CONSENT TO TREATMENT

Thank you for choosing Empowering Healthcare Services. Your initial appointment will take approximately 60 minutes. The fee for the intake session is $275.00, and subsequent sessions is $200.00. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have any other questions or concerns, please ask us and we will try our best to give you all the information you need. You can reach our office by email at info@empoweringhealthcareservices.com or phone at Our clinicians use a variety of approaches that are both evidenced-based and individualized to serve each client. We believe that our clients are ultimately the experts in their own lives. Throughout the therapeutic relation will be discuss treatment practices, goals, plan limitations.

HIPAA

This document also contains summary information about the Health Insurance Portability and Accountability ACT (HIPAA). HIPAA is a federal law that mandates privacy requirements and patient rights pertaining to the use and disclosure of you Protected Health Information (PHI) in connection with treatment, payment and health care operations. HIPAA requires me to provide you with a Notice of Privacy Practices (which is attached to this agreement). It explains HIPAA and its application to your PHI in great detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it contains important information about your rights, and we ask that you review them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; or unless there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or unless you have not satisfied any financial obligations you have incurred.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information shared with consultants, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or your child or children report about physical or sexual abuse; then by Georgia State Law, I am obligated to report this to the Department of Child Protective Services, d) where you sign a release of information to have specific information shared and 3) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law. In the unlikely event that your clinician is unable to provide ongoing services, a EHS clinician will provide those services and maintain your records for a period of 7 years. If an emergency situation arises for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency series in the community (911) for those services. EHS clinicians will follow those emergency services with standard counseling and support to the client or the client's family.

APPOINTMENTS AND CANCELLATION POLICY:

All services are by appointment only. If you must cancel an appointment, please let EHS now as far in advance as possible, but at least 24 hours business days in advance so that we can offer that time to someone else.
We will make every effort to offer an alternative appointment during the scheduled week. **Failure to cancel within 24 hours results in a late cancellation/no show fee of $150.00.**

For couples/family therapy appointments, we only meet when all parties are present. So if one person is late or unable to keep the appointment, we will not meet.

There are many valid reasons for late cancellations (sick child, business meeting, traffic jam). I make only one exception to this policy. If there is an area emergency (i.e. major snow storm), there is no charge for a late or missed appointment. For all other late cancels, there is a fee of $150.00.

If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be billed the cancellation/no show fee.

SERVICE FEES: Payment is due at the time of your scheduled session, and will be billed to your credit/bank card on file. Any insurance co-pays or deductibles are due at the time of the session. Unfortunately, we cannot extend credit or provide services until payment is made. *Clients understand they are fully responsible for all fees if insurance or other vendor does not pay for any reason.*

Fees will be discussed during the initial consultation. A statement for insurance submission and for your records will be available by the first week of the month for the previous month.

FINANCIAL/INSURANCE ISSUES: **If you have a health insurance plan, your visits may be reimbursed.** The monthly statement provided contains the standard information needed to swiftly process your claims. Most insurance plans cover a portion of fees for counselors, although the percentages and amounts vary widely. EHS will provide billing services to your insurance company for services provided.

While a patient's diagnosis is very sensitive information and is generally treated as such by insurance carriers. We cannot guarantee how any insurance carrier or employer respects this information. If you prefer that I do not release information to your insurance company for reimbursement purposes, or if your insurance carrier fails to reimburse you at the level you expected, you remain responsible for the fee for services.

You should be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that I provide you. Georgia permits me to send some information without your consent in order to file appropriate claims. We are required to provide them with a clinical diagnosis. Sometimes we are required to provide additional clinical information such as a treatment plans or summaries or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. Georgia law prevents insurers from making unreasonable demands for information, but there are no specific guidelines about what unreasonable includes. If we believe that your health insurance company is requesting an unreasonable amount of information, we will call it to your attention and we can discuss what to do. You can instruct us not to send requested information, but this could result in claims not being paid and an additional financial burden being placed on you. Once the insurance company has this information, it will

become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it (see fee schedule if applicable).

We sincerely appreciate your cooperation and if, at any time, you have any questions regarding insurance, fees, or payments please feel free to ask. You may have a copy of this form if requested.

CONTACT IN BETWEEN SESSIONS

Although we do not take calls when we are in session, we typically check the voicemail and email at the end of every hour. If you leave a message or an email, we will answer it as soon as other demands permit. Generally, calls and emails are returned within the same day, with the exception being weekends and holidays. If your call is urgent, please state that at the beginning of your message, as we may not fully listen to messages until the end of the day. Calls and emails at night and on weekends will usually be returned during the next business day.

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared.

ELECTRONIC COMMUNICATION: Telephone and email are not encrypted methods of communication, and some confidentiality risks exits with their use. Counselors at Friends in Transition sometimes communicate using these mediums. If you would prefer to not be contacted by telephone or email, please inform your counselor and we will honor this request.

CLIENT FOLLOW UP: Your counselor may follow up with you after counseling has ended. 1 month, 3 month, and 6 month follow up calls help us to see if gains made in counseling have been maintained. In addition, someone from our team might call you to ask for your feedback on your experience at EHS Services. If you would prefer not to be contacted, simply inform your counselor and your preferences will be respected.

We, the counselor and client, have read and fully understand and agree to honor this agreement.

Client(s)_____ Date_____

Parent/Guardian)_____ Date_____

Provider_____ Date_____

Please read the following items and ask any questions that you have of your counselor.

1. Services offered by Empowering Healthcare Services, LLC are offered to help clients (and family) cope with depression, anxiety, dementia, adjust to grief, loss, transitional anxiety (such as move into a senior living facility), and other mental illnesses.
2. All counseling sessions will adhere to the American Counseling Association Ethical Standards.
3. Clients may be requested to complete the Brief Symptom Inventory (BSI), in addition to other assessment that may benefit treatment. The Brief Symptom Inventory is an assessment tool that gives the counselor an overview of the client's symptoms and the severity at a specific point in time.
4. All counseling relationships as well as storage and disposal of records will be kept confidential within legal and ethical limitations. Unless the client poses harm to the Counselor, the client will be informed when information regarding the client is being released. Information may be released without the written consent of the client in the following circumstances:
    a. The client poses harm to himself or others
    b. Suspected abuse of children or the elderly
    c. The client is under the age of 16 and has been sexually or physically abused, raped or the victim of another crime.
    d. When information is ordered by a court subpoena or a parole officer
    e. The client requires hospitalization
5. Deception in any form will not knowingly be used as a form of treatment
6. A primary goal of intervention is for the client to be able to live effectively within his or her own value system
7. Effectiveness of interventions with individuals is greatest when clients share all information related to the problem(s).
8. The purposes, goals, techniques, procedural rules, limitations, risks, and benefits of the intervention have been explained. The client has the opportunity to discuss the type of counseling relationship and intervention proposed and have any questions answered.
9. Clients in a helping relationship with other human services professional must inform all professionals.
10. Clients have a right to terminate counseling at any time.
11. The client understands his/her financial obligations. If appointments are not cancelled within a 24 hour notice, the client will be responsible for fees. In addition, any fees charged to the clinic for release of information will be the responsibility of the client.
12. During the first interview, the therapist will assess the client to determine if he/she is likely to benefit from guidance, counseling, and/or assessment. The counselor may inquire about goals, life history, mental status, and source of occupational and emotional difficulty, if any.
13. If the client does not present for three consecutive sessions and does not notify his/her counselor that he/she will not be able to attend, the counselor will assume the client has prematurely terminated, and will close his/her file. In addition, if the client agrees to receive written correspondence, his/her counselor will notify him/her of the file closure in writing.

14. If the client is not seen over a 30 day period of time the case will be closed. In addition, if the client agrees to receive written correspondence, his/her counselor will notify him/her of the file closure in writing.

Concerning written correspondence:

☐ I can be notified via email if my counselor needs to send me written correspondence concerning my case.

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☐ Please do not contact me via writing, I prefer you only contact me via telephone.

I have read this informed consent and understand that my participation in therapy does not constitute any promise or guarantee of results. I understand that I am financially responsible for all incurred costs of treatment. I agree that anytime I am unable to keep a scheduled appointment, I will notify my counselor 24 hours prior to my appointment. If I fail to do this, I will be charged for the missed appointment.

_____ _____

Client Signature and Date Counselor Signature and Date

_____

Parent/Guardian Signature and Date

Client Insurance Information and Release

I authorize the release of medical information necessary to process any of my insurance claims, and I authorize payment of medical benefits directly to **Empowering Healthcare Services, LLC** for services rendered. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that I will be charged the insurance allowable rate, or standard fee if private pay for any missed appointments that are not rescheduled or cancelled within 24 hours of the scheduled appointment time.

The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or client that in consideration of the services to be rendered to the client he/she hereby individual obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

Name _____ Signature_____

Date _____

Insurance Information

Company Name: _____ Telephone #_____

Policy Holder's Name _____

Policy #_____ Group # _____

Policy Holders Social Security Number _____-_____-____ Subscribers DOB: _____

Relationship to client: _____

Client's Name: _____ Client DOB:_____

To be completed by Billing Office

Date: _____ Spoke with: _____ In Network or Out of Network

Policy effective :_____ Copay per visit: $_____ Coinsurance per visit: $_____

Deductible amount: $_____ Deductible met: $_____

Max Visits/Max Payable per Year _____ Out of Pocket per Year_____

Exclusions to Policy: _____

Claims Address: _____

Authorization #_____Sessions Approved_____ Auth. Dates: _____ thru _____