WELCOME LETTER

Welcome to Care Counseling Center.

I appreciate you taking a moment out to read this. I wanted to thank-you for choosing us to provide for your counseling needs and goals. We appreciate and acknowledge the courage it takes to want to make a change, and we are delighted, honored and privileged to be working with you through this journey.

Here at Care Counseling Center, we are committed to a single goal; we strive to help families and individuals achieve their goals with professional guidance and support.

Often our clients want to share with others about their progress and success. You will have the most success by completing the goals you came to achieve. We welcome you to share your progress with others. Please know that should you choose to refer a potential client to work with us that both of your information is confidential and protected under HIPAA guidelines. Care Counseling Center does not share information with others without your consent.

We very much welcome and appreciate new clients into our practice, so we can also help them achieve the goals that matter to them most. We look forward to getting started with you at your first appointment. Should you have any questions prior to our appointment please feel free to give us a call.

Thank-you,

Dr. María Rodríguez, LPC

Care Counseling Center
908-617-3235
1 West Cliff St
Somerville, NJ

ASSIGNMENT OF BENEFITS AND BILLING AUTHORIZATION FORM

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. You agree to fill out and execute any additional necessary forms that may be required for your particular insurance carrier. In some cases the exact insurance benefits cannot be determined until the insurance company receives the claim and the claim is adjudicated.

Client Name _____ Date of Birth _____

Insurance Policy Holder Name _____

Relation to client: ☐ self ☐ spouse ☐ parent

Primary Insurance _____

Secondary Insurance _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____

Primary Insurance Policy # _____ Group # _____

Secondary Insurance Policy # _____ Group # _____

Assignment of Benefits

I hereby assign all medical and mental health benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other mental health/medical plan, to issue payment check(s) directly to **Care Counseling Center** for therapy services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Care Counseling Center** to:

Care Counseling Center
908-617-3235
1 West Cliff St
Somerville, NJ

1. Release any information necessary to insurance carriers regarding my therapy and sessions. I understand that my therapist may be required to release certain information to the insurance company at their request in order to procure necessary authorizations and or process claims for payment. This information may include, but is not limited to types of service, dates of service, times of service, diagnosis, treatment plans, progress of therapy and at times, treatment notes and/or summaries. I authorize the release of such information if necessary, understanding the limits of confidentiality regarding the use of my insurance benefits. I also acknowledge receipt of **Care Counseling Center**'s Notice of Privacy Practices.

2. Request payment of insurance benefits be made directly to **Care Counseling Center** for services performed.

3. If necessary, file a formal written complaint, if permitted by law, on my behalf to the state Insurance Commissioner, or other appropriate state agency, if payment for services is not timely received.

I have requested therapy services from **Care Counseling Center** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Clinician Signature: _____ Date: _____

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THERAPY CONSENT, POLICIES, & AGREEMENT

PART I: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

STRUCTURE OF THERAPY:

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaborate to identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.

- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 50 minutes depending upon the nature of the presenting challenges and insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment and agree to adhere to the following policy: ***If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment prior to 24 hours of the scheduled appointment time. If you cancel or reschedule more than once, we may re-evaluate your needs, desires, and motivations for treatment at this time. Each insurance panel has a different policy on whether clinicians can charge for missed appointments. Check your provider's policies regarding cancellations and/or no shows.***

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment.

FEES: The fee for each therapy session is $_____. Payment is due at the time of service. Acceptable forms of payment are: exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus $30 for any returned check), or credit/debit card. In the event that a scheduled appointment time is missed or cancelled less than 24 hours in advanced, please refer to the "Appointments and Cancellations" policy above.

The clinician reserves the right to terminate the counseling relationship if more than 5 sessions are missed without proper notification.

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed.

In-home/on-site therapy services offer people comfort and flexibility. They are offered at a regular hourly rate. Cost for travel is based on the regularly hourly rate and is determined by the time it takes to

travel from the office to client's home or requested place of session and return trip. Time is configured by tracking and logging actual time via internet sites such as Google, Bing, MapQuest, etc. to determine travel time.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged a fee of $1500.00 FEE FOR COURT ORDERED APPEARANCE (to include travel time, court time, preparing documents, etc.) to include travel time, court time, preparing documents, etc.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, the cost is 1.50 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records.

PHONE CONTACTS AND EMERGENCIES: Office hours are from Monday - Friday 9am-3pm. If you need to contact the clinician for any reason, please call 908-617-3234 leave a voicemail, and a return call will be made 24 Hours or as soon as possible. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, dial 911.

PART II: CONFIDENTIALITY*:*

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any

attempts to contact you and keep your records confidential, I am required to comply with a court order.

- **Law Enforcement and Public health**: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.
- **Governmental Oversight Activities**: To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- **Upon Your Death**: To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/progress notes", except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to the couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one

party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.

- **Dual Relationships & Public**: Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (i.e.: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **Social Media**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.
- **Electronic Communication: If you need to contact me outside of our sessions, please do so via phone.**
    - **Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship.** Texting is not a substitute for sessions. **Texting and communicating outside a secure portal is not confidential**. Phones can be lost or stolen and emails can be intercepted. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client's phone.
    - **Do not use email for emergencies**. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment.
    - **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.
- **Sessions Outside the Office:** From time to time, clients like to meet in an alternate location (i.e. their home, in public, or somewhere more conducive for them). We may be able to accommodate this request, however, this can put your confidentiality at risk.

PART III: REASONS I DO NOT ACCEPT INSURANCE (*delete this section if you take insurance*)

- **Reduced Ability to Choose:** Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require "preauthorization" before you can receive services. This means you must call the company and justify why you are seeking therapeutic services in order for you to

receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company's list. Reimbursement is reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.

- **Pre-Authorization and Reduced Confidentiality:** Insurance typically authorizes several therapy sessions at a time. When these sessions are finished, your therapist must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not completely met. Your insurance company may require additional clinical information that is confidential in order to approve or justify a continuation of services. Confidentiality cannot be assured or guaranteed when an insurance company requires information to approve continued services. Even if the therapist justifies the need for ongoing services, your insurance company may decline services. Your insurance company dictates if treatment will or will not be covered. Note: Personal information might be added to national medical information data banks regarding treatment.
- **Negative Impacts of a Psychiatric Diagnosis:** Insurance companies require clinicians to give a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to: applying for a job, financial aid, and/or concealed weapons permits.
5. A psychiatric diagnosis can be brought into a court case (i.e.: divorce court, family law, criminal, etc.).

It is also important to note that some psychiatric diagnoses are not eligible for reimbursement. This is often true for marriage/couples therapy.

Why Clinicians Do Not Take Insurance: These involve enhanced quality of care and other advantages:

1. You are in control of your care, including choosing your therapist, length of treatment, etc.
2. Increased privacy and confidentiality (except for limits of confidentiality).
3. Not having a mental health disorder diagnosis on your medical record.
4. Consulting with me on non-psychiatric issues that are important to you that aren't billable by insurance, such as learning how to cope with life changes, gaining more effective

communication techniques for your relationships, increasing personal insight, and developing healthy new skills.

After reading my position on why I don't accept health insurance, you still may decide to use your health insurance. If you provide me with a list of therapists on your insurance provider list, I will do my best to recommend a therapist for you.

EMERGENCY CONTACT:

It is necessary that **a clinician Care Counseling Center** has someone to contact on your behalf. In case of an emergency who should we contact?

_____

Full Name Relationship Phone Number(s)

Please check here that you agree and sign below. Thank you.

☐ I agree to allow **Care Counseling Center** to contact my emergency contact on my behalf in the case of emergency

_____

Signature Date

Care Counseling Center
908-617-3235
1 West Cliff St
Somerville, NJ

PART IV: CONSENT

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **a clinician at Care Counseling Center** . My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Care Counseling Center** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to **Care Counseling Center**. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **Care Counseling Center** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Care Counseling Center to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Care Counseling Center** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Your signature signifies that you have received a copy of the "Therapy Agreement, Policies and Consent*" for your records.*

Printed Name of Minor Child	DOB	Date

Clinician Signature: _____ Date: _____

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PART IV: CONSENT (CLIENT'S COPY)

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Care Counseling Center** . My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Care Counseling Center** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to **Care Counseling Center** . I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **Care Counseling Center** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Care Counseling Center to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Care Counseling Center** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Your signature signifies that you have received a copy of the "Therapy Agreement, Policies and Consent*" for your records.*

Printed Name of Minor Child	DOB	Date

Clinician Signature: _____ Date: _____

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Provider EIN # _____
Provider NPI # _____

Date: _____ Expires: _____

GOOD FAITH ESTIMATE - INTAKE, EVALUATION & TREATMENT PLANNING

Client Name:	
Date of Birth:	
Address:	
Phone #:	Email:
Diagnosis to be Determined Pending Full Evaluation: The evaluation and treatment planning are expected to result in a recommended plan for continuing _____ (weekly, monthly) sessions; in such instance a new Good Faith Estimate for ongoing therapy will be provided according to the fee schedule provided below; the number of sessions to be determined with a total anticipated number of sessions being less than 52.	
Responsible Party (if not the client):	
Client's Contact Preference: [ ] By mail [ ] By email [ ] By phone	
Date of Scheduled Service: _____/_____/_____ [ ] Check this box if this service or item is not yet scheduled	

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IMPORTANT: A formal diagnosis may occur after a diagnostic assessment has been completed. Your therapist will discuss, as relevant, diagnosis(es) as applicable to treatment.

It is within your rights to decline a formal diagnosis.

Effective January 1, 2022, a ruling went into effect called the "No Surprises Act," which requires mental health practitioners to provide a "Good Faith Estimate" (GFE) about out-of-network care to any patient who is uninsured or who is insured but does not plan to use their insurance benefits to pay for health care items and/ or services.

The Good Faith Estimate works to show the cost of items and services that are reasonably expected for your mental health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment.

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person upon the initiation of psychotherapy, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

Good Faith Estimate

Primary Service or Requested/Scheduled: Intake, Evaluation & Treatment Planning

Estimated Total Cost:

_____ Session(s) of ____minutes session at $ _____ for a total of $_____ dollars.

This Intake, Evaluation & Treatment Planning Service can last anywhere between one to four sessions.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

_____

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INTAKE, EVALUATION & TREATMENT PLANNING

Unlike some medical services, with behavioral health services your clinician often cannot form an estimate of what services you will need and what they will cost until the clinician has evaluated you. Even then, the extent of the services you will need will be influenced by many factors. Your clinician will review your treatment plan and service needs with you throughout your treatment with us that may not be reflected in this estimate.

With the services included in the estimate, the therapist will assess your unique situation to gain a more accurate understanding of your presenting problems and goals for therapy. After which, the therapist will provide you with a Good Faith Estimate for treatment costs moving forward.

Most clients will attend one psychotherapy visit per week on average, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your individual needs and preferences. It is also important, when determining your total estimate, to take into consideration vacations, holidays, emergencies, and sick time.

Care Counseling Center recognizes every client's therapy journey is unique. How long you need to engage in therapy and how often you attend sessions will be influenced by many factors including:

- Your schedule and life circumstances
- Therapist availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them
- Personal finances and resources

You and your therapist will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge and/ or a new "Good Faith Estimate" will be issued should the frequency of session(s) or needs change. As related, you may request a new GFE at any time in writing during your treatment.

Good Faith Estimate Disclaimer:

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate is only an estimate—actual items/ service charges may differ. The Good Faith Estimate does not include any unknown or unanticipated costs that may arise and are not reasonably expected during treatment due to unforeseen events. You could be charged more if complications or special circumstances occur. Other potential items and/ or services associated with therapy charges may include but is not limited to no show/ late cancellation fee(s), record request(s), letter writing(s), legal fee(s)/ court attendance(s), professional collaboration(s), and in-between session supports). These potential items / services and associated fee(s) are discussed further within the "Therapy Consent, Policies, and Agreements" documentation and should these items / services be initiated a new Good Faith

Estimate will be provided. The Good Faith Estimate does not obligate the client to obtain listed items or services.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. **If this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill**.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount

.

Client/Legal Guardian Signature: _____ Date: _____

Printed Name: _____Date: _____

Client/Legal Guardian Signature: _____ Date: _____

Printed Name: _____Date: _____

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Somerville, NJ

Clinician Signature: _____Date: _____

Clinician Typed Name & Credentials: Date:

Provider EIN # _____

Provider NPI# _____

Date: _____ Expires: _____

GOOD FAITH ESTIMATE

Client Name:	
Date of Birth:	
Address:	
Phone #:	Email:
Diagnosis (if known/applicable):	
Responsible Party (if not the client):	
Client's Contact Preference [ ] By mail [ ] By email [ ] By phone	
Date of Scheduled Service: _____/_____/_____ [ ] Check this box if this service or item is not yet scheduled	
IMPORTANT: A formal diagnosis may occur after a diagnostic assessment has been completed. Your therapist will discuss, as relevant, diagnosis(es) as applicable to treatment. **It is within your rights to decline a formal diagnosis.**	

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Somerville, NJ

Effective January 1, 2022, a ruling went into effect called the "No Surprises Act," which requires mental health practitioners to provide a "Good Faith Estimate" (GFE) about out-of-network care to any patient who is uninsured or who is insured but does not plan to use their insurance benefits to pay for health care items and/ or services.

The Good Faith Estimate works to show the cost of items and services that are reasonably expected for your mental health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment.

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person upon the initiation of psychotherapy, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

Good Faith Estimate

Primary Service or Item Requested/Scheduled:	
Diagnosis Code:	
Service Code:	

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The fee for a traditional **50-minute psychotherapy session** (in-person or via telehealth) is **$____**. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your individual needs and preference. It is also important, when determining your total estimate, to take into consideration vacations, holidays, emergencies, and sick time.

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You may project any potential future cost(s) by multiplying the session fee of $_____by the total number of sessions. This will result in your total estimated cost for mental health service(s).

If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

We are providing you with this good faith estimate based on the information the clinician has available at this time and actual items, services, or charges may differ from this good faith estimate as treatment progresses. Here is a chart of typical fees for services the practice provides that will be in effect for January 1, 2022__ through December 31, 2023__. Please note that these fees are the same for both in-office services and for telehealth services.

Number of Weeks	Total estimated charges for 1 session per week	Total estimated charges for 2 sessions per week
1 Week of Service		
13 Weeks of Service (Approx. 3 Months)		
26 Weeks of Service (Approx. 6 months)		
39 Weeks of Service (Approx. 9 months)		
52 Weeks of Service (Approx. 12 Months)		

Estimated Total Cost for Anticipated Services: _____ Session(s) of ____minutes session at $ _____ for a total of $_____ Dollars.

During the course of psychotherapy treatment, you may be subject to additional costs based on time, frequency, and services rendered. See below for a list of possible additional services:

Additional Fees	Estimated potential fees based on time, frequency and services rendered
Cancellation Fee	
Record Request Fee	$1.50
Consultation With Other Providers	

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Letter or Report Writing	
Crisis Communication (between sessions)	
Travel Time for Out of Office Sessions or Court Appearances	$175 per Hours
Forensic and/or Legal Fees	A new Good Faith Estimate will be provided to you based on the services and amount of time services are needed

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Care Counseling Center recognizes every client's therapy journey is unique. How long you need to engage in therapy and how often you attend sessions will be influenced by many factors including:

- Your schedule and life circumstances
- Therapist availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them
- Personal finances and resources

You and your therapist will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge and/ or a new "Good Faith Estimate" will be issued should the frequency of session(s) or needs change. As related, you may request a new GFE at any time in writing during your treatment.

Good Faith Estimate Disclaimer:

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. Your provider may recommend additional services that are not reflected in this Good Faith Estimate.

The Good Faith Estimate is only an estimate—actual items/ service charges may differ. The Good Faith Estimate does not include any unknown or unanticipated costs that may arise and are not reasonably expected during treatment due to unforeseen events. You could be charged more if complications or special circumstances occur. Other potential items and/ or services associated with therapy charges may include but is not limited to no show/ late cancellation fee(s), record request(s), letter writing(s), legal fee(s)/ court attendance(s), professional collaboration(s), and in-between session supports). These potential items / services and associated fee(s) are discussed further within the "Therapy Consent, Policies, and Agreements" documentation and should these items / services be initiated a new Good Faith

Estimate will be provided. The Good Faith Estimate does not obligate the client to obtain listed items or services.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. **If this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill**.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount

Client/Legal Guardian Signature: _____ Date: _____

Printed Name: _____Date: _____

Client/Legal Guardian Signature: _____ Date: _____

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Printed Name: _____Date: _____

Clinician Signature: _____Date: _____

Clinician Typed Name & Credentials: Date: _____

Health Insurance Portability Accountability Act (HIPAA)

Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), 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 I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
- I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

- If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the NJ Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the NJ Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am 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.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of 1.50 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am 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. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of NJ Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

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

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Signature:_____ Date: _____

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MENTAL STATUS EXAM & DIAGNOSIS

Client Name:	Service Date:
	Time:

Brief Mental Status Exam:

Orientation

- ☐ Alert & Oriented X3
- ☐ If Less than 3, what is impaired?
- ☐ _____

Mood

- ☐ Euthymic
- ☐ Dysthymic
- ☐ Depressed
- ☐ Anxious
- ☐ Elevated
- ☐ Elated

Affect

- ☐ Congruent
- ☐ Labile
- ☐ Restricted
- ☐ Constricted
- ☐ Flat
- ☐ Blunted

Appearance

- ☐ Well-Groomed
- ☐ Unkempt
- ☐ Disheveled
- ☐ Bizarre

Speech

- ☐ Normal
- ☐ Soft
- ☐ Loud
- ☐ Slurred
- ☐ Pressured
- ☐ Hyperverbal

Activity Level

- ☐ Appropriate
- ☐ Restless
- ☐ Rigid
- ☐ Slowed
- ☐ Agitated
- ☐ Threatening

Attitude

- ☐ Cooperative
- ☐ Defensive
- ☐ Irritable
- ☐ Resistant
- ☐ Poor Boundaries

Thoughts

- ☐ Normal
- ☐ Concrete
- ☐ Inhibited
- ☐ Paranoid
- ☐ Inhibited
- ☐ Delusions
- ☐ Grandiose
- ☐ Tangential
- ☐ Flights of Ideas
- ☐ Circumstantial
- ☐ Perseverative
- ☐ Blunted

Insight

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Nil

Judgment

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Nil

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Suicidal Ideation	Homicidal Ideation	Self-Harm Ideation	Alcohol/Drug Use	Medication Status
☐ Denies All	☐ Denies All	☐ Denies All	☐ N/A	☐ Compliant
☐ Feeting Only	☐ Fleeting Only	☐ Fleeting Only	☐ Social Use	☐ Non-Compliant
☐ Intent	☐ Intent	☐ Intent	☐ Abuse	☐ Medication Change (List Below):
☐ Current Plan	☐ Current Plan	☐ Current Plan	☐ Dependent	
☐ Past Plan	☐ Contracted for Safety	☐ Past Attempts	☐ Intoxicated	
☐ Past Attempt		☐ Contracted for Safety	☐ Actively in Recovery	
☐ Contracted for Safety				

Client meets criteria for following DSM5 diagnosis/diagnoses:

Additional Observations/Notes:

Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

I, (Client's Name)_____ **DOB:**_____

hereby give my permission to **Care Counseling Center**, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

This information will be released/requested upon request to the following:

To/From:

_____

First and last name, phone, and address of person(s)

The type of information to be disclosed/requested is as follows:

To Be Released * *from **Care Counseling Center***	**To Be Requested** * *from third parties*
____Treatment Plans	____Treatment Plans
____Progress Notes	____Progress Notes
____Health/Medical Records (if applicable)	____Health/Medical/Academic Records
____Letter(s) of Progress	____Psychological/Psychiatric Evaluations
____Bio Psychosocial Evaluation/Assessment (if applicable)	____Court Documents
__ Verbal Communication	__ Verbal Communication
____Other (Specify): _____	____Other (Specify):

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), such records may be protected from disclosure under the HIPAA Privacy Rule).*

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **Care Counseling Center**.

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **Care Counseling Center** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **Care Counseling Center**. **Care Counseling Center** will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that **Care Counseling Center** will release only the minimum amount of information necessary to fulfill a request.

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This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Release:

_____

Signature Client/Next of Kin/Guardian Date

Signature: _____

Request:

_____

Signature Client/Next of Kin/Guardian Date

Date: _____

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TECHNOLOGY ASSISTED COUNSELING (TAC)
CONSENT, POLICIES, & AGREEMENT

This form is in **addition** to the regular Therapy, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign both in order to participate in Technology Assisted Counseling (TAC) sessions. TAC incorporates email, phone and video counseling. Prior to engaging in TAC an assessment/consultation will be done to assure that TAC is an appropriate form of counseling. This is to inform you about what you can expect regarding your participation in TAC counseling.

Benefits:
The benefits to TAC counseling are:

1. The ability to expand your choice of service provider.
2. More convenient counseling options including location, time, no driving, etc.
3. Reduces the overall cost and time of therapy due to not having to drive to and from an office.
4. Ability to have real time monitoring and reduces the wait time for scheduling office appointments.
5. Increased availability of services to homebound clients. clients with limited mobility, and clients without convenient transportation options.

Limitations:
It is important to note that there are limitations to TAC counseling that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. Due to technology limitations I may not hear all of what you are saying and may need to ask you to repeat things.
3. Technology might fail before or during the TAC counseling session.
4. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.
5. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

Logistics:
When I provide phone/video-counseling sessions, I will call you at our scheduled time or send you a link for our secure and HIPAA compliant video session. I expect that you are available at

our scheduled time and are prepared, focused and engaged in the session. I am calling you from a private location where I am the only person in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people or others who can hear you, I cannot be responsible for protecting your confidentiality. Every effort MUST be made on your part to protect your own confidentiality. I suggest you wear a headset to increase confidentiality and also increase the sound quality of our sessions. Please know that I cannot guarantee the privacy or confidentiality of conversations held via phone, as phone conversations can be intercepted either accidentally or intentionally. Please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment.

Please know that per best practices and ethical guidelines I can only practice in the state(s) I am licensed in. That means wherever you reside I must be licensed. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

Connection Loss During Phone Sessions: If we lose our phone connection during our session, I will call you back immediately. Please also attempt to call me at _____ if I cannot reach you. If we are unable to reach each other due to technological issues, I will attempt to call you 4 times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, your phone battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, I will call you from an alternate number. The number may show up as restricted or blocked please be sure to pick it up.

Connection Loss During Video Sessions: If we lose our connection during a video session, I will call you to troubleshoot the reason we lost connection. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e. technology, battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, we can either complete our session via. phone or plan an alternate time to complete the remaining minutes of our session.

Please list your main number and an alternate number below.

_____

__
Number(s)

Recording of Sessions:
Please note that recording, screenshots, etc. of any kind of any session is not permitted and are grounds for termination of the client-therapist relationship.

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Payment for Services:
Payments for services must be made **prior** to each session. I will charge your card on file or send you an invoice. Payment is to be completed prior to our session.

Cancellation Policy:
If you must cancel or reschedule an appointment, 24-hour advance notice is required, otherwise you will be held financially responsible. Should you cancel or miss an appointment with notification less than 24 hours this will result in being charged the ***full fee*** for your missed appointment. Cancellations must be communicated by phone, NOT email or text. If clients have more than 2 cancellations during the course of treatment/therapy the therapist and client will address the need for ongoing therapy. Should a client want to continue a client may be asked to pre-pay for sessions when they are scheduled. If the client cancels or misses the session with less than 24 hours notice and the session is pre-paid, this follows the cancelation guidelines and the payment will not be reimbursed for the missed or canceled session less than 24 hours. Phone/video sessions should be treated as regular in office sessions. If you are late getting on the phone, are unable to talk at our scheduled time, your battery has died and you are unable to access another confidential place to talk, or any other variable that would have you not be able to attend our session please know that you will be charged for the session. Please make the necessary arrangements you need to be available and present for your session.

Emergencies and Confidentiality:
I request an emergency contact for you. Please list the person's first and last name, relationship and phone number(s) of your emergency contact:

_____

___
Full Name Relationship Number(s)

I also request the address from which you are calling and the number to your local police department including area code in the area in which you are located during the time of our call.

_____

___
Street Address

_____

___
City State Zip Code

_____

___
City and State of Local Police Department Phone Number

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline

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at 800-784-2433.

If I have concerns about your safety at ***any*** time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

Consent to Participate in TAC Sessions:
By signing below you agree that you have read and understand all of the above sections of TAC informed consent. You agree that you also understand the limitations associated with participating in TAC counseling sessions and consent to attend sessions under the terms described in this document.

Client's Name: _____ Date: _____

Client's Signature: _____ Date: _____

Client's Name: _____ Date: _____

Client's Signature: _____ Date: _____

Clinician's Signature/Credentials: _____ Date: _____

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