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

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

Emergencies

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

Confidentiality

Patient information is held confidential by both legal and ethical standards. There are certain circumstances in which your provider may be required by law or choose 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
- Reporting to the police and courts about any crime by a client committed at GrowthINsight Counseling LLC, or against any person who works for us, or about any threat to commit such a crime

When working with a minor, the minor's confidentiality is important to have an effective therapeutic relationship. Your provider will speak with parents/guardians regarding an adolescent's confidentiality.

Appointments

Your provider wants to avoid being late for any client. Consequently, if you arrive late for your appointment, it will still end at the scheduled time, and the full fee will be charged. 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, cancel so another client can be offered the time. An appointment missed without canceling at least 24 business hours in advance will incur a $60 charge. Monday appointments must be canceled by 5:00 pm the prior Friday to avoid the late charge. Services may be terminated for three or more cancellations, missed appointments, or late arrivals.

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 consent to all use of telehealth. Telehealth communication is utilized between the 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 via email, text message, voice message, or 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 risk associated with electronic communication, and privacy cannot be guaranteed. If there is any form of electronic communication that you wish to prohibit, please notify your provide

Billing & Insurance

You have the right to use insurance benefits to cover mental health 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. In signing this informed consent for treatment, you state that you are aware of your insurance benefits, choosing not to use them, understand a CPT code will not be assigned to services, and waive any right to reimbursement from your insurance company. If at any point during treatment you decide to start using insurance benefits, please let your provider know by signing an Informed Consent for Treatment that grants permission for your clinician to provide all clinical information to your insurance company. Please be aware that services not considered medically necessary are not covered under health insurance. You also have the right to receive a Good Faith Estimate of expected costs. Good Faith Estimates will be uploaded to the client portal. Estimates of services that are not considered medical treatment will also be given an estimate uploaded to the client portal for clarity.

Fees Psychotherapy & Counseling

Individual: $125 (45 minutes)	Extended session: +$105 (per 30 minute unit)
Individual: $145 (60 minutes)	Consultation: $100
Family/Couples: $140	Assessment and Goal Planning: $150
Accountability check-in: $35	Psychiatric Diagnostic Evaluation: $175
Focus session: $55	Written Reports: $150
Urgent scheduling: $175	No Show/Late Cancel fee: $60

If you would like a session longer than customary, please schedule two appointments back-to-back to ensure that you will have ample time. If scheduling two appointments, you will be responsible for the fee for both sessions even if you do not use the entire time. The cost of psychotherapy with this provider is determined by length and type reflecting the Current Procedural Terminology (CPT) published by the American Medical Association.

All fees are due at the time of service. Fees will be charged to your credit card on file without prior notice. By signing this form, you authorize charges to your credit card through Stripe via SimplePractice for services rendered and any fees charged due to an appointment missed without 24 hours advance notice, as detailed in the appointment section of this document. In addition, you certify that you are an authorized user of the 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. 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.

Legal Proceeding Services: If an event arises in which Christy Pulsford GrowthINsight Counseling LLC 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 spent on the case including but not limited to travel time, case preparation, documentation, and other legal fees and travel expenses. Payment of these fees is required before Christy Pulsford testifies or appears in legal proceedings.

Fees are subject to periodic review and change. You will be notified a minimum of 30 days in advance of any change in fees through the client portal. Please check the client portal regularly for billing information.
"The Counselor, Social Worker, requires this information, 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 informed 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 to treatment by authorizing Christy Pulsford to provide psychotherapy and counseling 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 seek services for a dependent, you have full legal rights to make healthcare decisions for the dependent listed below.
- You elect to self-pay for services and authorize Christy Pulsford, GrowthINsight Counseling LLC, to charge the credit card you provided through Stripe for all services and late cancellation fees.

_____ _____/_____/_____
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