**Eric Dean Counseling & Consultation, LLC**
4242 Tuller Road, Suite B-2 Dublin OH 43017
eric@ericdeancounseling.com
(614) 654-7064 (p)

# PART 1 : CLIENT INFORMATION

Date: _____

Client's Name: _____

Date of Birth:_____ Relationship Status: _____

Gender: _____ Pronouns_____

Address: _____

City/State_____ ZIP: _____

Email Address: _____

Telephone Number(s)

Primary: _____ Cell Home Work OK to text/leave message? Y / N

Secondary: _____ Cell Home Work OK to text/leave message? Y / N

Parent/Guardian Name (for minor clients): _____

Referred By (if applicable): _____ May I thank them for the referral? Y / N

Emergency Contact**:** _____

Relationship: _____ Contact #: _____

**Reasons for Seeking Counseling**

_____

_____

_____

_____

**Medical History**

Your physical health (check one): Excellent ____ Good ____ Average ____ Declining ____

Are you under the care of a physician? Y / N

Physician: _____ Phone: _____

Address: _____

Date of last medical exam: _____

Do you authorize Eric Dean Counseling & Consultation LLC to contact the physician listed above in order to share clinical information regarding your treatment and to receive clinical information from the physician that may be helpful for treatment? **Please initial**: _____ Yes _____ No

Have you lost or gained a significant amount of weight recently? Y / N

Hours of sleep per night: _____ Sleep difficulties (if applicable): _____

Please list all significant present or past medical challenges (illnesses, injuries, disabilities):

_____

_____

_____

_____

Are you presently taking prescribed or OTC medication? Y / N

If yes, please list all medications:

Medication Purpose Dosage/day Date first prescribed

_____

_____

_____

_____

**Mental Health History**

Have you ever been diagnosed with a mental health disorder Y / N / Unsure

If yes, what was the diagnosis? _____

Please list any previous mental health services or counseling you received

_____ Time Period: _____

_____ Time Period: _____

_____ Time Period: _____

Was previous mental health treatment effective? Y / N

Please share any thoughts about experience: _____

_____

_____

_____

Are you feeling hopeless or that life is not worth living? Y / N

Are you having thoughts of harming yourself or others? Y / N

Have you ever attempted suicide? Y / N

Do you have access to weapons/firearms? Y / N

**Alcohol and Other Substances (Current Usage)**

Alcohol: Y / N If yes, how often? _____ Amount: _____

Other substance(s): Y / N, If yes, how often? ? _____ Amount: _____

Other substance(s) being used: _____

**Abuse History**

I have never been abused _____ I have witnessed abuse _____ I have experienced abuse _____

| Type of Abuse | Age(s) | Relationship to abuser | Witnessed or experienced? | Effects and Outcomes |
|---|---|---|---|---|
| Physical | | | | |
| Sexual | | | | |
| Emotional | | | | |
| Neglect | | | | |
| Other | | | | |

**Family History**

| Relationship | Name | Age | Major Mental and/or Physical Health Challenges | Living or Deceased? |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Brother / Sister | | | | |
| Brother / Sister | | | | |
| Brother / Sister | | | | |
| Brother / Sister | | | | |

Describe your parents' relationship: _____

_____

Describe your relationship with your parents/stepparents: _____

_____

_____

Your birth order(examples: “oldest”, “3rd out of 5”, etc.): _____

Describe your relationship with any siblings: _____

_____

_____

_____

Any other family background information that could be relevant: _____

_____

_____

_____

**Marital/Romantic Relationship History**

| **Name of Partner** | **Ages when Relationship Began** | **Length of Relationship** | **Still Together?** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Describe relationship with current partner or spouse (if applicable): _____

_____

_____

_____

**Children in Household/Family**

| **Name** | **Age** | **Sex / Gender** | **Relationship** (Biological parent, step-parent, adoptive parent, grandparent, etc.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please describe your relationship(s) with the child/children: _____

_____

_____

_____

**Spirituality, Community, Education, and Employment**

Religious affiliation (if applicable):_____

Do wish to incorporate your faith in the counseling process? Y / N / Unsure

What hobbies/free time activities do you enjoy? _____

_____

_____

Check last year of education completed:

Grade school ____ High School ____ College ____ Graduate/Professional School ____

Employment status? Employed ____ Unemployed ____ Disability ____ Other: _____

If employed, who is your employer: _____

Do you have military experience? Y / N

If yes, please describe: _____

_____

_____

_____

*The information given in these and the following forms are correct to the best of my knowledge. I understand that it is my responsibility to inform my therapist of any significant changes to this information.*

**Client's Printed Name**: _____

**Client Signature** (parent, if client is a minor): _____ Date: _____

# DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

**Name:** _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

*If this questionnaire is completed by an informant*, **what is your relationship with the individual?** _____
**In a typical week, approximately how much time do you spend with the individual?** _____ **hours/week**

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

| | During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems? | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
|---|---|---|---|---|---|---|---|
| I. | 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 | 4 | |
| | 2. Feeling down, depressed, or hopeless? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. Feeling more irritated, grouchy, or angry than usual? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. Sleeping less than usual, but still have a lot of energy? | 0 | 1 | 2 | 3 | 4 | |
| | 5. Starting lots more projects than usual or doing more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 6. Feeling nervous, anxious, frightened, worried, or on edge? | 0 | 1 | 2 | 3 | 4 | |
| | 7. Feeling panic or being frightened? | 0 | 1 | 2 | 3 | 4 | |
| | 8. Avoiding situations that make you anxious? | 0 | 1 | 2 | 3 | 4 | |
| V. | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)? | 0 | 1 | 2 | 3 | 4 | |
| | 10. Feeling that your illnesses are not being taken seriously enough? | 0 | 1 | 2 | 3 | 4 | |
| VI. | 11. Thoughts of actually hurting yourself? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 12. Hearing things other people couldn't hear, such as voices even when no one was around? | 0 | 1 | 2 | 3 | 4 | |
| | 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 14. Problems with sleep that affected your sleep quality over all? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind? | 0 | 1 | 2 | 3 | 4 | |
| | 17. Feeling driven to perform certain behaviors or mental acts over and over again? | 0 | 1 | 2 | 3 | 4 | |
| XI. | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? | 0 | 1 | 2 | 3 | 4 | |
| XII. | 19. Not knowing who you really are or what you want out of life? | 0 | 1 | 2 | 3 | 4 | |
| | 20. Not feeling close to other people or enjoying your relationships with them? | 0 | 1 | 2 | 3 | 4 | |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day? | 0 | 1 | 2 | 3 | 4 | |
| | 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco? | 0 | 1 | 2 | 3 | 4 | |
| | 23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0 | 1 | 2 | 3 | 4 | |

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# PART 2: CLINICIAN INFORMATION & CLIENT CONSENT

**Professional Disclosure**
I am a Licensed Independent Social Worker and hold a Master of Social Work degree from The Ohio State University. My license is issued by the State of Ohio Counselor, Social Worker & Marriage and Family Therapist Board. My license number is I.2103118.

**Areas of Competence**
- Diagnosis and Treatment of Mental and Emotional Disorders
- Counseling: Individual and Marital
- Populations: Adults and Adolescents

**Fee Schedule**
See Part 3 ("Financial Agreement")

**Limits of health**
Confidentiality is a hallmark of the counseling relationship and it is mandated by Ohio law and the NASW Code of Ethics. Some limits to confidentiality include:
- Any threat of harm to yourself or others
- Any actual or suspected child abuse, neglect, or endangerment
- Any actual or suspected abuse of the elderly, intellectually or developmentally disabled.
- I am court ordered to testify or release information
- The report of sexual exploitation by a therapist or counselor

Please understand that email, text, and voicemail messages can be vulnerable to interception and privacy violations. Please note that I limit texting largely to billing and scheduling related matters, and ask you to not communicate clinically sensitive information over electronic media. I attempt to respond to all communication within 24 hours.

**Payment Information:**
Full payment is due at time of service. You assume responsibility of full payment for services rendered. I accept Visa/MasterCard/Discover for payment.

**Business Associate Disclosure**
Eric Dean Counseling & Consultation LLC (EDCC) is part of an Organized Health Care Arrangement involving Seasons Counseling Services, LLC, (SCS) and Ohio Health Group. EDCC has a business associate agreement with SCS for the purpose of insurance reimbursement and associated billing. Some of your information may be shared with SCS for the sole purpose of insurance reimbursement and associated billing.

**Voluntary Nature of Counseling Relationship**
Counseling is voluntary (except where a client is ordered by a court to attend therapy), as are your choices about what to disclose. You and I are entering into a counseling relationship with no undue influence, and either of us is free to terminate counseling should we deem that action appropriate.

**Termination of Counseling Relationship**
Ideally, we will work together to decide when to terminate the counseling relationship. In the event that I determine that your needs are beyond the scope of my practice I will provide referrals to other counselors for you. You have the right to terminate the counseling relationship at any time. I will provide referrals at that time if you so desire. Files may be considered closed 2 months after our most recent session. Files are maintained for 7 years after termination and are then destroyed.

**Benefits & Risks of Counseling:**
There is great benefit to forging a therapeutic alliance with a professional therapist, although outcome cannot be guaranteed. Benefits include the development of a trusting and confidential professional relationship where the client and therapist work together towards specific and identified goals. It is the client's responsibility to be both open and honest in order to maximize the potential for positive benefit. The process of counseling can be an intense experience for some clients.

*Teletherapy* is any remote therapy that uses technology to help the therapist and client communicate. Risks include, but are not limited to, entering private information when using a public access computer or one that is on a shared network, violating employer policies related to use of work computers for personal communication, technology failure during a counseling session, and privacy violations. While I will do everything in my power to help you avoid these risks, signing this form indicates that you understand and accept these risks.

In an effort to maximize the benefits of counseling and to protect the professional relationship, communication outside of session should be limited to scheduling and billing matters, and clients should refrain from attempting to connect with their therapists on social media, offer them gifts, or invite them to events.

**Emergencies:**
I do not provide emergency mental health services. In the event of a mental health emergency please call 911 or go to the nearest emergency department. Net-Care Access provides emergency mental health services and can be reached at (614) 276-2273.

**Board Contact Information**
It is my aim to create a trusting and collaborative environment in which you would feel safe to raise any concerns you might have about the practice or your treatment. Concerns may also be addressed to the board which regulates the practices of professional counseling, social work, and marriage and family therapy in this state:

Ohio Counselor, Social Worker, and Marriage and Family Therapist Board,
77 South High Street, 24th Floor, Room 2468 Columbus, Ohio 43215-6171
(614) 466-0912

**I acknowledge that I understand and accept the contents of this form, and consent to treatment.**

_____ _____

**Client Signature** Date Parent/Legal Guardian of minor client Date

_____

Eric Lichtenfeld, LISW Date

**Eric Dean Counseling & Consultation, LLC**
4242 Tuller Road, Suite B-2 Dublin OH 43017
eric@ericdeancounseling.com
(614) 654-7064 (p)

## RELEASE OF INFORMATION AUTHORIZATION

I, _____authorize Eric Dean Counseling & Consultation, LLC to disclose to, obtain from, or exchange with the following persons and/or organizations information related to my care:

Name of Person or Organization: _____

Address: _____

Phone: _____

Email: _____

Information to be released, obtained, or exchanged includes (**please initial**):

_____ Assessment
_____ Diagnosis
_____ Treatment Plan or Summary
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Other Healthcare Information
_____ Medication Management Information
_____ Educational & Employment Information
_____ Presence/Participation in Treatment
_____ Progress Notes
_____ Treatment Status
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____Other_____

**Purpose**
This information may be used or disclosed in connection with mental health treatment, billing,
If the purpose is other than as specified above, please specify: :_____

**Revocation**
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Eric Lichtenfeld, LISW at eric@ericdeancounseling.com I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

**Expiration**
Unless sooner revoked, this authorization expires at termination, on the following date: _____, or as otherwise indicated:_____

**Conditions**
I understand that provision of services is not conditioned whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may result in my therapist having less information than needed to provide desired care, an inability to bill insurance, or other effects.

**Form of Disclosure**

I understand that, unless I make a written request that my therapist communicate with others in a certain format, information may be disclosed, obtained, or exchanged in any manner that my therapist deems appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

**Redisclosure**

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given and/or am retaining a copy of this authorization for my records.

_____ _____

**Client Signature** Date Parent/Legal Guardian of minor client Date

_____

Eric Lichtenfeld, LISW Date

If signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.):

_____*Please initial here if declining to sign authorization*

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# PART 3: FINANCIAL AGREEMENT

**Fee Structure**

Initial Diagnostic Interview: $165
Counseling Session (50 min): $145
Telephone calls over 5 minutes: $145/hour (pro-rated in 10-minute increments)
Services out of office: (e.g. court appearances): $150/hour (including roundtrip travel time)

**Health Insurance*:*** Sessions billed to health insurance are billed at a rate contracted with each specific insurance company. *That rate may be higher or lower than the rate listed above.* Client is responsible for their part of the fee associated with their insurance policy. That fee may include a deductible, a co-pay, or co-insurance depending on the individual insurance policy. Your credit card / HSA will be charged by Seasons Counseling once the Explanation of Benefits is processed.

**"Super Bills:"** Upon request, self-pay clients will be given a "super bill" to file with their insurance company. Self-pay clients are responsible for the entire fee. Clients are also responsible as for all interactions between the client and their insurance company.

**Cancellation/Rescheduling Policy:** Your clinician will make every effort to accommodate requests to reschedule appointments in keeping with the professional and personal values of Eric Dean Counseling. If you need to cancel or reschedule an appointment, please do so more than 24 hours before the scheduled time. Appointments cancelled or rescheduled within a 24-hour window are subject to a missed-session fee that is not billable to health insurance. The clinician, at their discretion, may waive the fee is the session is rescheduled for another time during the same business week. If the new appointment is cancelled, the late cancellation charge will be reinstated regardless of the amount of notice given. The fee structure is as follows:

24 hours to 1 hour prior to session: $75
Up to 60 minutes or not appearing for session: full session rate

This information is required by the counselor, social worker, and marriage and family therapist board, which regulates the practices of professional counseling, social work, and marriage and family therapy in this state.

**Ohio Counselor, Social Worker, and Marriage and Family Therapist Board,**
77 South High Street, 24th Floor, Room 2468 Columbus, Ohio 43215-6171
(614) 466-0912

I understand that I am required to remit payment to Eric Dean Counseling & Consultation LLC for services received on a self-pay basis and for charges associated with late cancellations, document preparation, and court appearances; and/or to Seasons Counseling Services for services billed to insurance. By completing the Credit Card Authorization Form, I give Eric Dean Counseling & Consultation LLC permission to store my credit card information as needed. I understand that I may be held responsible for the cost of missed sessions that are cancelled or rescheduled without 24 hours-notice.

I authorize the release of any information necessary to process insurance claims. All credit card payments are processed through Square. I understand that Eric Dean Counseling & Consultation LLC, will only release information necessary for the processing of payment.

_____ _____

**Client Signature** Date

I authorize Eric Dean Counseling & Consultation LLC and/or representatives of Seasons Counseling Services to communicate with me using email/text for the purpose sending credit card billing receipts and for communication about appointment times. I understand that Eric Lichtenfeld, LISW cannot ensure confidentiality of email communications, and acknowledge that I will govern communication outside of session accordingly.

_____ _____

**Client Signature** Date

**THIRD PARTY PAYER INFORMATION (party responsible for payment of services):**

**(*Complete only if the Responsible Party information is <u>different than</u> the Client Information)***

Organization/Business Name: _____

***OR***

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____

Fax: _____

**Eric Dean Counseling & Consultation LLC**
4242 Tuller Road, Suite B-2; Dublin, OH 43017
eric@ericdeancounseling.com
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## Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled. Credit card charges will be processed through Seasons and through Square.

| **Credit Card Information** |
|---|
| Card Type: ☐ MasterCard ☐ VISA ☐ Discover |
| Cardholder Name (as shown on card): |
| Card Number: |
| Expiration Date (mm/yyyy): CVV (back of card): |
| Cardholder ZIP Code (from credit card billing address): |

I,_____, authorize Eric Dean Counseling & Consultation LLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

**Client Signature** Date

**Eric Dean Counseling & Consultation LLC**
4242 Tuller Road, Suite B-2; Dublin, OH 43017
eric@ericdeancounseling.com
(614) 654-7064 (p)

## Insurance Information (if applicable)

Insurance Co. Name: _____ Phone: _____

Claims Mailing Address: _____

City: _____ State: ____ Zip:_____ Code:_____

Subscriber's Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Work: _____ Cell: _____

Client's Relationship to Responsible Party: _____

Subscriber's Employer: _____ Phone: _____

Subscriber's Soc. Sec: _____

Group No: _____

ID No: _____

I acknowledge that my insurance provider/plan may not cover the provided services, and that I am responsible for such costs.

_____ _____

**Client Signature** Date

**Eric Dean Counseling & Consultation LLC**
4242 Tuller Road, Suite B-2; Dublin, OH 43017
eric@ericdeancounseling.com
(614) 654-7064 (p)

## PART 4: ACKNOWLEDGMENTS

This is to acknowledge my receipt of following:

- *"NOTICE OF PRIVACY PRACTICES" (Appendix A)*
- *"SURPRISE BILLING PROTECTION" NOTICE (Appendix B)*
- *"RIGHT TO RECEIVE A GOOD FAITH ESTIMATE" (Appendix C)*

By signing below, I acknowledge that:

- I have received Eric Dean Counseling & Consultation LLC's *Notice of Privacy Practices*
- I have a right to receive a good faith estimate of services.
- I voluntarily consent to participate in telemental health services using videoconferencing equipment for the care, treatment, and services deemed necessary and advisable under the terms set forth herein.

Client Name (Please print): _____

**Client Signature**: _____ Date: _____

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# Appendix A: NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR CLINICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INFORMATION

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

Eric Dean Counseling & Consultation LLC is part of an Organized Health Care Arrangement involving Seasons Counseling Services, LLC, and Ohio Health Group programs which are designed to provide effective and clinically integrated care. In connection with those programs, we may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes in most instances without your consent under HIPAA, but we will obtain consent in another form for disclosing PHI for other reasons, including disclosing PHI outside of this practice or the Organized Health Care Arrangement, except as otherwise outlined in this Policy. In all instances we will only disclose the minimum necessary information in order to accomplish the intended purpose. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer, to Seasons Counseling Services, LLC or the Ohio Health Group to obtain reimbursement for your health care or to determine eligibility or coverage, which could include an audit.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice and participation in the Organized Health Group arrangement. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Disclosure*" applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization**

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information, including uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Examples of disclosures requiring an authorization include disclosures to your partner, your spouse, your children and your legal counsel. Any disclosure involving psychotherapy notes, if any are maintained , will require your signed authorization, unless we are otherwise allowed or required by law to release them. You may revoke an authorization for future disclosures, but this will not apply to disclosures already authorized.

**III. Uses and Disclosures Requiring Neither Consent nor Authorization**

We may use or disclose PHI without your consent or authorization as allowed by law, including under the following circumstances:

- **Serious Threat to Health or Safety:** If we believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s). We will inform you about these notices and obtain your written consent, if we deem it appropriate under the circumstances.
- **Worker's Compensation:** If you file a worker's compensation claim, we may be required to give your mental health information to relevant parties and officials.
- **Felony Reporting:** We may be required or allowed to report any felony that you report to us that has been or is being committed.
- **For Health Oversight Activities:** We may use and disclose PHI if a government agency is requesting the information for health oversight activities. Some examples could be audits, investigations, or licensure and disciplinary activities conducted by agencies required by law to take specified actions to monitor health care providers, or reporting information to control disease, injury or disability.
- **For Specific Governmental Functions:** We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, and for national security reasons, such as for protection of the President.
- **For Lawsuits and Other Legal Proceedings:** If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by law. We cannot provide any information without your (or your personal

or legal representative's) written authorization, or a court order and at times an administrative subpoena, unless the information was prepared for a third party. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information. If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.

- **Abuse, Neglect, and Domestic Violence:** If we know or have reason to suspect that a child under 18 years of age or a developmentally disabled or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child or developmentally disabled individual under 21, the law requires that we file a report with the appropriate government agency, usually the County Children Services Agency. Once such a report is filed, we may be required to provide additional information. If we have reasonable cause to believe that a developmentally disabled adult, or an elderly adult in an independent living setting or in a nursing home is being abused, neglected, or exploited, the law requires that we report such belief to the appropriate governmental agency. Once such a report is filed, we may be required to provide additional information. If we know or have reasonable cause to believe that a patient or client has been the victim of domestic violence, we must note that knowledge or belief and the basis for it in the patient's or client records.
- **To Coroners and Medical Examiners:** We may disclose PHI to coroners and medical examiners to assist in the identification of a deceased person and to determine a cause of death.
- **For Law Enforcement:** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Required by Law:** We will disclose health information about you when required to do so by federal, state or local law.
- **Public Health Risks:** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, non-accidental physical injuries, reactions to medications or problems with products.
- **Information Not Personally Identifiable:** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Other uses and disclosures will require your signed authorization.

**IV. Patient's Rights and Our Duties**

***Patient's Rights:***

- ***Right to Request Restrictions and Disclosures*** - You have the right to request restrictions on certain uses and disclosures of protected health information about you for treatment, payment or health care operations. However, we are not required to agree to a restriction you request, except under certain limited circumstances, and will notify you if that is the case. One right that we may not deny is your right to request that no information be sent to your health care plan if payment in full is made for the health care service. If you select this option then you must request it ahead of time and payment must be received in full each time a service is going to be provided. We will then not send any information to the health care plan for that session unless we are required by law to release this information.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. If your request is reasonable, then we will honor it.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record, except under some limited circumstances. If we maintain the information in an electronic format you may obtain it in that format. This does not apply to information created for use in a civil, criminal or administrative action or proceeding. We may charge you reasonable amounts for copies, mailing or associated supplies under most circumstances. We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to your PHI, you may ask that our denial be reviewed.
- ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request, but will note that you made the request. Upon your request, we will discuss with you the details of the amendment process.
- ***Right to an Accounting*** – With certain exceptions, you generally have the right to receive an accounting of disclosures of PHI, not including disclosures for treatment, payment or health care operations, for paper records on file for the past six years and for an accounting of disclosures made involving electronic records, including disclosures for treatment, payment or health care operations, for a period of three years. On your request we will discuss with you the details of the accounting process.
- ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

***Our Duties:***

- **Complaints and Effective Date** - If you are concerned that we have violated your privacy rights, or you disagree with a decision we make about access to your records, you may file a complaint with us and we'll consider how best to resolve your complaint. Contact our Privacy Officer, listed below, if you wish to file a complaint with us. In the event that you aren't satisfied with our response to your complaint, or don't want to first file a complaint with us, then you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., 200 Independence Avenue S.W., Washington, D.C. 20201, Ph: 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/compliants/. **There will be no retaliation against you for filing a complaint**. This notice is effective 2/01/22.
- **Privacy and Security Officer** - The Privacy and Security Officer for the practice is Eric Lichtenfeld, LISW. You may contact him if you have any questions about any Privacy or Security Policies, or if you wish to file a complaint with the practice.

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## Appendix B: SURPRISE BILLING PROTECTION

(Self-pay clients only)

This document describes your protections against unexpected medical bills.

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On January 1, 2022, the federal government began requiring all healthcare providers to offer a "good faith estimate" of services. While this broad mandate is intended to keep patients from being surprised by high charges for hospital stays and medical procedures, it also includes outpatient mental health services. I charge for services following each visit. This means that, unless there is a problem with credit card processing, you will rarely carry a balance of more than one session and thus never experience an unexpectedly large bill. That being said, I am providing this information in compliance with the government regulation.

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I am "in-network" with the following insurance companies: Cigna, Medical Mutual, Aetna, and Ohio Healthy through an Organized Health Care Arrangement involving Seasons Counseling Services, LLC and Ohio Health Group. If you do not have coverage with one of these four companies or, if you choose not to bill your health insurance company, you are considered "self-pay".

It is important that you understand that you can choose to get care from a provider in your health plan's network, which may cost you less than my out-of-pocket (self-pay) fee. If you would like to work with an "in-network" provider, contact your health insurance company for a list of in-network mental healthcare providers.

My "self-pay" fee for the first (diagnostic) session is billed at $165. Subsequent sessions (50min) are billed at $145 per session.

Upon request, self-pay clients will be given a "super bill" to file with their insurance company. Self-pay clients are responsible for the entire fee. Clients are also responsible as for all interactions between the client and their insurance company. Keep in mind, your reimbursement from your insurance company may not cover my entire fee. Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

**With my signature, I am consenting and acknowledging that:**

- I am giving up some consumer billing protections under federal law.
- I will have to pay the full charges for these services.
- I was given this written notice that explained my provider is not in my health plan's network (or that I am not using my health plan for these services), described the estimated cost of each service (see above), and disclosed what I may owe if I agree to be treated by this provider.
- I fully and completely understand that some or all of the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider before receiving services.

**Client Signature:** _____ Date: _____

*Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.*

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## Appendix C: YOUR RIGHT TO RECEIVE A GOOD FAITH ESTIMATE

On January 1, 2022, the federal government began requiring all healthcare providers to offer a good faith estimate of services. Although you will rarely carry a balance of more than one session and thus never experience an unexpectedly large bill (as I charge for services following each visit), I am providing this information in compliance with the regulation and in the spirit of transparency.

*You have the right to receive a "Good Faith Estimate"*
*explaining how much your care will cost.*

- Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.
- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.