ES COUNSELING OFFICE POLICIES

Financial Responsibility Policy

We are committed to providing you with a clear understanding of the financial policy. If you have any questions or concerns, do not hesitate to ask. Educate yourself with the following and initial that you fully understand each policy.

At each visit, please confirm we have the correct and complete insurance information. We request a copy of your driver's license, **valid credit card** and current insurance card at the first visit. You will be responsible for any and all deductibles, co-payments and services not covered by insurance. It is your responsibility to stay informed of insurance changes, deductible balances, authorization requirements, etc. Client's initials: _____

At each visit, copayments, co-insurance and payments for self-pay services and balances are due in full at the start of session. *Personal checks are accepted only on a single case basis*. We accept cash, MasterCard and Visa credit cards, debit and Health Savings Account (HSA) cards. Transactions under $25 need to be paid for by cash only. If the client is a minor, the adult who brings the child is responsible for paying the fee at the time of service or for paying **prior** to the appointment. It is your responsibility to bring exact change for your payments. No change will be given and any overpayment will be credited to your account. If you are unable to pay on the day of service, please call more than 24 hours prior to your appointment to reschedule your visit to avoid the no show/cancellation fee. The no show or cancellation fee for appointments cancelled within 24 hours of the appointment is **the rate of the session.**
Your session rate: $ _____ ☐ insurance co pay _____☐ self pay rate _____ Client's initials: _____

All sessions, including the initial appointment are subject to the no show or cancellation fee. The fee is based upon the rate of your session. Your credit card will be charged if first appointment is missed.
Client's initials: _____

It is **required** that you provide credit card information to be kept in your confidential patient record to cover any no show or cancellation fee that you may acquire. Please confirm the card is valid. The card will have a validation transaction completed after your first visit. Your credit card information will be processed in the event of a no show or cancellation and you will be sent a receipt of the transaction to the e-mail address on file. A $2.50 service charge will be charged to your account for each 'declined' transaction due to incorrect information provided or for deficit of funds, and for any payment of balance after two attempts for reimbursement through invoicing. A service charge will also be added if a credit card is not physically present to swipe. Client's initials: _____

If your account requires outside collection efforts, you will be responsible for the balance. A lapse in treatment will not erase the balance due. Prior to sending the statement to a collections service, we will send two courtesy account statements indicating the unpaid balance. If an outstanding client balance is on the account, no further appointments will be scheduled, and any outstanding appointments will be cancelled until the balance has been satisfied in full. As a business, it is our responsibility to only provide services for which payment will be made. Client's initials: _____

Credit Card Authorization

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other including HSA/FSA
Cardholder Name (as shown on card): _____
Card Number: last 4 of credit card on file: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize ES Counseling, LLC to charge my credit card above for agreed upon charges related to counseling sessions. I understand that my information will be saved to file for future transactions on the account for the person listed above.

_____ _____
Credit Card Holder Signature Date

Telephone calls, e-mails and legal/forensic or other record reviews completed by your provider to coordinate care with parents, attorneys and other non-medical providers will be billed at the rate of $25 per 15 minutes. Completion of medical forms, including but not limited to disability forms, Family Medical Leave Act (FMLA) forms and other reports or letters written for legal or financial purposes require a payment by the client. The fee is dependent upon the length of time used to complete the paperwork, including treatment summaries, and is billed at the rate of $25 per 15 minutes of time. You will be given an estimate of charge and this will be paid prior to completion. Forms will not be completed in session and may take up to 14 business days. It is the therapist's discretion what records will be released and a treatment summary will be provided in lieu of records. Medical records released directly to other medical providers for collaboration and coordination of care are complimentary; however if a client requests their own records, the charge is $1 per page and at the rate of $25 per 15 minutes of time for completion. Requests for records will take up to 10 business days, or 14 calendar days depending on when they are requested. Please plan accordingly. Client's initials: _____

Thank you for your attention and cooperation. By signing below, you understand that regardless of insurance status, you are responsible for your account. You have read the information and understand the policy.
Client's initials: _____

Although we understand the symbolic meaning behind personal gifts, timely payment of services when rendered is our payment. We are unable to accept any gift over the value of $15. Client's initials: _____

HIPAA & Confidentiality Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. The rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of the practice

Primary Care Provider or Pediatrician: _____
Address: _____
Phone: _____ Fax : _____
☐ I choose not to release information to my primary care provider regarding treatment received at ES Counseling.

I have also been informed of and given the right to review the Summary of the HIPAA Privacy Rule, which contains a more complete description of the uses and disclosures of my protected health information (PHI), and my rights under HIPAA. Location: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

Psychotherapy notes do not have to be released unless by judicial court order. For this reason, I understand if notes are requested, a treatment summary may be given in lieu of the notes, and therefore I may incur a charge for this service.

I understand that I may revoke this consent to contact my Primary Care provider, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____ Relationship to Patient: _____
Signature: _____ Date: _____

Intern Policy

ES Counseling utilizes the assistance of interns at times, both for observation and for therapy administration practice. Additionally, there will be times when a student or Masters level intern will accompany me into visits observing or shadowing me. At times, it will be necessary to tape session via camera for either live review or recorded to observe therapist style, technique and skill. Interns and students benefit from being able to treat clients under a trained therapist and this experience is vital to their growth and education while simultaneously providing ES Counseling therapists with current and updated methods through collaboration with interns and other students. Continuing therapy education is beneficial for everyone involved and provides therapy clients with additional support while fostering the therapists' learning and growth. It is important that students or Masters level interns be allowed to accompany me into therapy visits with clients or that we will observe live sessions or record sessions. Confidentiality is strictly enforced. HIPPA guidelines are strictly followed and footage is not used for any other purpose unless permission if given by client. By signing this statement, I am agreeing to allow Edna Schaefer, LMHC to be accompanied by a Masters level intern when working with me/my child. By signing this, I, _____ (client/parent/guardian name) agree to the terms and conditions and will comply with the statements above.

By signing this, I, _____(client/parent/guardian name) consent to allow specific sessions to be observed via camera or recorded with prior notification.

Sickness Policy

When you or your child is sick, talk therapy is not optimal, and in turn, is less beneficial. Therefore, if you or your child has a fever over 99 degrees, has a thick, yellow/green nasal discharge, is coughing without relief or has vomited or had diarrhea within the past 24 hours, please call and cancel the therapy session as soon as possible. You must be symptom-free for 24 hours, without the use of medications including Tylenol to have the appointment. If you would not send your child to school, please do not bring them to our office. Because we work so closely, our concern is not only your health, but also maintaining the health of our office, other clients, and our health. Client's initials: _____

Social Media Policy

In our best effort to protect your privacy, we will not accept requests or invitations from clients or their first degree relatives for any social media to include, but not limited to Facebook, Twitter, LinkedIn, Pinterest, Instagram, Google+, Tumblr, or personal blogs. We have a monitored Facebook business page for ES Counseling and welcome 'likes,' but we will not respond to email or instant messaging through that site. We are appreciative of word-of-mouth referrals, however we cannot confirm or deny past or current client's treatment to potential or new clients. If you choose to write a recommendation on a business review site for ES Counseling, please keep in mind that you may be sharing personal information in a public forum and we support your decision to create a pseudonym that is not linked to your regular email address or friend network for your own privacy and protection (if you wish to remain anonymous). The same is the case for any reviews you may complete online.

____ I have read and understand this policy on social media