OFFICE & FINANCIAL POLICIES and THERAPY CONSENT

PART I: THERAPEUTIC PROCESS

Welcome from To Be Known Therapy Services! We look forward to working with you. The intent of this document is to inform patients about the office and financial policies of Veronica Thomas, LLC doing business as To Be Known Therapy Services (BKTS), and to obtain your consent to treatment.

Patient Name: _____ Date of Birth: _____

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional responses. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for **45 minutes** depending upon the nature of the presenting challenges. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

PART II: POLICIES

FEES: The fee for each therapy session is $**100**. Payment is due at the time of service. Before beginning treatment, you will be asked to sign a Credit Card Authorization Form to pay for services. Other acceptable forms of payment are: exact-amount cash and check (an NSF fee of $50 will be charged for any insufficient-funds checks returned). BKTS does not accept health insurance.

If full payment for services is not received within 7 days of the date of service, a 1.5% interest charge plus a re-billing fee of $2.00 will be charged to you the following month. To avoid interest charges and re-billing fees, financial arrangements must be approved in advance by your therapist.

All costs for services outside of a session will be billed to you. The therapist charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care.

CREDIT CARDS: If Patient provides a credit card, HSA or debit card (the "Card") for payment, it will be charged at the time of service or immediately thereafter. Patient affirms that any card provided is a valid Card, Patient is an authorized user of the Card, and will not dispute the payments as long as the transactions correspond to the BKTS fees. Patient authorizes BKTS to retain and electronically store the Card information with a credit card management system. Patient hereby fully and forever releases BKTS from any liability associated with the Card, including, but not limited to, any unauthorized charges not made by BKTS.

Why Clinicians Do Not Take Insurance: BKTS' decision not to take insurance involved consideration of enhanced quality of care and other advantages for patients:

1. You are in control of your care, including choosing your therapist, length of treatment, etc.
2. Increased privacy and confidentiality (except for limits of confidentiality).
3. Not having a mental health disorder diagnosis on your medical record.
4. Consulting with me on non-psychiatric issues that are important to you that aren't billable by insurance, such as learning how to cope with life changes, matters of faith that are important to you, gaining more effective communication techniques for your relationships, increasing personal insight, and developing healthy new skills.

If you prefer to utilize a therapist that accepts your insurance provider, BKTS will do its best to recommend a therapist for you.

APPOINTMENTS AND CANCELLATIONS: You are responsible for keeping track of and attending each appointment and agree to adhere to the following policy: ***If you cannot keep a scheduled appointment, you MUST notify the office via phone or email to cancel or reschedule the appointment at least 24 hours in advance of the scheduled appointment time.***

If you do not attend an appointment ("No Show"), or cancel within 24 hours of the appointment time ("Late Cancel"), in a 12-month calendar year:

- The first time you Late Cancel, you will be charged a fee of $50 for the session.
- The second time of a Late Cancel, you will be charged a fee of $100 for the session.
- The third time of a Late Cancel and thereafter, you will be charged your full session rate.
- Any time you No Show, you will be charged your full session rate.

This appointment has been held for you, and therefore, cannot be used by another person in need. As a result, there are no exceptions to this policy. Moreover, the clinician reserves the right to re-evaluate your needs and motivations for treatment, or even terminate the therapeutic relationship, if more than 3 sessions are cancelled and/or missed with or without proper notification.

LATE ARRIVAL: If you arrive late for your session, we will use the balance of your scheduled time available for your session because this appointment has been held for you.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged the clinician's hourly rate in quarter hours for travel time, court time, preparing documents, letters, court prep time, etc. See the section on Fees.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, the cost is $1 per page. Payment for your medical records will be due prior to or upon receipt of the copies, and can be picked up at the office. Please allow at least 1 week to prepare medical records.

PHONE CONTACTS AND EMERGENCIES: Office hours are from 9:00a.m. through 5:00p.m. If you need to contact the clinician for any reason please call the office number and leave a voicemail, and a return call will be made within 24 Hours or as soon as possible. **BKTS does not provide emergency services.** In case of an emergency, you can access emergency assistance 24 hours per day by calling 988 or the National Suicide Prevention Lifeline at 1-800-273-8255 or by calling emergency services at 911. If either you or someone else is in danger of being harmed, dial 911.

PART III: CONFIDENTIALITY

One of our top priorities is to protect patient privacy and individually identifiable health information. We follow the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and existing Michigan law. Patients must give specific authorization for the disclosure of their Protected Health Information (PHI). Patient records will be stored electronically through HIPAA compliant web-based and electronic medical records (EMR) software.

BKTS utilizes third party companies for billing, credit card payments and/or collecting on its behalf. In the course of their services, these companies may receive, transmit or maintain your PHI and are subject to HIPAA Privacy Rules. By entering into treatment at BKTS, you are granting us specific authorization to disclose your PHI for these purposes; you are acknowledging that your PHI will be shared with third parties for these limited business purposes, and agreeing that BKTS is not responsible or liable for the privacy practices of these third parties.

Anything said during therapeutic treatment of a patient at BKTS is confidential and may not be revealed to a third party without written authorization, ***except*** for the limitations identified in the HIPAA Notice of Privacy Practices that has also been provided to you. Please also note the following additional confidentiality issues:

- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes", except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Couples Counseling & "No Secret" Policy:** When working with couples, I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists to one party or the other. However, if one party requests a copy of couples or family therapy records in which they participated, I will require an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.
- **Social Media**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical records.
- **Electronic Communication: If you wish to contact me electronically outside of our sessions, please review the Electronic Communications Policy. You must download the HIPAA compliant Spruce Health App and/or the Patient Portal.** Any electronic communication is part of your medical record.

EMERGENCY CONTACT: It is necessary that To Be Known Therapy Services has someone to contact on your behalf. In case of an emergency, you agree to allow BKTS to contact this person:

_____

Full Name Relationship Phone Number(s)

PART IV: IN-PERSON SERVICES

Risks of Opting for In-Person Services: You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus and any other viruses or public health risks.

If You or a Therapist is Sick: You understand that we are committed to keeping you, the therapists, and all of our families safe and healthy. If you show up for an appointment and we believe that you have a fever or other symptoms, or believe you have been exposed to a virus, BKTS will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

Your Confidentiality in the Case of Infection: If you have tested positive for the coronavirus, we may be required to notify local health authorities that you have been in the office. If we have to report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that we may do so without an additional signed release.

PART V: IN-PERSON THERAPY CONSENT and ACKNOWLEDGMENT

My signature below indicates:

1. I have read and understand the information contained in the Office and Financial Policies (OFP) and the Therapy Consent of To Be Known Therapy Services (BKTS). I have discussed any questions that I have regarding the OFP. My signature below indicates that I am voluntarily giving my informed consent to receive in-person counseling services and agree to be bound by the terms and conditions listed in the OFP. I authorize BKTS to provide counseling services that are considered necessary and advisable. I understand that BKTS has agreed to provide me with counseling services in reliance upon my agreement to comply with the OFP.

2. I acknowledge that I am financially responsible for payment of all services received from BKTS (and that BKTS does not accept insurance payments or reimbursements as a form of payment), and for any additional charges billed to the account, including, but not limited to: Late Cancel fees, No Show appointment fees, interest charges, NSF fees, or any other charges incurred, less credits or payments posted to my account. I understand that in the event that fees are not paid by me, BKTS may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney. If the account is sent to a collection attorney or agency, I agree to be responsible for all attorney fees, collection fees and expenses for collection of any balances due.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek therapy treatment for minor(s) in my custody and give permission to BKTS to provide in-person treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain therapy services for my minor, I will provide the appropriate court documentation to BKTS prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

4. *I have received a copy of the "Office & Financial Policies and Therapy Consent" for my records.*

Acknowledgement: I have read and agree to the terms of "Office & Financial Policies and Therapy Consent". I acknowledge that I am the client or the legal representative of the client, and I agree that my drawn or generated signature is a legally binding equivalent to my handwritten signature.

Printed Name	Signature	Date

Printed Name of Minor Child	DOB	Date