Christy Pulsford MSW, LISW-S, LICDC GrowthINsight Counseling LLC
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Informed Consent for Treatment

Thank you for your interest in our services. This document provides important information about our services and policies so that you and your provider can work together effectively.

Emergencies

In the event of a mental health crisis, please call 911 or visit the closest emergency room. Christy Pulsford, GrowthINsight Counseling LLC, does not provide crisis care or work outside office hours.

Confidentiality

Patient information is always held confidential in accordance with both legal and ethical standards. This information includes but is not limited to session notes, test results, written reports, and financial information. However, there are certain circumstances in which your provider may be required by law to breach patient confidentiality or choose not to maintain confidentiality and share information. These circumstances include:

- If your provider believes that a patient/client is a danger to themselves or others
- If your provider believes that an individual is the victim of child/elder/disabled adult abuse or neglect
- Court-mandated subpoenas
- Reporting to the police and courts about any crime by a client committed at our program, or against any person who works for us, or about any threat to commit such a crime
- Your insurance/employee assistance program carrier requests confidential patient information in order to authorize treatment or reimbursement (IF CHOOSING TO USE INSURANCE ONLY)

Please be aware that information may be sent by your insurance company to the policyholder.

When working with a minor, the confidentiality of the minor is also important in order to have an effective therapeutic relationship. Your provider will speak with parents to try and ensure that minors experience a similar degree of confidentiality as adults. However, in some circumstances, parents may have the right to examine a minor's treatment or billing records.

If you or your family member was referred to us by another health care provider, we request you sign a release of information to allow us to provide them with a summary of information and/or progress updates in order to coordinate care with them. We also request that you sign a release of information to your personal care physician. However, you may decline to do so. Once signed, you may revoke the right for your providers to share information but must do so by written request.

Telebehavioral Health

Telebehavioral health refers to services or communications provided via electronic means such as phone, fax, video, email, internet, and text. This also includes voice mail, voice messaging, and portal messaging. Electronic communications are used in this practice. By consenting to this form, you are consenting to all use of telehealth. Telehealth communication is utilized between provider and clients, patients, parents, and guardians. In addition, telehealth may be used with a referring physician, agency, or any other person or entity to whom you signed a release of information or verbally requested that we communicate. Appointment reminders and billing statements are routinely sent to you as an email, text message, voice message, or through the client portal. Please know that our phone, fax, email, and portal are HIPAA compliant and under a BAA. Email is encrypted with TLS. Nonetheless, security breaches are possible with any system. Therefore, you need to be aware that there is always some degree of risk associated with any form of electronic communication, and privacy cannot be guaranteed. If there is any form of electronic communication that you wish to prohibit, please discuss it with your provider.

Appointments

Please be respectful of others by being mindful of your scheduled time. Understand that your provider wants to avoid being late for any client. Consequently, if you arrive late for an appointment, it will still end at the scheduled time. Insurance may not cover an abbreviated appointment, and therefore, you will be responsible for the full fee of the scheduled appointment.

Please remember to cancel or reschedule 24 business hours in advance. This is necessary because a time commitment is made to you and is held exclusively for you. If you cannot use that time, please cancel so another client can be offered the time. Monday appointments must be canceled by 5:00 pm the prior Friday to avoid late charges. An appointment missed without canceling at least 24 business hours in advance will incur a $75 charge. Insurance does not cover late cancellation/missed appointment fees, and the credit card on file will be charged. Your case will be reviewed for closure if it is the third or subsequent late arrival, no-show, or cancellation. Services may be terminated for frequent cancellations, missed appointments, or late arrivals.

Billing & Insurance

You have the right to use insurance benefits to cover services with your provider if you have an insurance carrier that your provider accepts and your policy provides benefits that cover your provider's services. Insurance may cover all, some, or none of the costs associated with the services that you receive. You will be billed at our standard fee rates for services not covered by your insurance company or services provided under out-of-network benefits. It is your responsibility to contact your health insurance carrier prior to your appointments in order to understand your benefits and coverage. It is advisable to ask your insurance provider if you have a deductible that needs to be met before benefits are provided and if there is a limit to the number of sessions covered per year. Insurance does not cover the cost of two appointments on the same day. It is your responsibility to inform your provider of any changes in insurance plans. It is also your responsibility to obtain any necessary authorization/precertification prior to your appointments. Failure to do so may result in non-payment by your insurance carrier or reduced benefits, and you will be responsible for the full payment of charges.

Please understand that having health insurance benefits does not guarantee coverage for our services by your insurance carrier. If you schedule a self-pay appointment or service, then in signing this agreement, you acknowledge that our providers and office staff will not be submitting any claims for services rendered to your insurance company and that a numeric CPT code will not be assigned to the appointment. Services without an assigned CPT code are self-pay only and not reimbursable. You also have the right to receive a Good Faith Estimate of expected costs of any self-pay appointments. Good Faith Estimates will be uploaded to the client portal.

All fees are due at the time of service, including insurance co-payments, deductibles, and self-pay fees. Fees will be charged to your credit card on file without prior notice. There will be a $25 fee for returned checks. Additionally, if payment for services is not received by the insurance company due to a denied claim or claim adjustment within 60 days of the original filing of a claim, you will be responsible for the bill in full. Services can be terminated for non-payment. If services are terminated for nonpayment, you may request a list of other local service providers from your clinician.

By your signature on this form, you authorize charges to your credit card through Stripe via SimplePractice for services rendered and any session that is not canceled at least 24 business hours prior to the scheduled session. In addition, you certify that you are an authorized user of this credit card and will not dispute these scheduled transactions with the bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. Please be aware that credit card transactions could be linked to Protected Health Information.

Fees - *CPT codes indicate services that may be covered by insurance.*

Individual: $125 - CPT 90832
Individual: $130 - CPT 90834
Individual: $150 - CPT 90837
Family: $130 - CPT 90846/90847
Urgent Scheduling: $175 – CPT 90839
Psychiatric Diagnostic Evaluation: $175 - CPT 90791

Accountability Check-in: $45
Focus Session: $65
Consultation: $130
Written Reports: $150
Missed Appointment fee: $75
Late Cancellation fee: $75

Additional codes
CPT +90875 - $25
CPT 90839 - $175

The cost of psychotherapy with this provider is determined by length reflecting the Current Procedural Terminology (CPT) published by the American Medical Association. Equivalent services not assigned a CPT code will be charged the equivalent fee. Fees are per unit. Fees are periodically reviewed and subject to change. You will receive 30 days' notice prior to any change in fees through the client portal. Please check the client portal prior to every appointment.

If an event arises in which Christy Pulsford is subpoenaed or becomes involved in legal proceedings that result from her treatment of the identified patient/client, the person agreeing and consenting to this form agrees to pay a rate of $150 per hour of time spent on the case plus travel expenses. This includes but is not limited to: travel time, case preparation, documentation, and other legal fees and travel expenses. Payment of these fees is required prior to Christy Pulsford testifying or appearing in other legal proceedings. Insurance does not cover these fees. Clinician will only present treatment facts in legal preceedings and will not make recommendations if subpoenaed.

"This information is required by the Counselor, Social Worker, and Marriage and Family Therapist Board, which regulates the practices of professional counseling, social work, and marriage and family therapy in this state."

Counselor, Social Worker, and Marriage & Family Therapist Board
77South High Street, 24th Floor, Room 2468
Columbus, OH 43215-6171 Tel: (614) 466-0912

Agreement

Your signature below indicates the following:

- You have read the information in this consent, understand it in its entirety, had all questions answered to your satisfaction, and agree to abide by its terms during your professional relationship with Christy Pulsford, GrowthINsight Counseling LLC.
- You consent for treatment by authorizing Christy Pulsford to provide psychotherapy, counseling, and consultation services; assessment & diagnostic evaluation services; and all other services listed in this consent to the identified patient/client (i.e., you or your dependent child/adult).
- If you are seeking services for a dependent, you have full legal rights to make healthcare decisions for the dependent listed below.
- You authorize Christy Pulsford, GrowthINsight Counseling LLC, to charge the credit card you provided through Stripe for all fees not directly reimbursed by insurance. This includes but is not limited to co-pays, deductibles, denied claims, and fees charged, which are not covered by your insurance plan. You will pay all fees charged for appointments missed, canceled, or changed without 24-hour notice.
- You authorize Christy Pulsford, GrowthINsight Counseling LLC, and Simple Practice to provide your insurance company with all information requested by the company. You authorize your insurance company to reimburse GrowthINsight Counseling LLC Christy Pulsford directly for the services provided.
- You understand that if GrowthINsight Counseling LLC Christy Pulsford is not a preferred provider for your insurance company, you may use out-of-network benefits if your insurance plan provides them. If using out-of-network benefits, you will be seeking reimbursement yourself from your insurance company and authorize GrowthINsight Counseling LLC Christy Pulsford and Simple Practice to assist by providing superbills and clinical information needed to seek reimbursement for services provided. You will pay the provider directly for all services at the full rate at the time services are rendered.

_____ _____/_____/_____

Name of Patient/Client (please print) Date of Birth

_____ ____/_____/_____

Signature of Patient/Client Date

_____ ____/____/____

Signature of Parent or Legal Guardian Date

_____ ____/____/_____

Signature of Clinician Date