Christy Pulsford MSW, LISW-S, LICDC
affiliate of Macks Psychology Group
8050 Beckett Center Drive Suite 314, West Chester, OH 45069
7799 Joan Drive, West Chester, OH 45069
Phone: (513) 204-5746   Fax: (513) 229-3707
Website: www.christypulsford.com

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, 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 patient appointments, session notes, test results, written reports, demographic information, 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 him/herself 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 may require confidential patient information in order to authorize treatment or reimbursement (IF CHOOSING TO USE INSURANCE BENEFITS ONLY)

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. Additionally, in an effort to coordinate care, providers at the Macks Psychology Group may share pertinent clinical information about a patient with each other. This information will only be shared between providers working at the Macks Psychology Group.

Additionally, if you or your family member was referred to us by another health care provider, we will 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 understand that we take great care to avoid being late for any patient. 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). You may cancel an appointment by calling us at 513-204-5746. If you miss an appointment without canceling at least 24 hours in advance for therapy/counseling/coaching then the appointment will incur a fee. A no-show/late cancelation will incur a $50 charge. If it is the third or subsequent noshow/late cancelation it will incur a charge of $100 and your case will be reviewed for closure.

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

Individual Psychotherapy: $100 (CPT 90834) 40-45 minutes
Individual Psychotherapy: $125 (CPT 90837) 55-60 minutes
Family Psychotherapy: $125 (CPT 90847) 50 minutes
Diagnostic Evaluations: $150 (CPT 90791) 75-90 minutes

Individual Therapy/Counseling: $100 (no CPT code) 45 minutes
Coaching: $100 (no CPT code) 45 minutes
Relationship/Family Counseling: $125 (no CPT code) 50 minutes
Initial Consultation: $100 (no CPT code) 45 minutes
Assessments and Updates: $125 (no CPT code) 60 minutes
Session add on fees: $25 for play therapy or interactive complexity (CPT +90785)

Phone Calls over 10 minutes: $25 10-20 minutes, $50 21-30 minutes, $75 31-40 minutes, $100 41-50 minutes
Written Reports: $150

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. This includes: 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

Billling & Insurance

You have the right to use insurance benefits to cover your services with your provider if you have an insurance carrier that your provider accepts, and, your insurance policy provides benefits that cover your provider's services for you &/or your family member. 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 appointment in order to understand your benefits and coverage. It is also your responsibility to obtain any necessary authorizations/precertifications prior to your appointment. Failure to do so may result in non-payment or reduced benefits, and you will then 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 rather than an insurance-based appointment, 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. Insurance co-payments, deductibles, and self-pay fees are due at the time of service and can be paid by cash, check, or credit card. There will be a $25 fee for any returned checks. Additionally, if payment for services is not received within 60 days of an insurance claim, you will be responsible for the bill. Please note that a collection agency is used for bills over 60 days past due from the time of the first bill, 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.

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 your provider.
- ❖ You consent for treatment by authorizing Christy Pulsford MSW, LISW to provide diagnostic assessment and/or treatment services to the identified patient/client (i.e. you or your dependent child or adult).
- ❖ If you are seeking services for a dependent, you are a biological parent, adoptive parent, or legal guardian with full legal rights to make healthcare decisions for the dependent listed below.
- ❖ You have made the following payment choice (please mark one)
  - o I do not want information regarding diagnosis or clinical care to be released to my health insurance company and elect to self-pay. I will not use my insurance benefits for services provided by GrowthINsightCounseling LLC Christy Pulsford MSW, LISW and waive any right to reimbursement from my insurance company.
  - o I authorize Christy Pulsford MSW, LISW 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.
  - o I understand Christy Pulsford MSW, LISW is not a preferred provider for my insurance company and I will be using out-of-network benefits. I will be seeking reimbursement by my insurance company and authorize GrowthINsight Counseling LLC Christy Pulsford MSW, LISW to assist by providing information needed to seek reimbursement for services provided.

____	_____/_____/________
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