Informed Consent for Outpatient Treatment

Your Rights: As a client of H.A.L.O. Educational Systems LLC, you have several rights. You have the right to:

- Decide not to participate in specific types of services, and to decide to terminate services.
- A safe environment, free from emotional, physical, and sexual abuse.
- Be treated with respect by self, staff, and other clients.
- Be free from discrimination from self, staff, and other clients, including but not limited to racial, sexual, religious, age, gender, or economic discrimination.
- Complete and accurate information about your treatment including goals, methods, potential risks and benefits, and progress.
- Information about the professional capabilities and limitations of any professional involved in your treatment.
- Receive treatment from trained and qualified professionals.
- Written information about fees, payment methods, and lengths and duration of sessions and treatment.
- Be informed about the limits of confidentiality, the situations in which your counselor and/or the agency is legally bound to disclose information to outside persons or agencies, and the types of information that will be disclosed.
- Know if your counselor will discuss your case with supervisors or peers.
- Request the release of your clinical information to any agency or person that you choose.
- Be referred to appropriate community services, based on individual needs, as we are able to identify them.
- If you are asked to leave the program, to know why you are being asked to leave and what conditions you must meet in order to return to H.A.L.O. Educational Systems, LLC.
- You have the right to cancel 24-48 hours prior to a scheduled appointment.

What to expect from the H.A.L.O. LLC, Program: Individual and group Counseling. It is a process in which you work with a counselor in order to resolve problems and meet agreed upon goals. Counseling is not like a visit to a medical doctor. Rather, it calls for a *very active effort on your part.* In order for counseling to be most successful, you will have to work on things that are discussed both during sessions and at home. Counseling can have risks and benefits. Counseling often involves discussing unpleasant aspects of your life and you may experience uncomfortable feelings as a result. However, counseling has also been shown to help individuals resolve specific problems and reduce feelings of distress.

Appointments: Our time will normally be 50 minutes and are scheduled based upon your needs. We ask that you be on time for appointments. If you need to cancel or reschedule an appointment, please contact your counselor as soon as possible. If you do not show up for two (2) sessions in a row, your counselor may terminate services. **We will bill you for missed appointments** that have not been canceled or rescheduled at least 24 hours in advance at your normal session rate. **All cancellations must be done by phone call ONLY, No e-mail or texting.**

Drug Screening: As part of your program clinicians have the option of performing oral fluid testing both in person and/or remotely during your routine telemedicine visits. In partnership with our lab Aegis, we mail the kit directly to you. You and a member of the HALO team will complete instructions on administration. Your package will include a return mailer pack you can drop in the mailbox for USPS pickup. HALO clinicians will be observing the oral fluid collection via the video platform.

Fees and Payment: Payment of fees for services is expected on the day that services are delivered. HALO participates in most insurance plans. We provide services based on a sliding fee scale. Depending on program service, standard pricing ranges from $65.01 fee to $159.87 per session. Although we will not refuse services to any eligible person because of an inability to pay in full, we ask that you make payment plan arrangements with a member of financial department and any balance must be paid in full prior to receiving additional services unless special arrangements are agreed upon with your counselor.

Dual Relationship Disclosure: HALO has various clinicians; however, it is our ethical responsibility to disclose in writing that the managing director's daughter is employed at HALO in the financial department.

H.A.L.O. accepts VISA, MASTERCARD, and DISCOVER.

Individuals referred to H.A.L.O. Educational Systems, LLC. for a DWI/DUI service plan must have a **ZERO** balance before completion paperwork will be sent to the State.

Confidentiality: The confidentiality of client records maintained by H.A.L.O. Educational Systems, LLC. is protected by federal law and regulations. Generally, we may not say to a person outside of this agency that a client receives services here, or disclose any information identifying a client as an alcohol or other drug abuser. The exceptions to this include (a) permission granted to_____ _____ _____ , _____*(relationship)* (b) if the disclosure is permitted by court order, (c) the disclosure is made to medical personnel in a medical emergency, or (d) to report suspected child abuse and neglect or suspected elder or incapacitated adult abuse, neglect, or exploitation.

Violation of the federal law and regulations by this agency is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines. Federal law and regulations do not protect any information about a crime committed by a client either on HALO property, against any person who works for H.A.L.O. LLC, or any threat to commit such a crime. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for federal laws and 42 CFR part 2 for federal regulations)

Consultation and Supervision: Each counselor at H.A.L.O. Educational Systems, LLC participates in regular clinical supervision and peer case consultation with clinicians who are bound by the same standards of confidentiality. The goal of this supervision and consultation is to provide the most effective and helpful services to our clients and to continually improve our skills as clinicians.

Treatment Records: The laws and standards of professional counseling mandate that we keep records of your treatment. You have the right to receive a copy of your record, or we can prepare a summary of your treatment for you instead. Due to the professional nature of these records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you arrange to do so in the presence of your primary counselor so that the contents can be discussed. *We reserve the right to withhold the release of your records to outside agencies if you have an outstanding balance*.

Emergency Services: Your counselor's regular office hours are_____. In the event of an emergency when your counselor is not available, you can call 603 359-3321 or These supports are available to you 24 hours a day, 7 days a week. **Hotline at 800-639-6095** or **Suicide Hotline 800-273-8255** WCBH **Emergency Services 1-800-564-2578**. DHMC **Emergency 1-800-556-6249.**

Consent to Contact: I grant permission to receive – (Please circle best means of communication)

Phone - Voicemail | Text | Email as separate consent is required for telehealth services.

We will NOT correspond via text other than appointment reminders.

Signed Consent for Treatment: By signing the agreement below, you are confirming services and responsibility to pay for all services rendered and additionally that you have read and agree to all conditions stated above.

"My counselor and I have agreed that I am responsible for all fees. I agree to pay $_____ per session. I am authorizing my _____ insurance/ CARD to be billed. If applicable, Insurance cards will be photocopied. I have read and/or had explained all of the preceding statements. I understand my rights and responsibilities for the services rendered by H.A.L.O. LLC. I agree to these conditions of my counseling as provided in this agreement."

_____ _____
Client Signature Date

_____ _____
Counselor Signature Date

CANCELLATION NOTICE

HALO Educational Systems has 24-hour cancellation/rescheduling policy.

If an appointment is missed, canceled or changed with less than 24 hours' notice, there will be a $75 charge. HALO Educational Systems realizes that there are many things that come up in people's day to day lives.

While truly sympathetic, HALO Educational Systems cannot absorb the financial responsibility of any last minute cancellations. HALO Educational Systems does not double book appointment times but rather reserves specific times for each patient affording individual care. In fairness to all clients, this policy is in effect regardless of the reason for the cancellation. By signing below, you acknowledge that you have read and understand the Cancellation Policy

(You should note that insurance companies do not typically reimburse for missed appointments.)

_____ _____

Signature of Client / Parent Date

_____ _____

Counselor Signature Date

H.A.L.O. Educational Systems, LLC.

Helping All Learn Options

www.HALOEducationalSystems.com

Canaan, New Hampshire 03741
Phone : (603) 523-8804

Lebanon, NH 03741
Fax: (603) 523-8804

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the *H.A.L.O. Educational Systems, LLC.* Notice of Privacy Practices. I understand that *H.A.L.O. educational Systems, LLC.* has the right to change its Notice of Privacy Practices from time to time and that I may contact *H.A.L.O. Educational Systems, LLC* at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Client Name (Print)

_____

Signature of Client/Legal Representative

_____

Relationship to Client

_____

Date

FOR OFFICE USE ONLY

PRINT PLEASE

I have attempted to obtain the patient's signature on this form, but was not able to for the following reason:

Date: Please document the reasons you were unable to obtain the signature.

Initials:

Health Questionnaire

Name: _____ Date: _____
Age: _____ Date of Birth: _____ Height: _____ Weight: _____
Primary Care Physician: _____
Dr. Address & Phone: _____

When was your last medical exam? _____
How would you rate your present health? ____ Good ____ Fair ____ Poor
List any medical conditions that you have: _____
_____
Name of the physician monitoring this condition(s): _____
List any medications that you are currently taking: _____
_____
Who prescribes these medications to you? _____

Have you seen a psychiatrist or counselor before? Yes ____ No ____ When? _____
Please explain: _____
_____
Have you ever had an accident? ___ Head Injury? _____

When do you go to bed? _____ What grade are you in/level of education?_____
do you like school?_____ Did you/do you have any significant relationships?__

Check any of the following problems that you experience:

____ Lack of appetite	____ Frequent Colds/flu	____ Bladder control
____ Appetite Change	____ Stomach problems	____ Bowel problems
____ Nervousness	____ Fatigue	____ Anxiety
____ Fears/phobias	____ Obsessive thoughts	____ Compulsive behaviors
____ Panic attacks	____ Confusion	____ Nightmares
____ Intrusive thoughts	____ Sleep disturbance	____ Difficulty concentrating
____ Flashbacks	____ Depression	____ Feelings of unreality
____ Headaches	____ Difficulty relaxing	____ Pain

____ Other health concerns: _____
Any Parent History of above: _____

Concussions_____ Loss of Consciousness _____

Clinician Use Only

Notes:

Referrals Made:

Follow-up needed:

H.A.L.O. Educational Systems, LLC.

Helping All Learn Options

Canaan, New Hampshire 03741
Phone : (603) 359-3321 Fax (603) 523-8804

CONSENT/AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I,_____(Client) DOB _____

authorize **H.A.L.O. Educational Systems, LLC**. to ☐ disclose to obtain from ☐

(Person)_____(Agency)_____

(Address)_____

PHONE ( ) _____ EMAIL: _____@_____

(Name or Title, Address and Phone Number of the Person or Organization to which the Disclosure is to be made or received

the following information: (Please Initial each Consent)

☐	Attendance in treatment	☐	Social/Family History
☐	Course and results of treatment	☐	History of Medical treatment
☐	Treatment plan	☐	History of Psychiatric treatment/ Counseling
☐	Treatment recommendations/Aftercare plan	☐	Medical history (including medication history)
☐	Discharge plans/Discharge summary	☐	Drug/Alcohol test results
☐	Substance use history	☐	Biopsychosocial Assessment
☐	Diagnostic summary and diagnoses	☐	Substance abuse Evaluations and recommendations
☐	Legal History	☐	Physical Exam/TB test
☐			
☐	Other (please specify) _____		

The purpose or need for the disclosure authorized herein is to: *(provide integrative treatment approach)*_____

(Purpose of disclosure, as specific as possible)

I understand that my alcohol/drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it. If not previously revoked, this consent expires automatically as follows: *(One Year from the date of signature)*_____

(Specifications of the date, event, or condition upon which this consent expires)

I understand that generally my treatment may not be conditioned on whether I sign a consent form. I have read this release and understand its contents.

_____ _____

Signature of Client *Date*

_____ _____

Signature of Witness / Counselor *Date*

HALO

Corporate: 44 Roberts Rd
Canaan, NH 03741
www.HALOEducationalSystems.com

Private Practice Policies Regarding Telehealth

TELEHEALTH / TELEMEDICINE

I understand that telehealth (or telemedicine) is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when they are located at a different site than the provider; and hereby consent to **Staff and affiliates at HALO Educational Systems, LLC** to provide psychotherapy services to me via telehealth.

I understand that:

(a) Services and procedures that are not covered in a face-to-face setting under my insurance are not covered under telehealth.
(b) Services delivered via audio-only telephone, facsimile, or electronic mail messages are not considered telehealth and are not covered.
(c) HALO will determine whether the conditions being diagnosed and/or treated are appropriate for a telemedicine encounter.
(d) The federal and state laws that protect privacy and the confidentiality of medical information also apply to telehealth psychotherapy.
(e) HALO will contact me through a video portal that is HIPAA-compliant for security, but that there are no absolute guarantees that such technological boundaries cannot be broached or that information will not be lost during technological failures.
(f) Costs for psychotherapy provided via telehealth may be covered by insurances when the client receiving those services is located in a state in which the therapist holds a current license to practice and that HALO is currently licensed in Vermont and New Hampshire only.
(g) I will be responsible for any copayments or coinsurances that apply to my telemedicine visit or will be paying HALO's fee in full if coverage is not available.
(h) I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
(i) I may revoke my consent orally or in writing at any time by contacting HALO. As long as this consent is in force (has not been revoked) HALO may provide health care services to me via telemedicine without the need for me to sign another consent form.

Client Signature_____Date_____

Please Print full name_____

HALO Therapist Signature_____Date_____