Manifest Counseling – Informed Consent for Treatment

SERVICES OFFERED

Manifest Counseling, LLC is a limited liability company offering trauma-informed therapeutic services within the state of Missouri. My name is Nigel Cook, and I am the sole proprietor of Manifest Counseling, LLC. I am a licensed clinical social worker (LCSW) in the state of Missouri (MO #2020017473). This is an informed consent outlining the rights and expectations of receiving therapeutic services from me.

CONFIDENTIALITY

One of your rights as a therapy client is a right to confidentiality. "Confidentiality" means that any information disclosed to me in session will be kept private and not shared with other people. This includes written and verbal information shared both during and outside of appointments. This also extends to information stored in confidential case files. Generally, no one will learn of our work together without your explicit written permission.

However, there may be circumstances in which I am required by law to breach confidentiality, even without your permission. If I do reveal these things, I am not required by the law to tell you that I have done so. Those reasons are as follows:

1) **Previously unreported child/elder abuse**: Missouri State Law (#210.110, 2.14.140, 210.1650) requires that all mental health professionals to report any and all known or suspected cases of child or elder abuse. "Child" is anyone under the age of 18 and "Elder" is anyone age 60 or above. This includes any previously unreported abuse or neglect that may have occurred to persons currently meeting the age criteria mentioned above, regardless of whether or not the abusive/neglectful situation has ceased.
2) **Intent to Harm Self**: For your own safety, if you disclose serious intent to harm yourself and/or end your own life, I will break confidentiality. This may include (but is not limited to) contacting emergency services, medical professionals, or crisis intervention specialists. Decisions to break confidentiality for this purpose are made with your best interests in mind.
3) **Intent to Harm Others**: If you threaten to harm another person, I must warn that person and the authorities.
4) **Court Orders**: There may be instances in which I am required by law to disclose information about you for legal purposes (e.g., court testimony, court-mandated treatment, etc.).

If you are a client under the age of 18, your legal guardian is legally entitled to all information discussed in treatment. However, my operating philosophy is that minors are entitled to the same rights of confidentiality detailed throughout this document. By signing below, both the minor client and legal guardian acknowledge that information disclosed will be kept confidential (i.e., not shared with the legal guardian), unless the information pertains to an immediate safety concern and/or meets the criteria for breaching confidentiality outlined above. If a legal guardian has concerns about a minor's right to confidentiality, and would like to be informed of certain information discussed in treatment, that can be negotiated between the minor, the legal guardian, and me at any time during treatment.

All clients receiving services will have a confidential case file containing clinically-relevant information regarding diagnosis, treatment planning, and progress in therapy. You have a right to review your clinical chart at any time, or get copies for other providers to review.

As a common courtesy, if you become aware of my work with another individual (e.g., seeing them in the waiting room, them disclosing our work together with you, etc.), I ask that you maintain that individual's confidentiality. This also means that if they become aware of my work with you, they will be expected to maintain your confidentiality as well. I do not acknowledge my work with clients to other clients, even if both parties are aware of our work together.

If I wish to record a session, I will get your informed consent before doing so. You have the right to prevent any such recordings.

If you have an individual who you would like me to share information with and/or have participate in certain sessions (e.g., spouse, medical provider, etc.), please complete a "Release of Information" form for each individual. You can complete or revoke this form at any point during treatment.

RISKS AND BENEFITS TO TREATMENT

There are benefits to participating in therapeutic services. First, therapy will provide you a safe space to process intense or distressing emotions that are causing clinically significant symptoms or impairments in your life. Second, therapy will help you develop coping strategies to address these symptoms and impairments. However, attending therapeutic services can potentially cause emotional, psychological, and physical distress. If you find that therapy is causing significant impairments in your life, please inform me as soon as possible and we can work collaboratively to address your concerns.

You have the right to be informed of all the therapeutic strategies or modalities I use in our work together, as well as my rationale for using them. You also have a right to refuse a therapeutic intervention I recommend. If I plan to use any unusual or newer technique, I will tell you beforehand and discuss its benefits and risks.

ELECTRONIC COMMUNICATION

Please complete the "Electronic Communication" form if you consent to electronic communication via text message or email. Other forms of electronic communication (e.g. social media, other apps) are not permitted forms of communication. Electronic communication is subject to all standards listed in the "CONFIDENTIALITY" section of this consent form.

HIPAA COMPLIANCE

I will provide you with a separate "Notice of Privacy Practices" form. This Notice explains how I may use or disclose your health information, and what rights you have in regard to your health information. The law requires that I obtain your signature acknowledging that I have provided you with this information. Manifest Counseling, LLC is a HIPAA compliant organization, and the information contained within this informed consent is consistent with HIPAA standards regarding confidentiality and health information.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

PARTICIPATION AGREEMENT

Therapy will work most effectively if done consistently. Therefore, it is recommended that appointments be scheduled on a weekly basis. If you do not wish to attend therapy on a weekly basis, a different treatment schedule can be negotiated.

If you do not attend a scheduled appointment without prior notice, then you will still be charged the full rate for the hour. If the appointment is cancelled with less than 24-hours' notice, you will be charged 50% of the rate listed in the "FEE FOR SERVICES" section of this consent form. You will not be charged for appointments cancelled with more than 24-hours' notice.

If you miss multiple appointments without prior notice, or if you stop contacting me despite our agreement to work with one another, I will assume you are no longer interested in services at that time and close your file. You will have a right to resume services with me at a later time. If I discontinue services, I will provide you with referrals to other providers offering similar services.

FEE FOR SERVICES

Fees are payable at the time of service. Your fee per 45-50 minute session is $130. You will NOT be charged for your initial consultation appointment.

Please complete the "Electronic Payment Authorization" form, and the billing company Simple Practice will send you a billing statement via e-mail at the completion of each month of service. If you plan to utilize your insurance plan as an out-of-network provider, this billing statement will be necessary to request reimbursement. If a report, letter, or consultation with an outside party is requested, you will be billed for any time needed to prepare documentation or to conduct an in-person or phone consultation and the standard service fee is $130 per 50-minute hour.

Refusal to pay may result in discontinuation of services. Inability to pay due to unforeseen life circumstances can be discussed, and a new rate can be negotiated at that time. If you are currently receiving a rate reduction due to hardship previously discussed, please write that amount here $_____, which corresponds to a ____% discount.

QUESTIONS OR COMPLAINTS

If you have any questions or complaints about the services I am providing, please reach out to me as soon as possible (918-813-7843 or nigel@manifestcounselingstl.com). I encourage clients to take an active role in their treatment, including expressing concerns and inquiring about their treatment.

STATEMENT OF ACKNOWLEDGEMENT

By signing below, you acknowledge an understanding of and agreement to all of the information contained within this form. You also acknowledge that you have a right to revoke your consent at any time, and are not required to provide me with a reason. Revoking consent will result in an immediate discontinuation of services. You also acknowledge that you have been offered a copy of this form, as well as the "Right of a Psychotherapy Client" form, for your personal records.

Name of Client (Printed): _____

Signature of Client: _____ Date: _____

Name of Legal Guardian: _____

Signature of Legal Guardian: _____ Date: _____

(If different from client)

Signature of Clinician: _____ Date: _____

Manifest Counseling – Notice of Privacy Practices

Policy Name: Notice of Privacy Practices Effective Date: 9/4/2020

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

In August 1996, the federal government passed the "Health Insurance Portability and Accountability Act of 1996" or HIPAA. Among other things, this law directed the Department of Health and Human Services to establish regulations to prevent unauthorized uses or disclosures of health information. I will refer to the federal law and regulations together as the "privacy law." The privacy law requires that I prepare this "Notice of Privacy Practices for Protected Health Information" (or simply this "Notice") to describe how I may use your Protected Health Information and your rights and my duties. Your Protected Health Information (PHI) generally means your health information created or received by me, which identifies or could identify you. Your PHI relates to your physical or mental health or condition, your health care, or payment for your health care.

1. Uses or Disclosures Permitted with Your Written Consent

    - With your consent, I am permitted to use your PHI within my office and to disclose your PHI to others outside my office. When I use or disclose your PHI or request your PHI from someone else, I will make reasonable efforts to limit it to the minimum necessary.
    - I am permitted to use or disclose your PHI for the following purposes:
    - Treatment. Treatment generally means providing, coordinating, and managing your health care with other health care providers (such as your doctor) or third parties (such as a school teacher or counselor). Treatment also includes consultations with and referrals to other health care providers.
    - I may also contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.
    - Payment. Common payment activities include verifying insurance coverage, billing and collection, or reviewing health care services for medical necessity, justification of charges, and so on.
    - Health Care Operations. Health care operations are certain administrative, legal, financial, or quality improvement activities needed to keep my practice running smoothly. Health care operations include professional accreditation, certification, or licensing, implementing and complying with government regulations and agencies, and business and professional liability insurance.
    - Business Associates. I sometimes hire individuals or companies to perform certain jobs for me, for example, secretarial, copying, or billing services. The privacy law refers to these hired individuals and companies as "business associates." I may need to disclose your PHI to these business associates so they may do their jobs. To protect your privacy, their contracts with me require that they take certain steps to protect your PHI.

2. Uses or Disclosures Permitted Without Your Written Consent or Authorization: In limited cases, the privacy law permits me to use and disclose some of your PHI without your authorization or consent. Some examples of such cases are:

- Emergencies, disasters, or to avert a serious threat to health or safety. An emergency is generally defined as a situation, which requires immediate action to prevent death or serious injury.
- When required by law. For example, to report child abuse, neglect, or domestic violence, to respond to a court order or subpoena, to show government agencies that I am complying with the privacy laws.
- For public health purposes. For example, to authorized public health authorities for health oversight activities or to prevent or control disease or injury.
- For law enforcement purposes. For example, in response to a legitimate inquiry from a law enforcement official investigating a crime, or to report certain types of wounds or injuries.
- Relating to decedents. For example, if the death might have resulted from criminal conduct, to identify the deceased person, to determine the cause of death, to allow funeral directors to perform their duties, or for organ donation purposes.
- Specialized government functions. For example, the PHI of veterans and armed forces personnel may be disclosed to military authorities. PHI may be disclosed for national security and intelligence activities. PHI of inmates may be disclosed to corrections officials. PHI may be disclosed to comply with workers' compensation or similar programs.
- I will strive to release only the minimum necessary information and only to the proper authorities. When possible and permitted, I will attempt to notify you of such uses or disclosures.

3. Other Uses or Disclosures: Other uses and disclosures will be made only with your written authorization. You may revoke your authorization in writing.

4. You have the right to:

    - Request restrictions on certain uses and disclosures of protected health information. I am not required to agree to a requested restriction, but, if I agree to a restriction, I am bound by that agreement.
    - Request to receive confidential communications of protected health information by alternative means or at alternative locations. For example, you might not wish to be contacted at work. Please let me know if you have any such needs.
    - Inspect and copy your protected health information. We may charge a reasonable fee to cover the cost of copying, postage, or preparing written explanations or summaries.
    - Amend your protected health information.
    - Receive an accounting of disclosures of protected health information.
    - Obtain a paper copy of this Notice upon request.

5. Requests for Access to PHI: You must submit a request for access to inspect or copy your protected health information to me in writing. I must act on your request no later than 30 days from the receipt of your request.

6. Confidential Communications: You must submit a request for confidential communications to me in writing. I may require information on how payment, if any, will be handled and details on how you wish to handle the communication or contact.

7. My Duties: The privacy law requires that I maintain the privacy of your PHI and provide you with notice of my legal duties and privacy practices with respect to your PHI. I am required to abide by the terms of this Notice as currently in effect. I reserve the right to change the terms of this Notice and to make new Notice provisions effective for all your PHI that I maintain. You may obtain a revised Notice on request.

8. If you have a complaint: You may complain to me or to the Secretary of the Department Health and Human Services if you believe I have violated your privacy rights. You will not be retaliated against for filing a complaint.

9. Contact Information: If you have any complaints or questions regarding this Notice or your health information, please contact me. My mailing address is:

Nigel A. T. Cook, MSW, LCSW
Manifest Counseling
4050 West Pine Blvd. Apt. 4118
St. Louis, MO 63108
My phone number is: 918-813-7843

Notice of Privacy Practices Receipt and Acknowledgment of Notice

Client Name: _____ DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Manifest Counseling's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Nigel A.T. Cook at 918-813-7843.

Signature of Client: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____
(If different from client)

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, _____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

Manifest Counseling - Client Email/Texting Informed Consent Form

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1. Risk of using email/texting
   - The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:
   - Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   - Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
   - Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
   - Employers and on-line services have a right to inspect emails sent through their company systems.
   - Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   - Email and texts can be used as evidence in court.
   - Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts
   - Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct.
     Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:
   - Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
   - Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
   - All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
   - Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
   - Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
   - Provider is not liable for breaches of confidentiality caused by the client or any third party.
   - It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement

   I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

   Client name: _____

   Client signature: _____ Date: _____

   Parent/Legal Guardian name: _____

   Parent/Legal Guardian signature: _____ Date: _____

Manifest Counseling – Client Electronic Payment Authorization

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CLIENT ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, MasterCard and Discover. Service fees will be deducted from the designated account at the time services are rendered.

Client Information:

Client Name: _____ Date of Birth: _____
Address: _____ City_____ State: _____ Zip: _____
Home Number: _____ Mobile Number: _____

Cardholder Information:

Please indicate the name and address associated with the credit or debit card you wish to use.
Name: _____
Address: _____ City_____ State: _____ Zip: _____
Email: _____

I authorize any service fees to be deducted from the credit or debit card ending in _____ (provide the last four digits of the card).
Cardholder Signature: _____ Date: _____

Credit/Debit Card Information:

Please provide your payment information below. The debit or credit card information you provide on this form will be destroyed once your first payment has been made.
Card Type (circle one): Visa / MasterCard / Discover
Card Number: _____Expiration Date: _____

Health Insurance Out-of-Network Guidance

Call the number on the back of your insurance card for the Benefits Department. Write down every answer you receive. You can ask for explanations of anything you don't understand. Ask to speak to a supervisor if you are not happy with the answers you are getting. You'll need careful records later if the company fails to follow through with what they've told you.

Questions you may want to ask:

1) What is your name and extension number?
_____

2) Does my policy cover *Out-of-Network, Licensed Clinical Social Workers*?
___ Yes ___ No

3) My therapist is willing to provide a statement of Session Dates Attended, the CPT code, and the Diagnosis. Is this acceptable to the insurance company? ___Yes ___ No

4) Does my policy cover:
Individual Psychotherapy? (CPT code 90834) ___ Yes ___ No
Group Psychotherapy? (CPT code 90853) ___ Yes ___ No

5) What mental health *Diagnoses* are NOT reimbursable?
_____

6) How many *Sessions* are covered per year? _____

7) What is the *Lifetime Maximum* for mental health benefits? $_____

8) What is my *Out-of-Network Deductible?* $_____

9) What is the *Allowed Amount* of the fee?
- Individual session (My fee is $130, CPT code is 90834): $_____
- Group session (My fee is $60, CPT code is 90853): $_____

Many insurance companies will reimburse a percentage of the total fee paid. For example, your company may reimburse you 80% of the total fee paid, or $80. Other companies will substitute the $100 fee for what they deem appropriate, regardless of what you paid. For example, your company may say that they will reimburse you 80% of the "allowed amount" of the fee. You paid $100 for an individual session, but your insurance company only allows $60. Therefore, you will be reimbursed 80% of $60, or $48. They may try to withhold this information from you and can legally do so. Ask to speak to a supervisor and say that you cannot plan your medical expense budget without this number.

10) What percent of the *Allowed Amount* will be reimbursed? _____%

11) How do I file claim?
_____

Important Considerations

- Insurance reimbursements may vary from month to month:
- At the beginning of your therapy, there will be a wait until your insurance company begins to pay your benefit.
- In January of each year, you will not get any money back until your deductible is met. If you apply other family medical expenses to your deductible, you will start getting benefits sooner, and more of your therapy will be paid for.
- Toward the end of the year, your insurance reimbursements will stop if the number of sessions is limited.
- Your out-of-pocket medical expenses can be minimized if your employer offers a pre-tax medical "flexible spending account."
- Ask your accountant about taking a medical tax deduction for psychotherapy.
- You may save money with an insurance plan that has a higher premium, but better benefits for out-of-network therapy (called *Preferred Provider Organization*, or *PPO*).
- Beginning January 2010, new legislation requires many insurance plans to provide the same benefits for mental health as for physical health, with many of these limits removed—very good news!

Manifest Counseling – Release of Information

I hereby authorize Nigel A.T. Cook, MSW, LCSW at Manifest Counseling to release and obtain information both written and verbally about:

Client Full Legal Name: _____ DOB: _____

to and/or from the following individual(s):

Name of Recipient of Information: _____

Relationship to Client: _____

Address: _____

Phone Number: _____

for the following purpose(s):

Description of information to be disclosed:

_____

_____

_____

Reason for information to be disclosed:

_____

_____

_____

for the following length of time:

_____ One year from today's date: ___/___/___

_____ At the termination of services

_____ Until a specified event or date (Please List): _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time days, except to the extent that action based on this consent has already been taken. This consent will expire upon fulfillment of the purposes stated above. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer protected by federal privacy regulations.

Signature of Client: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

(If different from Client)

Signature of Clinician: _____ Date: _____