Christy Pulsford MSW, LISW-S, LICDC GrowthINsight Counseling LLC
8050 Beckett Center Drive, Suite 314 | West Chester, OH 45069
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Consent for Treatment

Thank you for your interest in 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 of 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 contract or 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)

Please be aware that information may be sent by your insurance company to the primary and secondary insurance policy holder.

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, in some circumstances parents may 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 order to coordinate care with them. 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.

Appointments

Please be respectful of others by being mindful of your scheduled time. Understand that we want 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.

Please remember to cancel or reschedule at least 24 business hours in advance. This is necessary because a time commitment is made to you and is held exclusively for you. If you are not going to be able to use that time, please cancel so another client can be offered that time. You may cancel an appointment by calling (513) 847-3891. An appointment missed without canceling at least 24 business hours in advance will incur a $50 charge. An appointment missed with less than 2 hours' notice will incur an additional $50 charge for a total of a $100. Insurance does not cover late cancellation fees. 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, late arrivals or inconsistent attendance.

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

Psychotherapy & Clinical Counseling
Individual: $100 - CPT 90832
Individual: $120 - CPT 90834
Individual: $140 - CPT 90837
Family: $140 - CPT 90847/90846
Marital/Couples: $140
Interactive Complexity: $20 - CPT 90875 add-on

Other Services
Consultation: $100
Behavioral Health Coaching: $100
Assessment and Update: $140
Psychiatric Diagnostic Evaluation: $160 - CPT 90791
Written Reports: $150

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 periodically reviewed and subject to change. You will receive 60 days notice prior to any change in fees.

If an event arises in which Christy Pulsford is subpoenaed or becomes involved in legal proceedings related to her services with 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. 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 and not reimbursable. A Good Faith Estimate of expected costs of any self-pay appointment will be uploaded to the client portal.

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 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.

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 at 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 request that we communicate with. 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.

Agreement

Your signature below indicates the following:

- You have read the information in this Consent 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 services, consultation and coaching services, assessment & diagnostic evaluation services, and all other services in this consent for treatment agreement 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, and Simple Practice to provide my insurance company or EAP with all information requested by the company. I authorize my insurance company or EAP 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 or EAP plan and all claims denied by my insurance company or EAP. I will pay all fees charged for appointments missed, cancelled, changed or arrived too late without 24-hour notice.
    - 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 Simple Practice to assist by providing superbills and clinical information needed to seek reimbursement for services provided. I will pay my provider directly for all services at the time services are rendered.

_______________________________________	_____/_____/________
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