Laura L. Otto, LMHC, LPC, NCC, CCMHC
Licensed Professional Mental Health Counselor
583 West Skippack Pike • Suite 410 • Blue Bell PA 19422
Phone: 267-405-6803 • Facsimile: 267-604-9190 • Email: laura_otto@att.net

CLIENT INFORMATION

Patient Name:____DOB:______________

Address:____

City_____________________________________State___________Zip Code_____________

Cell:______________________________________Home:_______________________________

Email:____

Primary Insurance:____

Primary Insured's name:_____________________________________DOB:_________________

Patient's relationship to Primary:____

Insurance ID:____________________________Group Number:__________________________

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Authorization To Release Form For Insurance Purposes

Patient Name:____D.O.B:________________

Address:____

Information is being released to (Your Insurance Company Name):

____

Specific Information is to be released:

- Copies of psychiatric intake evaluation, summary of treatment progress.

Purpose for releasing information:

Establishes reasons for providing insurance coverage of mental health services and for additional authorization of services.

I understand that my records are protected under a section 5100.34 of the Pennsylvania Mental Health Procedures Act and the Pennsylvania Drug and Alcohol Abuse Control Act, and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in state of federal regulations. I also understand that I may revoke this consent at any time except for the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:
Termination of therapy (specification of dates, event, or condition upon which this consent expires)

I,_______________________hereby authorize Laura L. Otto, LPMHC to release the information stated above.

Patient____ Date __________________

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PAYMENT FOR SERVICES

I am asking all patients to leave a valid credit card number on file for payment should the insurance company determine that a deductible or coinsurance was required at the time of visit. Insurance companies have various plans and it is not always possible to determine the copayment accurately at the time of visit. Please note that Laura L. Otto, LPMHC will only bill you for the service or part of the service if your insurance company determines that you are liable for the payment.

____Master card ___Visa card

Credit Card Number____

Expiration Date:____________________

CCV: ____________________________

Credit Card holder's name____

By signing I acknowledge that I am responsible for any copayments or deductibles as required by my insurance policy.

Client____ Date _________________

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CONSENT TO TREATMENT

I, ___________________________________, acknowledge my voluntary participation in therapeutic treatment with *Laura L. Otto, LMHC, LPC, NCC, CCMHC*, the therapist responsible for the progress of my treatment.

I understand I may discontinue treatment at any time. I understand I may review the contents of my treatment records with my therapist, and my records may not be released to outside parties without my written consent.

I understand the fee set for my treatment is *$100* for each scheduled 60-minute session, due at the end of session. Or I am using my health insurance in which then my copay or deductible is due at time of service.

I am encouraged to address any questions or concerns with my therapist. I also agree that this contract may change based on my financial status/capabilities.

Client____ Date __________________

Therapist ____ Date __________________

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OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies so please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it represents an agreement between us.

THERAPEUTIC SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for an active effort on your part to participate in your own treatment. In order for therapy to be successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to provide benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there is no guarantee of what you will experience in your work with me.

INITIAL SESSION

Our first session(s) will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation for the first session. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we decide to continue, I will usually schedule one appointment of 60-minutes duration sessions may be more or less frequent as needed.

PROFESSIONAL FEES

My fee is **$100** per 60-minute appointment. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge **$200** per hour for preparation and attendance at any legal proceeding.

CANCELLATION /NO SHOW POLICY

While a medical doctor has the ability to schedule up to 35 patients in a day, a therapist dedicates their entire day to 6 or 7 clients. Therefore, it is common practice for almost all mental health professionals to have a cancellation policy so that we may properly accommodate and be respectful of each of our clients' schedules, as well as our own. Please read carefully and if you have any questions please feel free to discuss with me in person.

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Once we schedule an appt. together that slot is reserved exclusively for you. When a session is cancelled without adequate notice, it is extremely difficult for me to fill that time slot and offer it to another client who may genuinely be in need of it. **Therefore, clients may cancel or reschedule an appointment at any time, as long as they provide 24 hours' notice.** If you cancel an appointment with less than 24 hours' notice, or you do not show up for your scheduled appointment you will be charged your regular session fee regardless of the reason for cancellation.

*Exceptions to this policy will be made if a cancellation is due to sickness or inclement weather, or if I am able to reschedule your appointment for another day in the same week.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held unless we have agreed on other arrangements. Acceptable forms of payment are cash, check or credit card. There will be a $25.00 fee for any returned/NSF checks. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

If your insurance company does not cover fees for any reason, you will be financially responsible for all charges. All services provided which are not covered by insurance will be billed separately.

CONTACTING ME

The best phone number to reach me on, whether it be through phone call or text, is 267-405-6803. In addition, I can be contacted via e-mail at laura_otto@att.net. Since I am frequently in session, I am often not immediately available by telephone so if by chance you do not reach me please leave a message on my confidential voicemail with times that may be convenient for me to call you back.

Phone calls, texts messages and e-mails will be received and answered during my office hours **between the hours of 10:00am-9:00pm Monday through Friday.** Occasionally I am able to answer or respond outside of those hours but please know not to expect this.

Please remember texting is not intended to replace a therapy session. The primary use of text messages are for the purpose of scheduling or for quick check-ins or questions.

I will make every effort to return calls/texts/emails within 24 hours, with the exception of weekends, holidays and vacations. During weekends, holidays and vacations expect that you will hear back from me as soon as possible on the next business day.

Please remember that technology is not infallible. If you text or email me and do not receive a response back within 24-48 hours, please send the message through again to make sure I've received it.

In times I am away from the office for an extended time I will inform you well in advance and provide you with the name of a colleague to contact or schedule a session with if needed while I'm gone.

SAFETY

Please note that Text messages and Emails should NEVER be used as a way to reach out to me if you feel you are in immediate danger of harming yourself or someone else. If such an instance occurs, please refrain from texting or emailing and instead call me. If I do not answer, please leave a message and I will respond as soon as possible. If you do not hear back from me in a timely manner, please take care of yourself and call 911 or go to the local nearest emergency room.

It is understood that if you are trying to contact me outside of the available office hours provided, you are responsible for your own safety. This includes evenings, weekends, holidays and vacation. If you are feeling unsafe and try to contact me either during or outside my offices hours but do not receive an immediate response you may wish to take one of following courses of action: Call 911, go to your nearest local emergency room, call the national suicide hotline 1-800-273-8255 (TALK), text the Crisis Text Line: text START to 741-741. I will contact you as soon as I am available.

PROFESSIONAL RECORDS

As I am sure you are aware, I am required to keep professional records of our work together. You are entitled to receive a copy of these records; however, because they contain information that can be misunderstood by someone who is not a mental health professional, I recommend that you review them in my presence so that we can discuss the contents.

I work with a group of independent mental health professionals, under the name Blue Bell Psychology Group. This is a group of independently practicing professionals which share certain resources. While the members share office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained, and no member of the group can have access to them without your specific, written permission.

MINORS

In accordance with Act 2004-247 of the Pennsylvania State Legislature, juveniles aged 14-18 may provide sole consent for their mental health treatment and release of information from said treatment, including to parents or guardians. For minors under age 14, parental/guardian consent is required and full access to patient records is allowed, however, it is my policy to request from parents that they agree to relinquish access to patient records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that the patient will seriously harm him/herself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of treatment when it is complete. Before giving them any information, I will discuss the matter with the patient, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. There are some situations in which I am legally obligated to take action to protect others from harm, even if I must reveal some information about a patient's treatment. For example, if I

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believe that a child is being abused, I may be required to file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations are rare, and should one occur, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. If you request, I can provide you with relevant portions or summaries of the state laws regarding these issues.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. I look forward to working with you.

Client____ Date __________________

Therapist ____ Date __________________

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Notice of Privacy Practices

The next Health Insurance Portability and Accountability Act (hereinafter referred to as 'HIPAA') regulations requires Laura L. Otto, LPMHC and affiliates (hereinafter referred to as L.O.) to inform all my clients of their rights regarding their personal medical information.

A record is made each time you visit a hospital, physician or other health care provider and it includes symptoms, examination and test results, diagnoses, treatment and a plan for future care. This information is most often referred to as your "medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy, and enable you to relate to who, what, where and why others may be allowed access to your health information.

This notice gives you information required by law about the duties and privacy practices of L.O. to protect the privacy of your individually identifiable health information or Protected Health Information (hereinafter referred to as 'Information'), as that term is defined under HIPAA, in providing for your medical treatment.

The effective date of this notice is February 1, 2020. Upon your request, L.O. will provide you a copy of her current Notice. L.O. reserves the right to make the new changes apply to HIPAA maintained by L.O. before and after the effective date of the new Notice.

Purposes for which the Practice May Use or Disclose Your Medical Information with Your Consent

L.O. may request your consent for the use and disclosure of your Information for treatment, payment or health care operations as described below:

Treatment Purposes. For example, your Information may be disclosed to your doctor or another specialist who referred you to L.O.

Payment. For example, your Information may be used and disclosed to submit claims to your insurer and/or to obtain payment for services provided.

Health Care Operations. For example, your Information may be used and disclosed to engage in coordination of your care, inform you of appointment dates, or to convert your medical record to an electronic record.

Health Care Services. Your Information may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

Use and Disclosures with Your Verbal Consent

Except as provided below, your Information will not be used for any non-routine purposes unless you give L.O. your written authorization to do so. L.O. may request your authorization to use and disclose your Information for research purposes. If you give L.O. written authorization to use or disclose your Information for a purpose that is not described in this Notice, then with certain exceptions, you may revoke it in writing at any time. Your revocation will be effective for the information L.O. maintains, unless she has taken action in reliance of your authorization.

Use and Disclosures without Your Consent or Authorization

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As required by law. L.O. must provide your Information to the U.S. Department of Health and Human Services and to you upon request.

To Business Associates. Your Information may be disclosed to L.O. business associates who require the information to perform a function for her (i.e. accountant). Each business associate of L.O. must agree in writing to ensure the continuing confidentiality and security of your information.

Additionally, your Information may be used and disclosed without your consent, opportunity to agree or disagree or authorization for other reasons including:

To comply with legal proceedings, such as a court or administrative order or Subpoena; To law enforcement officials for limited law enforcement purposes;
For research purposes in limited circumstances;
To a coroner, medical examiner, or funeral director about a deceased person;
To an organ procurement organization in limited circumstances;
To avert a serious threat to your health or safety or the health or safety of others;
To a governmental agency authorized to oversee the health care system or Government programs;

To federal officials for lawful intelligence, counterintelligence and other national security purposes;
To public health authorities for public health purposes; and
To appropriate military authorities, if you are a member of the armed forces.

Your Rights

You may make a written request to L.O. to do one or more of the following concerning your Information:

To put additional restrictions on L.O.'s use and disclosure of your Information
To communicate with you in confidence about your Information by a different means or at a different location from that which L.O. is currently communicating.

To see and get copies of your Information
To correct your Information
To receive a list of disclosures of your Information that L.O. and associates make for certain purposes for six (6) years prior to your request (after June 1, 2019), with certain exceptions for disclosures made to you or made pursuant to your authorization.

To send you a paper copy of this Notice if you receive Notice by e-mail/Internet.

If you want to exercise any of these rights described or require further information about L.O.'s privacy practices, please contact her at the address below. Please know that in certain instances, L.O. does not have to agree to your request. L.O. will give you the necessary information and forms for you to complete and return. Records requested for yourself, L.O. will charge you a fee of $0.60 per page for copying and postage if mailed to your home.

Complaints

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If you believe your privacy rights have been violated by L.O. you have the right to complain to her or to the Secretary of the U.S. Department of Health and Human Services. You may file a written complaint with L.O. or with the U.S. Department of Health and Human Services.

Contact Office

To request additional copies of this Notice or to receive more information about L.O.'s privacy practices or your rights, please contact:

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Client____ Date ___________________

Therapist ____ Date ___________________