Connections Counseling, LLC

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Child & Adolescent Informed Consent

Client-Guardian-Counselor Service Agreement

Welcome to Connections Counseling, LLC. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling or parent of a client, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you and to your parents. These rights and responsibilities are described in the following sections.

Goals of Counseling

There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the quality of your connections or learning to be assertive. Others may be more immediate goals such as decreasing anxiety and depression symptoms or changing behavior. I will work with you and your parent(s)/guardian(s) to identify goals for treatment. You will be an integral part of this decision-making progress.

Please initial that you understand and accept the Goals of Counseling policy_____ _____.

Risks/Benefits of Counseling

Counseling is not easily described because it varies greatly depending on the clinician, the client, and the particular problems a client brings. Counseling, while having both risks and benefits, requires an active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. Unlike some services you may receive from a physician, counseling involves your participation and cooperation.

Due to the nature of counseling there is a risk of unpleasant memories or emotions (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) emerging. There are no guarantees that counseling will work for you and progress may happen rapidly or slowly depending on the complexity of the issues you're tackling, so a specific timeframe is not always possible. I will do my best to give you the tools and skills needed to cope with these feelings beforehand but it is not always possible to predict how you will respond.

Potential benefits include a significant reduction in feelings of distress, improved self-knowledge, an understanding of strengths and limitations, improved relationships, improved problem-solving, new coping skills, and resolutions of specific problems. Given the nature of counseling, it is difficult to predict what exactly will happen, but it is hoped that counseling will help you to manage the risks and experience at least some of the benefits.

Please initial that you understand and accept the Risks/Benefits of Counseling_____ _____.

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Appointments

Appointments will ordinarily be 55 minutes in duration, once per week at a time we agree on, although sessions may be schedule more or less frequently as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you may be required to pay the Late Cancellation Fee ($50). It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible the cancelation fee.

Please initial that you understand and accept the Appointments policy_____ _____.

Confidentiality

I will make every effort to keep your personal information private. If you wish to have information released, you and your guardian will be required to sign a consent form before I will release any information and you, or your guardian, have the right to revoke that release at any time. However, there are some limitations to confidentiality of which you need to be aware.

Emergencies

If you are involved in a life-threatening emergency while in my office and you, or your guardian, is not capable of providing permission, I will share information I believe is pertinent to the specific emergency to obtain necessary medical care for you.

Court Proceedings

If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you and your guardian provide written authorization or a judge issues a court order. If I receive a subpoena from anyone other than a court judge for records or testimony, I will notify your guardian so that they (or their attorney) can file a motion to quash (block) the subpoena and can give the reasons why I think your records should be protected from disclosure. ***Please note that I do not provide forensic evaluations or testify in court proceedings.***

Protecting Others from Harm

If I have reason to suspect that a child or vulnerable adult is being abused, neglected or exploited, I am required by Alaska law to immediately make a report and provide relevant information to the appropriate state agency (i.e. Office of Children's Services). If I have reason to suspect you are threatening serious bodily harm to another person, I am required by law to take protective actions, which will include notifying your guardian and may include notifying the potential victim, the police, or seeking appropriate hospitalization.

Protecting You from Self-Harm

If you threaten to harm or to kill yourself, I am required to make all necessary arrangements to protect your safety—a process that may include seeking acute care for you — by notifying your guardian or others who can help provide protection.

Consultation

At times I may find it necessary to consult with other professional counselors to provide you with the best possible care. When consulting with other professionals I do not share any information that may reveal your identity and only share information that is necessary for the purpose of the consultation (i.e. techniques that we've tried or complex issues). The professionals I consult with are held to the same standards of confidentiality.

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Coordination of Treatment Among Professionals

When it is helpful for other professionals (such as your physician or psychiatrist) to gain access to all or parts of your treatment records, data can be released from your file if you or your guardian provides ***written*** permission (in the form of a Release of Information Form).

Please initial that you understand and accept the Confidentiality policy_____ _____.

Services for Minors

For clients under 18 years old, the law provides parents the right to examine a child's treatment records. It is my policy to request parents waive this right to protect the therapeutic relationship between myself and their child. I will provide parents with general updates about our work together or specific information that your child and I agree will be shared with you present. The exception to that rule is if in my clinical judgment I believe there is a risk of serious harm to your child or someone else. In this case, I will notify you of my concern. Whenever possible I will talk to your child first to discuss my concerns and what information I will be sharing. It is often beneficial to include one or more family members in treatment sessions. A schedule for such sessions may be determined following the initial evaluation session or be set up on an "as needed" basis.

Please initial that you understand and accept the Services for Minors policy_____ _____.

Record Keeping

I will keep records of your counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should you wish to have your records released, you are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept until the child is at least 25 years old. Records will be kept either electronically on an external hard drive or in a paper file and will be stored in a secure location.

Please initial that you understand and accept the Record Keeping policy _____ _____.

Fee Schedule

Regular session fees are $225 for a 55 minute session and $500 for a Psychosocial Assessment that will typically take 90 minutes. If you choose to bill your own insurance I will provide a receipt for each payment which can be submitted to your insurance company for reimbursement. Depending on your insurance company, I may be able to bill insurance directly, in which case you will only be responsible for the portion your insurance does not cover. Other professional services you might request (such as telephone conversations that last longer than 10 minutes, meetings or consultations with other professionals, or preparing documents for court) also have a fee of $150/hr. Insurance often will not reimburse for these services. You will be expected to pay for each session or other service at the time it is given, unless other arrangements are made ahead of time.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires me to provide summaries, you will be expected to pay for the professional time required at the rate of $150/hr which in insurance will not reimburse. If you require an expert evaluation for your court case (i.e. custody cases) please seek out someone who specializes in this area and is willing to testify in court as this is not my area of expertise.

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In cases in which an outstanding balance accrues, I will discuss the balance with you. In unusual financial hardship, your guardian and I may negotiate a fee adjustment or installment payment plan. Letters or statements may be given or sent to you within 90 days that the balance is accrued, unless other arrangements are made. I may engage an outside collection service, if accounts become unreasonably delinquent and an alternative payment arrangement has not been made. If a collection agency is used, a delinquent account fee (30% of the outstanding balance) will be added. Please do not hesitate to ask questions about payment or other policies. Fees are subject to change at counselor's discretion but will be discussed with you prior to any changes taking effect.

Please initial that you understand and accept the Fee Schedule policy_____ _____.

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information which will become part of the insurance company files. By signing the insurance agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover counseling fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee to be covered by the patient. In addition, most insurance companies have a yearly deductible, which is an out-of-pocket amount that must be paid by the patient before insurance begins paying any amount for services. Any amount not covered by insurance will need to be paid before the session.

If I am not able to bill your insurance plan directly, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Please initial that you understand and accept the Insurance policy_____ _____.

Contact & Emergencies

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. You may choose to send me an email instead. If you feel you cannot wait for a return call and need to speak with someone immediately call the 24-hour Crisis Hotline at 563-3200. If it is a life threatening emergency, go to your local hospital or call 911.

Please initial that you understand and accept the Contact & Emergencies policy_____ _____.

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Email

I may request your email address. You have the right to refuse to divulge your email address. You may email me if you need to cancel or reschedule an appointment or for administrative services. I may also use your email address to send valuable therapeutic information such as tips for depression or relaxation techniques that we discuss in sessions. Due to lack of HIPPA compliance at this time I will not be able to discuss your therapeutic issues via email. If you would like to receive any correspondence through email, please **print** your email

address here _____

If you would like to **opt out** of email correspondence, please initial here _____ .

Please initial that you understand and accept the Email policy_____ _____.

Teletherapy

I provide teletherapy via a HIPPA approved platform for established clients on an as needed basis. Typically, in-person sessions are preferred as they are more interactive and productive. When using teletherapy I am not able to control who may be able to hear or see you from your location during our session. I will take the same precautions on my end as I do for in-person sessions. If you would like me to set up a teletherapy connection please print your preferred email and I will send you an invite to join me on VSee.

Please initial that you understand and accept the Teletherapy policy_____ _____.

Account Balances

Payment for services is expected at the end of your session. If you have insurance you are responsible for the co-pay/co-insurance at the time services are rendered. You may do this by paying in the office with cash, check, or credit card, using your bank's bill pay feature, or completing a credit card authorization form which will be charged at the end of every session. I use an outside biller that will be sending invoices monthly. Unless we have made other arrangements, the balance is due upon receipt of the statement. Any balance that is 90 or more days past due will be charged 5% of the balance on a monthly basis unless a written payment arrangement is in place. If there is a balance that is more than 120 days past due and no payment arrangements have been made, the account will be sent to collections.

Please initial that you understand and accept the Account Balances policy _____ _____.

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Client Name (please print) _____

Consent to Counseling

Your signature below indicates that you have read this Agreement and agree to its terms.

Client Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

HIPAA

As federal law, the Health Insurance Portability and Accountability Act (HIPAA) became effective on April 14, 2003. HIPAA provides privacy protections for medical records and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). PHI is your medical, billing and demographic information collected and created or received by me for the purposes of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of your PHI. The Notice, which is included with this agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that we obtain your signature acknowledging that I have provided you with this information.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

Your signature below indicates that you have been provided a copy of my Notice of Privacy Practices.

Client Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

Acknowledgement of Receipt of Disclosure Statement

Your signature below indicates that you have been provided a copy of my Disclosure Statement as required by the Alaska Board of Professional Counselors.

Client Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

Clinician Signature _____ Date_____

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