Seed of Hope Counseling
Hope. Connect. Grow.
229 E. Center Street Kingsport, TN 37660
423-530-7042

Welcome to Seed of Hope Counseling (SoH)! This is an opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies. Your therapist will answer any questions you have regarding these policies.

Clinical Training Site: **Initial here**: _____
Seed of Hope Counseling is a clinical training site for graduate students in marriage & family therapy and/or professional counseling.
Would you be willing to see a intern? Please circle: YES / NO
Would you be willing to have an intern sit in with you and your therapist? Please circle: YES / NO

Appointments: **Initial here**: _____
Appointments are usually scheduled for 53-60 minutes (therapy hour) and are made by the therapist and/or the SOH office staff at **(423)530-7042**. The frequency of visits will vary depending on your individual needs and the availability of your therapist. The practice hours will vary by clinician. However, office hours for appointments are usually Monday through Friday between the hours of 8 a.m. and 5 p.m. **If an appointment is missed or is canceled with less than a 24-hour notice, you will be billed $100.00 which will not be covered by insurance**. Anyone who misses more than 3 appointments without appropriate notification within a 12-month period may be discharged and referred elsewhere for treatment. You may discontinue treatment at any time, but you are asked to notify your therapist of your decision.

Tele-Therapy: **Initial here**: _____
Tele-therapy is offered as a line of service at SoH. Tele-therapy can be utilized for ongoing services if desired or can be used in the event that there is a reason preventing either the therapist or the client from being present in the office (this could be due to a medical condition or other reasons). The therapist and client will determine the appropriateness of tele-therapy and schedule accordingly.
Would you be willing to engage in tele-therapy if neccessary? Please circle: YES / NO
I hereby consent to engage in telehealth with SoH as part of my professional clinical counseling. **Initial here**: _____
"Telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.
Tele-therapy will be conducted using the HIPPA compliant platform, CounSol within our electronic health record platform. A link will be sent to your email to setup a portal.
If technology fails during your virtual appointment, the appointment will be immediately switched from a video call to a phone appointment. Please note that the telephone is not the preferred method of SoH.
The following rights and responsibilities apply to tele-therapy:
1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws protecting confidentiality of my medical information also apply to tele-therapy. The Limits of Confidentiality Statement apply to tele-therapy. Seed of Hope will be taking all necessary steps to protect confidentiality in SoH's environment. I understand that it is my responsibility to protect my confidentiality in my environment.
3. I understand there are risks and consequences from tele-therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that the therapy session could be disrupted or distorted by technical failures. In the event of a disruption, the session will switch a phone conversation.
4. Confidentiality through email is not guaranteed. Email communication should occur within the CounSol EHR platform.
5. I understand that I may benefit from tele-therapy, but that results cannot be guaranteed or assured.

Fees: **Initial here**: _____
You are responsible for payment at each session. Payment is expected at the time of your session unless other arrangements have been made in advance. Payment can be made with cash, check, or credit card**. Payments should be made payable to Seed of Hope Counseling.** Our services are billed at a flat rate of $100/therapy hour for services performed by licensed marriage and family therapist or licensed professional counselor with mental health specialist designation. Services performed by a resident therapist will be billed at a $75/therapy hour rate and services performed by student interns will be billed at $50/therapy hour. ***I agree to the billable rate noted previously based on my therapist's credentials.***

Insurance Option: **Initial here**: _____

Another option available at SOH is to utilize your insurance carrier which may pay for a portion of the fee. The billable insurance rate is $125/therapy hour for licensed therapists. **Residents and student interns cannot bill insurance.** The therapists vary on insurance carriers for which they are providers. It is your responsibility to find out your mental health benefits and if the individual therapist is a provider for your health plan. **If you opt to use your health coverage, you will be responsible for your portion of the fee (ex: copays, deductibles) to be paid at the time of service.** It is your responsibility to obtain prior authorization for treatment from your insurance carrier.

Additional Billable Services: **Initial here**: _____

You may also be billed for any other services such as telephone conversations lasting more than 5 minutes, or completion of forms or letters requested on your behalf at a prorated $100 per 60 minutes**.**
In the event, your therapist is subpoenaed to court a fee of $200 per hour will be billed.

Substance Use: **Initial here: _____**

We respectfully serve clients struggling with addiction and would appreciate your respect in turn by not attending counseling if you are high or intoxicated. The work we are doing together will not be effective in these circumstances so we will cancel the session if needed. Sessions cancelled for this reason will count as a late cancellation and appropriate fees may apply. Repeated instances will indicate a lack of readiness to do recovery work and no further sessions will be scheduled until a commitment to counseling can be made. Alcohol and illicit drugs are **not** permitted on SOH premises.

Treatment Philosophy: **Initial here: _____**

Brief therapy is goal-directed, solution-focused treatment. Each therapist may utilize different theoretical approaches and will discuss with you the benefits and goals involved. You will be expected to assume an active role in the treatment process. Although the course of your treatment is designed to be helpful, the therapist cannot make any guarantees about the outcome of your treatment. Although there are believed to be many benefits of counseling, people tend to make changes in the course of treatment which can be uncomfortable and challenging. Certain diagnoses can result in preexisting conditions in the future for insurance coverage. Treatment records are not written in a manner which serves to be helpful to support disability claims. SOH **does not perform** Child Custody Evaluations.

Limits of Confidentiality Statement: **Initial here: _____**

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged". However, there are limits to the privilege of confidentiality**.** These situations include:

1. Suspected abuse or neglect of a child, elderly person, or a disabled person
2. When your therapist believes you are in danger of harming yourself or others. If you report that you intend to physically injure someone, the law requires your therapist to inform that person as well as the legal authorities.
3. If your therapist is ordered by a court to release information as part of a legal involvement in litigation, etc.
4. When your insurance company or another third-party payee is involved.
5. As a result of a natural disaster whereby protected records may become exposed.
6. When otherwise required by law.
7. When you sign a Release of Information giving your permission for the therapist to share your protected information with a designated person.

Record Keeping: **Initial here: _____**

Charts are maintained in an electronic health record provided by CounSol. CounSol has several safety features to protect your personal information, including advanced encryption techniques to make your personal information difficult to decode, firewalls to prevent unauthorized access, and a team of professionals monitoring the system for suspicious activity. CounSol keeps records of all logins and actions within the system. A clinical chart is maintained describing your condition, treatment, dates of services, and progress notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

Complaints: **Initial here: _____**

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please inform us immediately and discuss the situation. You have the right to submit a grievance to your therapist at any time during care or to directly to the State of Tennessee LPC and LMFT Licensing Board.

Emergency Access: **Initial here: _____**

In an emergency you are instructed to call 911 or go to a local ER. Your individual therapist will instruct you how you may access him/her. Each therapist is responsible for managing his/her case load in emergency after hours. If you are unable to access your individual therapist, one of the other therapists in the office may assist you in a crisis. You may also call Respond at 1-800-366-1132.

Client Consent for Treatment:

You are hereby consenting to treatment with _____ until you otherwise notify SOH. By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction. You accept, understand and agree to abide by the contents and terms of this agreement.

_____ _____

Signature of Client Date

_____ _____

Signature of Therapist Date

Parent/Guardian Consent for Child or Dependent Treatment:

Please circle: YES / NO

I have legal responsibility for, (*name of child/dependent*) _____ and I consent to treatment with *(name of therapist)* _____ to see previously mentioned child/dependent with and/or without me being present in the same session. I understand that the therapist is the holder of confidential privilege-the right to withhold disclosure of private information about said child/dependent. However, in the interest of developing a trust relationship between the therapist and the child/dependent, I give the therapist permission to reveal or withhold information that in his/her clinical judgment is necessary to best help and protect my child/dependent.

_____ **_____**

Signature of Parent/Legal Guardian **Signature of Parent/Legal Guardian**