Christy Pulsford MSW, LISW-S, LICDC GrowthINsight Counseling LLC
affiliate of Macks Psychology Group
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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 an emergency or crisis, please call 911 or visit the closest emergency room or other urgent care facility. Please leave us a voicemail message briefly describing the emergency, your present location, and preferred contact phone number. Your provider will make every effort to return your call within one business day (or sooner if possible).

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. 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
- Your insurance carrier requests confidential patient information in order to authorize treatment or reimbursement (IF CHOOSING TO USE INSURANCE BENEFITS ONLY)

Additionally, in an effort to coordinate care, providers at Macks Psychology Group may share pertinent clinical, scheduling, and billing information about a patient/client with each other. This information will only be shared between employees and providers employed by or associated/affiliated with Macks Psychology Group.
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 the same degree of confidentiality as adults. However, parents do have the legal right to examine a minor's treatment 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 ordinate to coordinate care with them. However, you may revoke the right for your providers to share information but must do so by written request.

Appointments

Please be respectful of others by being mindful of your scheduled time. Understand that we take great care to avoid being late for any client. Consequently, if you arrive more than 15 minutes late for an appointment, we may not be able to see you on that day (although we will make every effort). Accordingly, if you would like to schedule extended sessions please discuss this with your provider. You may cancel an appointment by calling 513-204-5746. An appointment missed without canceling at least 24 hours in advance will incur a $50 charge. If it is the third or subsequent late arrival, no-show or cancellation your case will be reviewed for closure. Services may be terminated for frequent cancellations, missed appointments or inconsistent attendance.

Minor Children

It is our policy to consider an 18-year-old who is still in high school a "minor" and the parent or guardian is responsible for the copay and/or deductible.

Fees - *All fees are due at time of service. CPT codes indicate services that may be covered by insurance.*

Individual Psychotherapy (55 minutes):	$125	(CPT 90837 or equivalent service with no CPT code)
Family Psychotherapy (50 minutes):	$125	(CPT 90847/90846 or equivalent service with no CPT code)
Abbreviated Individual (40 minutes):	$100	(CPT 90834 or equivalent service with no CPT code)
Diagnostic Evaluations:	$150	(CPT 90791 or equivalent service with no CPT code)
Interactive Complexity	$20	(CPT 90875 add-on code)
Consultation (45 minutes):	$100	
Marital/Couples (50 minutes):	$125	
Coaching (40 minutes):	$100	
Assessments and Updates:	$125	
Written Reports:	$150	
Phone Calls over 7 minutes:	$25 8-20 minutes, $50 21-30 minutes, $75 31-40 minutes, $100 41-50 minutes	

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 expenses. Payment of these fees is required prior to Christy Pulsford testifying or appearing in other legal proceedings.

"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

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. 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. *All fees are due at time of service* including insurance co-payments, deductibles and self-pay fees. Fees will be charged to your credit card on file unless alternative arrangements have been made. 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. A collection agency is used for bills over 60 days past due from the time of the first invoice, or payment may be sought through the local municipal small claims court. The collection agency fees and/or legal fees are charged directly to the patient's delinquent account. In addition, it is important to know that the collection agency may release information related to unpaid balances to third parties including attorneys and national credit reporting agencies. 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.

Telebehavioral Health

Telebehavioral health refers to services or communications provided via electronic means such as phone, video, email, or text. Electronic communications at this practice are usually provided via telephone. However, we will communicate through email when requested and/or when responding to an email from you or a legal guardian. Patient/Client reports may also be sent via email if you request, and information may be faxed or emailed to a referring physician, agency, or any other person or company to whom you request that we send information. Additionally, appointment reminders and billing statements may be sent to you as an email or text message or voice message. Please know that our phone, fax and email are all secure and HIPAA compliant. Nonetheless, security breaches are possible with any system, and you need to be aware that there is always some degree of risk, no matter how minimal, associated with any form of electronic communication. If there is any form of electronic communication that you wish to prohibit, please discuss it with your provider, Christy Pulsford.

Agreement

Your signature below indicates the following:

- You have read the information in this Consent to Treatment and agree to abide by its terms during your professional relationship with Christy Pulsford, GrowthINsight Counseling LLC, and Macks Psychology Group.
- You consent for treatment by authorizing Christy Pulsford to provide psychotherapy & counseling services, assessment & diagnostic evaluation services, and all other listed services 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 have made the following payment choice (please mark one)
  - I authorize Christy Pulsford, GrowthINsight Counseling LLC, Macks Psychology Group, and Simple Practice to provide my insurance company with all information requested by the company. I authorize my insurance company to reimburses GrowthINsight Counseling LLC Christy Pulsford directly for the services provided. I will self-pay for all services and fees charged which are not covered by my insurance plan and all claims denied by my insurance company.
  - I understand GrowthINsight Counseling LLC Christy Pulsford is not a preferred provider for my insurance company and I will be using out-of-network benefits. I will be seeking reimbursement myself from my insurance company and authorize GrowthINsight Counseling LLC Christy Pulsford and Macks Psychology Group to assist by providing superbills and clinical information needed to seek reimbursement for services provided. I will self-pay for all services and fees charged which are not covered by my insurance plan.
  - I understand that my insurance plan may not cover services unless they are considered medically necessary by them. Therefore, I will self-pay for the diagnostic evaluation if it does not find symptoms consistent with a diagnosis in which treatment is considered medically necessary.

_____	_____/_____/_____
Name of Patient/Client (please print)	Date of Birth
_____	_____/_____/_____
Signature of Patient/Client	Date Signed
_____	_____/_____/_____
Signature of Parent or Legal Guardian	Date Signed
_____	_____/_____/_____
Signature of Clinician	Date Signed