Plainfield Counseling Center

24012 W. Renwick Rd. Unit 204
Plainfield, IL 60544
P: 815-676-4688
F: 815-676-4498
www.plainfieldcounselingcenter.com

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Plainfield Counseling Center, LLC's independent licensee clinicians originate and maintain physical and electronic health records which are securely stored describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and treatment information to my bill, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Confidentiality

In general, the privacy of all communications between a client and a clinician are protected by law. Your clinician will only release information to others about you and our work together if we have your written permission. However, please note that there are rare exceptions to this policy. Your medical records are maintained by your clinician, please direct all Releases of Information to your clinician, Plainfield Counseling Center, LLC does not maintain or have access to your records or protected health information (PHI). Your clinician will not release sensitive material via text or email unless initiated by you or directed to by you as these mediums are less secure. Telehealth services may be provided via an encrypted, HIPAA compliant service. At times your clinician may use third party services to deliver your healthcare, such as an electronic medical records company. Third party service providers have signed Business Associate Agreements (BAAs) to protect your PHI.

There are some situations in which we are legally obligated to take action to protect others from harm, even if it is necessary to reveal some information about a client's treatment. For instance, if your clinician believes that a child, elderly person or disabled person is being abused, we are legally required to file a report with the appropriate state agency. If your clinician believes that a client is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police or seeking hospitalization for the client. If the client threatens to harm him or herself, your clinician may be obligated to seek hospitalization for him or her or to contact family members or others who can provide protection. These situations have rarely occurred in your clinician's practice. If a situation should arise, your clinician will make every effort to fully discuss it with you before taking any action.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

If I am engaging in group psychotherapy, I understand that each group member is expected to maintain confidentiality of information discussed in group. This allows for a safe atmosphere for everyone involved. However, confidentiality of information shared in groups cannot be assured because group members are not legally bound by the same confidentiality laws as clinicians.

Minors

Patients under 12 years of age and their parents (or legal guardians) should be aware that the law allows parents to examine their child's treatment records. When children between the ages of 12 and 17 are seen alone, the content of these sessions is kept confidential; between therapist and child. Parents of children between 12 and 17 years of age cannot examine their child's records unless their child consents or unless the therapist finds no compelling reason for denying them access to those records. Parents of children between 12 and 17 years of age are entitled to information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided and services needed. If the clinician believes that the child is in imminent risk of harming himself/herself, or others, the therapist will notify the parents (or legal guardian) of this concern. Before giving the parents any information, the clinician will (if possible) discuss the matter with the child, and the clinician will try and handle any objections the child may have with what the therapist is prepared to discuss with the parents. I understand that the parent completing this form is the parent responsible for all associated medical costs.

Cancellations

I understand that I must call to cancel an appointment at least 48 hours (2 days) before the time of the appointment. If I do not cancel at least 48 hours in advance, I will be charged a $50.00 fee for that appointment. I am aware that if I violate the cancellation policy three (3) times within a three (3) month period my clinician will determine if therapy services will continue. This policy is to allow adequate time for clinicians to schedule other clients who may want that appointment time.

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Consent to Treatment or Psychological Assessment

I acknowledge that I have received, have read (or have had read to me), and understand the information about the services I am considering. I have had all my questions answered fully. I do hereby seek and consent to take part in **treatment** and/or **psychological testing** by the clinician named below. The clinician is an independent practitioner/licensee at Plainfield Counseling Center, LLC and is responsible for their own clinical work, professional conduct, and records maintenance, not Plainfield Counseling Center, LLC or any of its other licensee clinicians. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

Please be aware that at times animal assisted therapy dogs may be in use by our staff. These dogs have either completed or are in the process of completing rigorous animal assisted therapy certification. If you do not wish to receive animal assisted therapy please inform your clinician. Emotional Support Animals are permitted within the practice, however if an animal is excessively noisy or disruptive they may not be permitted on the premises.

I understand that no promises have been made to me as to the results of assessment, treatment or of any procedures provided by this therapist. I am aware that I may stop assessment or treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may encounter other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Agreement to Pay for Professional Services

I request that the clinician named below provide professional services to (please circle):

Myself **My Partner and I**

My Family Members/Partner: _____

My Child/Dependent: _____

I agree that this financial relationship with this clinician will continue as long as the clinician provides services or until I inform him or her, in person or by certified mail that I wish to end it. I agree to meet with this clinician at least once before stopping therapy and agree to pay for services provided to me (or this client) up until the time I end the relationship. The parent of a minor completing this form is responsible for the financial relationship. I understand that account statements will be mailed and/or emailed to the addresses that I have indicated. If you are unable to pay your account statement please contact your clinician as flexible payment arrangements can be discussed. Reasonable attempts to collect balances via, mail, email, and phone will be made including the last resort of outstanding balances being forwarded to a collections agency.

Your provider will file insurance claims for services rendered or we can provide you with an insurance claim form for you to submit to your insurance company for reimbursement. This is a service that we provide for you, but please remember that your insurance contract is between you and your insurance company - **not the healthcare provider**. You are ultimately responsible for payment. We cannot accept responsibility for collecting from your insurance company nor negotiating a settlement on a disputed claim. I agree that I am responsible for the charges for services provided by this clinician to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account. I understand that I am financially responsible for payment of services that may not be covered (such as telehealth and educational testing), deductibles, and/or co-payments and missed appointments. If I am privately paying, I agree to this clinician's fee of $ _____ per session and/or $_____ per hour or entire battery cost $_____of psychological testing, interpretation, and report writing. If account balances for psychological testing are unpaid the assessment report may be

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withheld. **Co-pays, deductibles, privately payment agreements, and out of network fees are to be collected at each appointment.**

Plainfield Counseling Center, LLC and its independent licensee clinicians do not accept Medicare, Medicaid, or AllKids insurance and are considered "Opt Out". Signature of this form acknowledges engaging in a "Private Contract".

Payments (such as checks and credit cards) which do not pass deposit (such as "bouncing" a check) are subject to a $25.00 processing fee. If you should request a copy of your clinical records, you will be charged $0.50 per page and a $20.00 handling fee if mailed. If myself, my minor, or anyone attending an appointment with me causes any damage to Plainfield Counseling Center, LLC, any of its independent clinicians' property or building property, I understand that I will be held responsible for costs associated with repairs and/or replacement. I understand that I will utilize restroom facilities that are consistent with the gender I identify with. Children are expected to be monitored in the lobby and hallways and please limit talking on cellphones or playing loud video clips/music in the lobby to respect noise levels.

Clients will be charged an appropriate fee for any professional time spent in responding to information requests or conducting services outside of psychotherapy. Examples of this may include court appearances and attendance at Individual Educational Plan (IEP) meetings and completing disability paperwork. If you become involved in legal proceedings that require the participation of Plainfield Counseling Center, LLC or any of its independent clinicians, and if the attorneys do not pay the fees, you will be billed for their professional time, even if the professional is called to testify by another party. Because of the complexity of legal involvement, the hourly rate will be $350.00 per hour for preparation, travel, and attendance at any legal proceeding. Court related services include talking with attorneys, preparing documents, depositions, travel time, preparation for testimony and court appearances. Charges for court related services are not covered by insurance and must be paid prior to services being provided.

If my account balance exceeds $300.00 services may be suspended until a payment arrangement has been agreed upon or my balance falls below $300.00 An account that has not been paid for more than 90 days without payment arrangements being made will be eligible for collection proceedings. This may involve utilizing on file credit card, legal action, hiring a collection agency, or going through small claims court. This "Signature on File" will be valid from this date and this agreement is in force for two years for the start date and thereafter, this Agreement shall automatically renew for successive one (1) year periods (each a "Renewal Term"), unless terminated as provided herein. A photocopy of this document may act as an original.

Decision to Meet Face-to-Face

If you and your clinician meet in person you have agreed to the following. If there is a resurgence of the pandemic or if other health concerns arise, however, your clinician may require that you meet via telehealth. If you have concerns about meeting through telehealth, you and your clinician will talk about it first and try to address any issues. You understand that, if your clinician believes it is necessary, your clinician may determine a return to telehealth for everyone's well-being. We have determined that in-person services are appropriate at this time for your situation for the following reason(s):

☐ Condition/Functioning Worsening ☐ Crisis ☐ Client Not Appropriate for Telehealth
☐ Need for Increased Level of Care ☐ Intervention Not Appropriate for Telehealth
☐ Psychological/Neuropsychological Testing ☐ Insurance Does not Cover Telehealth
☐ Other: _____

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, your clinician will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue may need to be discussed.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, your clinician, families, other staff and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.

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- You will only keep your in-person appointment if you are symptom free
- Your clinician will utilize a touchless thermometer when you enter the office. If it is elevated (100.3 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment and proceed using telehealth. If you wish to cancel for this reason, you won't be charged the normal cancellation fee
- You will wait in your car or outside until your clinician advises you to enter the building, our waiting room is closed until further notice. Family members who may be present must wait outside of the building
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building
- You will adhere to the safe distancing precautions we have set up in the therapy/testing room
- You will wear a mask in all areas of the building including your clinician's office, however your clinician may waive this requirement only in their individual office
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands)
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocol
- You will take steps between appointments to minimize your exposure to COVID
- If you have a job that exposes you to other people who are infected, you will immediately let your clinician know
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let your clinician know and if a resident of your home tests positive for the infection or is suspected of any sickness, you will immediately let your clinician know and begin/resume treatment via telehealth

The above precautions may change if additional local, state or federal orders or guidelines are published. If that happens, you and your clinician will talk about any necessary changes.

Our Commitment to Minimize Exposure

Your clinician and Plainfield Counseling Center, LLC have taken significant measures to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let your clinician know if you have questions about these efforts.

Risks of Opting for In-Person Services

I understand that by coming to the office, I am assuming the risk of exposure to the coronavirus (or other public health risks). I understand that exposure to disease-causing organisms and objects as well as personal contact with others, including but not limited to your clinician and other individuals you encounter in the building, as well as objects within the building involves a certain degree of risk that could result in illness. After fully and carefully considering all the potential risks involved, I hereby assume the same and agree to release and hold-harmless my clinician, Plainfield Counseling Center, LLC, and any of it's independent licensees from and against, all claims and liability resulting from exposure to disease-causing organisms and objects, such as COVID-19.

If You or Your Clinician Are Sick

You understand that your clinician is committed to keeping you, our staff, their personal safety, and all of our families safe from the spread of this virus and other diseases. If you show up for an appointment and your clinician believes that you have a fever or other symptoms, or believe you have been exposed, your clinician will require you to leave the office immediately. Services will be by telehealth as appropriate.

If your clinician tests positive for the coronavirus, they will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, your clinician may be required to notify local health authorities that you have been in the office. If your clinician is required to report this, they will only provide the minimum information

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necessary for their data collection and will not go into any details about the reason(s) for your visits. By signing this form, you are agreeing that your clinician may do so without an additional signed release.

Telehealth

This Informed Consent for Telehealth contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully and let your clinician know if you have any questions. When you sign this document, it will represent an agreement between you and your clinician.

Benefits and Risks of Telehealth

Telehealth refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person psychotherapy and telehealth, as well as some risks. For example:

- Risks to confidentiality. Because telehealth sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. Your clinician will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of your session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to gain access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, your clinician will not engage in telehealth with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telehealth, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telehealth work.

- Efficacy. Most research shows that telehealth is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room.

Electronic Communications

We will decide together which kind of telehealth service to use. You may have to have certain computer or cell phone systems to use telehealth services.

Confidentiality

Your clinician has a legal and ethical responsibility to make best efforts to protect all communications that are a part of our telehealth. However, the nature of electronic communications technologies is such that it cannot be guaranteed that our communications will be kept confidential or that other people may not gain access to our communications. Your clinician will use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that your electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telehealth sessions and having passwords to protect the device you use for telehealth). The extent of confidentiality and the exceptions to confidentiality that are outlined in your Informed Consent still apply in telehealth. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telehealth

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From time to time, we may schedule in-person sessions to "check-in" with one another. Your clinician will let you know if they decide that telehealth is no longer the most appropriate form of treatment for you. Your clincian will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telehealth than in traditional in-person therapy. To address some of these difficulties, you and your clinician will create an emergency plan before engaging in telehealth services. Your clinician will ask you to identify an emergency contact person who is near your location and who they will contact in the event of a crisis or emergency to assist in addressing the situation.

Identified Emergency Contact Person (Name and Phone Number): _____

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call your clinician back; instead, call 911, or go to your nearest emergency room. Call your clinician back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and your clinician will wait two (2) minutes and then re-contact you via the telehealth platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call your clinician on the phone number provided to you.

Fees

The same fee rates will apply for telehealth as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telehealth sessions in order to determine whether these sessions will be covered.

Records

The telehealth and face to face sessions shall not be recorded in any way unless agreed to in writing by mutual consent. Your clinician will maintain a record of our session in the same way they maintain records of in-person sessions in accordance with legal and ethical standards.

Signature of Patient: _____Date:_____

Printed Name of Patient: _____

Signature of Partner/Family Member (if applicable):_____Date:_____

Printed Name of Partner/Family Member (if applicable): _____

Signature of Legal Representative: _____Date: _____

Printed Name of Legal Representative: _____

I, the clinician, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Clinician: _____Date:_____

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Credit Card Authorization Form

It is required to keep a credit card (no Debit Cards) on file for guarantee of payment. Credit cards on file will not be charged until balances exceed 60 Days Overdue or otherwise discussed with your clinician. If payment arrangements have not been established, I understand that the treating clinician is not required to contact me prior to charging the credit card on file at the 60 Days Overdue mark. The balance will not be charged if a payment plan has been worked out with your clinician. Any fees that I incur which are associated with credit card charge Plainfield Counseling Center, LLC or my clinician is not responsible for. **I also acknowledge that if I cancel or miss an appointment with less than 48 hours notice I will be charged a $50 missed session fee. 48 hours notice allows time to offer the appointment time to another client. Exceptions to this policy for emergencies are allowed on a case by case basis to be approved by your clinician.**

I, _____ hereby authorize Plainfield Counseling Center, LLC and/or it's independent clinicians to keep my credit card number on file and to use that account to pay any outstanding fees associated with my treatment. My credit card information will be kept confidential.
I authorize Plainfield Counseling Center, LLC and its associates to charge my bill directly to the credit card listed below:

Type of credit card:
_____ Visa _____ MasterCard _____ American Express _____ Discover

Card #: _____/_____/_____/_____ Expiration Date: _____/_____ CVV code_____

Cardholder's Name: _____ Phone Number: (_____) _____ - _____

Email: _____

Billing Address for credit card:

_____

Signature of Card Holder: _____

By completing this form I agree to:
1. Keep this credit card on file with Plainfield Counseling Center, LLC or its independent clinicians.
2. Prior to the 60 Days Overdue I will receive notification via mail, email, and/or phone of my balance and will make arrangements for payment.
3. Bill all outstanding balances 60 Days Overdue to the above card.
4. This authorization is valid until I provide my clinician with written cancellation.

My signature below shows that I understand and agree with all of these statements.

Signature of Patient or Responsible Party: _____Date:_____

Printed Name of Patient or Responsible Party: _____