A Tousaint Counseling & Consulting, LLC

**CONSENT FOR SERVICES**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**

**Parents/Guardians (for minor client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Residential Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. \_\_\_\_\_City \_\_\_\_\_\_\_\_State \_\_\_ Zip code \_\_\_\_**

**Address Affiliated with Health Insurance Plan: (leave blank, if same as above)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt. \_\_\_\_\_ City \_\_\_\_\_\_\_\_State \_\_\_ Zip code \_\_\_\_\_**

**Psychotherapy Services:** Participation in therapy includes both risks and benefits, including the risk that symptoms or distress may increase during treatment. Benefits can include decreased emotional distress, greater insight and awareness, more adaptive coping skills and behaviors, and improved communication and interpersonal relationships. Therapy cannot be guaranteed, and effectiveness of treatment depends on a variety of factors, including the client’s level of participation and effort. The client should be aware that they have options for treatment. Attending therapy is voluntary, and client may end treatment at any time. If the client decides that they would like to seek another provider for therapy, therapist will provide referrals to other providers.

**Length of Treatment:** Length of treatment will be determined by therapist and client together and will vary based on the client’s needs and severity of symptoms. If you are using health insurance to pay for services, please be advised that your insurance provider may have limits on the number of sessions that will be covered. If for any reason, therapist or client feels that it is necessary or advisable to end treatment before discussed length, therapist will provide you with appropriate alternative referrals.

**Fees:** All sessions are 50 minutes. In-network insurance will be billed directly. For out-of-network insurance, you may request a statement to seek reimbursement. Co- payment/ Payment is due and payable at the time of service. A Tousaint Counseling & Consulting LLC accepts cash, check, or credit card for payment. Returned checks will incur a $15 fee. If there are two or more session/ co-payment balances on your account, future services cannot be rendered until past due balance is paid. After 60 days, balance will be transferred into a collections account. For additional services, such as documentation, attending meetings, providing consultation, or phone calls longer than 15 minutes, a pro-rated charge may be applied.

Standard session rate is **$100** and is billed directly to insurance network or client, via invoice. There may be a copayment cost applicable to your account, depending on insurance benefits. Copayments are paid via invoice. A sliding scale is available upon request.

**Parental Involvement for Minor Clients**: When a minor is the client, parents may be requested to participate in treatment through family sessions or parenting sessions. **A parent/guardian is required to remain on-site during all individual sessions of a minor client.** Parents have a legal right to request information and records about their child’s treatment; however, privacy allows children and adolescents to better benefit from the therapy process as they can more openly express themselves. **By consenting to services with A Tousaint Counseling & Consulting, LLC, you are agreeing that your child’s therapy disclosures may be held as confidential.** Therapist will inform parents of any significant safety concerns.

**Cancellation Notice**: All cancellations of appointments should be made at least 1 hour in advance of appointment. If appointments are cancelled at least 1 hour in advance, there is no penalty. Cancellations may be left on my voicemail at (504)270-1723, emailed to atousaintcounseling@gmail.com, or completed manually through Schedulista link. **50% of full session fee is charged/billed if client gives less than 1-hour notice or no-show for a scheduled appointment, unless in case of emergency.** If applicable, please provide proof of emergency to avoid fee.

If you cancel or no-show for two consecutive sessions, your reserved appointment time may be released.

**Court:** A Tousaint Counseling & Consulting does not testify in court as a witness and does not provide court testimony for marital or custody disputes. If required to testify in civil court, due to court order or subpoena, therapist will require payment in advance of my standard fee of $125.00 per hour during the entire time at the court or at the dispositions, including travel time.

**Confidentiality:** Information that you discuss with your therapist is usually confidential and will not be
discussed with anyone not covered under the HIPAA regulations. Please request Notice of Privacy Practices, as necessary. This means that under most circumstances what is told in a therapy session will not be reported to anyone, even to other family members (except for in the case of a minor). If you wish for information to be disclosed, you may sign a request to release information.

 These are the limits to confidentiality:

1. If you are a serious danger to yourself
2. If you threaten serious harm to others
3. If I have reasonable suspicion or am told of abuse or neglect of a child, elder, or dependent adult
4. If I am ordered by a court to release records or as otherwise required by law
5. If you are using a mental health insurance policy to pay for your visits, I may be required to provide certain diagnostic and treatment information in order to obtain payment for services
6. To coordinate services with your primary care provider, your psychiatrist, your referring doctor and/or other relevant providers as stated in the HIPAA regulations

All treatment records are the property of this therapist and will be stored in both a secure electronic and paper health record. You may submit a written request for your records, and I will determine whether it is appropriate to release these records.

**Scheduling & Availability:** All appointments, both in person and teletherapy, are booked at [www.atousaintcounseling.schedulista.com](http://www.atousaintcounseling.schedulista.com). Appointments are available Monday- Thursday 11am- 7pm.

**Therapist Contact Between Sessions:** You may contact me via message in the secure client portal. You may also submit and sign documents via the client portal. Please expect a response within 24- 48 hours. To register for access to portal, please visit https://atousaintcounseling.clientsecure.me.

**In the case of a psychiatric emergency or crisis, call Orleans Mobile Crisis at 504- 826- 2675 or Jefferson Parish Mobile Crisis at (504) 832-5123. In case of immediate emergency, please call 911.**

**Email & Text Messaging:** Email and text should not be used for crisis or emergency situations, as you may not receive an immediate response. Neither are a secure, confidential form of communication and should not be used for discussion of clinical issues or for urgent communications. Please use the secure messaging center in client portal for contact, however, please expect a 24- 48-hour response. Do not text emergent matters. Follow emergency protocol (i.e. mobile crisis or 911).

**Teletherapy:** To participate in teletherapy, client must also consent to the following criterion:

* I hereby consent to engage in telemedicine with A Tousaint Counseling & Consulting LLC as the main venue for my psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications.
* All teletherapy sessions are completed on the Simple Practice platform. Client must have access to a video phone/ computer, stable internet and access to this website to participate in teletherapy.
* If connection is lost or glitchy, client will simply refresh the screen and wait 10 seconds. If longer time is needed for reconnection, please call therapist immediately at 504-270-1723.
* Client must complete an emergency plan with therapist, including the identification of nearest relative and hospital.
* The laws that protect the confidentiality of medical information also apply to telemedicine.
* If client is found to not be a good candidate for teletherapy, client will be terminated and referred to a local provider.
* Client understands that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, of client’s medical information could be disrupted or distorted by technical failures; the transmission of client’s medical information could be interrupted by unauthorized persons; the electronic storage of client’s medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur.
* Client must inform therapist upon crossing state lines or international boundaries, while under teletherapy treatment.

**CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as “healthcare operations”). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby authorize A Tousaint Counseling & Consulting, LLC to share information to my insurance companies concerning the client’s diagnosis and treatment. I hereby authorize A Tousaint Counseling & Consulting, LLC to provide treatment for me and/or my dependents and authorize payment for services. I guarantee payment of all co-payments, co-insurance, and services not covered by insurance. I understand that any balance maintained longer than three months (90 days) will be sent to a collections account.

I understand that insurance coverage of mental health services requires medical necessity and a mental health diagnosis. Insurance coverage cannot be guaranteed at the time of service.

I understand that it is the responsibility of the patient to keep this office informed of any changes in insurance, residency &/or phone number as soon as possible. If I do not inform this office of the changes, I must pay for all fees not covered by your current or previous insurance companies.

I understand that for out-of-network services, I am initially responsible for all payment. I may be provided with a superbill at my request that can be submitted to my insurance company for possible reimbursement. I understand that reimbursement depends on my out-of- network benefits and is not guaranteed.

**CONSENT FOR SERVICES AND ACKNOWLEDGMENT OF RECEIPT OF HIPAA- PRIVACY NOTICE**

Signature of Client/Guardian Date

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 Signature of Therapist Date

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