credit cards. By signing the line below, you agree to have your credit card information securely stored by Seaside Counseling Services, until your file has been closed. You also authorize your therapist, or billing representative to charge your credit card for any outstanding financial responsibilities over 30 days past due. Charges are typically made for such items as copayments, no show/late cancellation fees,
and deductible payments.

_____ _____

Client Signature/Guardian Signature if under 18 Date

1. First and last name as it appears on your credit card:

_____ _____

First Last

2. Card type (please circle): Visa MasterCard Other: _____

Card Number: _____

Expiration Date: _____

Card Verification Code: _____

The Verification number is a 3-digit number printed on the back of your card. It appears after and to the right of your card number.

3. Payment Schedule:
   - _____ Make a recurring payment of $_____ after each session for my copayment.
   - _____ Make a recurring payment of $70.00 for a no show/late cancellation.
   - _____ Make a recurring payment for each session until my deductible is met.
   - _____ Not interested in recurring payments at this time.

4. Billing Address:
   - _____ My billing address is the same as it appears on the paperwork submitted on the Patient Information Sheet.
   - _____ My billing address is different from that submitted on the intake paperwork.

   Street address: _____

   City: _____ State: _____ Zip Code _____

5. Contact Information

   Email address: _____

   Phone number: _____

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508-591-0696

Policies and Practices to Protect the Privacy of Your Health Information

HIPPA and CONFIDENTILITY INFORMATION

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Effective/Last Revised Date: September 7, 2011

Consultation and Counseling is required by federal law to protect the privacy of your health information in the context of your mental health and substance abuse health care administered by this agency. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by posting it in our website www.seasidecounselingservices.com

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - --- Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another Therapist. Another example would be when we release your treatment plan to your insurance company and/or to your primary care physician.
  - --- Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - — Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

HOW WE USE OR DISCLOSE INFORMATION

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the U.S. Department of Health and Human Services, if necessary, to ensure that your privacy is protected; and
- Where required by law.

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about your conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **To process** claims for health care services you receive.
- **For Treatment.** We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your general health.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health related products and services.
- **To Referral Sources.** If you are referred through another agency such as your Primary Care Physician, Juvenile Court, DFCS, Psychiatric Hospital, CMHC, etc., we may share summary information and admission and discharge information with the referral source. In addition, we may share other health information with the referral source for case management purposes if the referral source agrees to special restriction on its use and disclosure of the information.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical or mental health care to you.

We may use or disclose PHI ***without your consent*** or authorization in the following circumstances under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including social service or protective service agencies. If we have reasonable cause to believe that a child has been abused, we must report that belief to the appropriate authority. If we have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report that belief to the appropriate authority.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations. If we are the subject of an inquiry by the Georgia Composite Board, we may be required to disclose protected health information regarding you in proceedings before the Board.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena. If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release information without your written consent, subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **Serious Threat to Health or Safety.** If we determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, we may disclose information in order to provide protection against such danger for you or the intended victim.

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws relating to job-related injuries. We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.
- If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law.

If none of the above reasons applies, **then we will obtain your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you have given us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based upon your authorization. To revoke an authorization, contact the phone number listed below on this notice.

HIGHLY CONFIDENTIAL INFORMATION
Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* — You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing therapists. On your request, we will send your bills to another address.)
- *Right to Inspect and Copy* — You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process. Your therapist may also deny access to your Psychotherapy Notes.
- *Right to Amend* — You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* — You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* — You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise these policies and procedures, we will notify you by mail or on your next session. You may obtain a copy of this notice at the local office or website.

V. Complaints

- If you have any questions about this notice or want to exercise any of your rights, please call .508-591-0696 Please specify that your question or concern is in reference to your mental health and/or substance abuse protected health information.
- **Filing a Complaint.** All complaints must be in writing. If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

Compliance Department – Privacy Complaints
Seaside Counseling Services
P.O. Box 4097
Plymouth, MA 02361
Attn.: Megan McGraw Anderson

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **We will not take any adverse action against you for filing a complaint.**

VI. Cancellation Policy
In the Event of an emergency, you will not be charged for session cancellation. Cancellations for any other reasons that are not received by clinic staff at least 24 hours prior to the scheduled session will be billed at the session rate. Your insurance company will not pay for missed appointments.

VII. Financial Responsibility
Seaside Counseling Services, PC will assist you in completing and filing any insurance forms, which may be utilized for payments for services; however, you maintain full responsibility for paying all charges for services rendered. You will need to provide all required insurance information when checking in for services and you will need to update any changed insurance information immediately upon the date of change. All co-payments and unsatisfied deductibles are to be paid at the time of services rendered. does accept payment by cash, check or credit/debit card..

VIII. Effective Date, Restrictions, and Changes to Privacy Policy
This notice will go into effect on September 1, 2011. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain.

IX. Patient's Consent
I consent for my therapist to disclose my protected health information (PHI) as required by my insurance company. Furthermore, if my insurance company requires coordination of care with my Primary Care Provider (PCP), I consent for my therapist to disclose my protected health information to my PCP. I have read this statement of Seaside Counseling Services' practices and policies and I both understand and approve of its content.

Printed Name of Client

Witness

Signature of Client and/or Guardian

Date

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Client Information

Client's Name: _____ DOB_____

Client's Address: _____

_____

Client's phone numbers:

Home: _____

Cell:_____

Work: _____

Indicate your preferred way of being contacted by Seaside Counseling Services with a *

Email: _____

Legal Guardian (if applicable): _____Phone #_____

Person Financially Responsible: _____ Phone #_____

Primary Care Physician_____ Phone #_____

Psychiatrist (if applicable)_____ Phone #_____

Emergency Contact: _____Phone #_____

Referred by: _____

Primary Policy Holder Information

Name:_____

Address(if different from Client): _____

_____

Employer: _____

Primary Insurance Company: _____

Subscriber ID#_____ Co-pay Amount:_____

Auth #_____ Detectible met? _____yes _____no

Signature_____ Date_____

_____

OFFICE USE ONLY

Dx: _____Date: _____Therapist: _____

Seaside Counseling Services
Additional Information

Name_____ Date_____

How did you hear about us? _____

Reason(s) for seeking therapy:_____

_____

_____

Has client seen another therapist in the past year? _____no _____yes # of times_____

List any medication that you are currently taking_____

_____

Allergies_____

Health Concerns_____

_____

Family members (or others residing in the client's home):

Name_____Relationship_____Age____

Name_____Relationship_____Age____

Name_____Relationship_____Age____

Name_____Relationship_____Age____

Name_____Relationship_____Age____

Place of Employment_____

Your Education Level _____

Hobbies/Activites_____

Other information or concerns you would like your therapist to be aware of?

_____

_____

_____

_____

_____

_____

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Financial Agreement and Disclosures

Seaside Counseling Services, in compliance with national standards of ethics, is required to disclose all billing and financial matters regarding psychotherapy services. We are further required to have financial matters reviewed on a regular basis. As a client of Seaside Counseling Services, you understand:

1. The usual and customary rate for providing direct face-to-face psychotherapy services is:

• Initial Office Visit	(60 minutes)	$ 150
• Psychotherapy	(45-50 minutes)	$ 100
• Psychotherapy (brief)	(25-30 minutes)	$ 75
• Family/Couples	(45-50 minutes)	$ 125

2. You will be billed $70 for not giving a minimum of 24 hours notification of cancellation. This outstanding balance must be paid prior to additional psychotherapy services being delivered.

3. Your copayment/payment toward deductible is due at the beginning of each session.

4. The returned check fee is $30.

5. We also charge for our time when you require written correspondence. This is billed according to the amount of time utilized with a minimum fee of $20. This would include correspondence such as letters to other practitioners, disability applications, report writing etc. Insurance will not pay for correspondence. We do not charge for customary insurance filing. Telephone/email consults are also billed at regular rates. The first 5 minutes we consider a professional courtesy to our relationship; thereafter, the time is billed at regular rates to the nearest quarter hour.

6. We will periodically review the financial status of your account to address questions or concerns you may have regarding reimbursement issues involving third-party payers and balances due to Seaside Counseling Services.

Please discuss any questions or concerns you may have regarding the financial arrangements concerning your psychotherapy services. We hope we have clarified some of the more common questions we receive about your financial arrangements with our insurance companies and HMOs.

_____ _____

Client Signature/Guardian Signature if under 18 Date