Oak Hill Counseling and Wellness
3 Exchange Street, Suite 2A, Pawtucket, Rhode Island 02860
OakHillCounseling@gmail.com
www.OakHillCounseling.com

Pages 1 - 3 are for you to keep. You do not need to bring them to your appointment

CLIENT SERVICES AGREEMENT

Welcome to Oak Hill Counseling and Wellness, LLC (OHCW). This document contains important information about business policies, our professional services and legal obligations. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that OHCW provides you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached separately from this Agreement, explains HIPAA and its application to your personal health information in greater detail, and our practice is in general accordance with HIPAA policies. The law requires that OHCW obtains your signature acknowledging that we have provided you with this information prior to commencement of treatment.

It is important that you read these documents carefully before your initial session. If you have any questions about the paperwork, we can discuss them at the initial appointment. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless OHCW has taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

CLINICAL SERVICES

This document serves to reflect as your consent to therapeutic services at OHCW. Both the client and therapist have rights and responsibilities in the therapeutic relationship. Engaging in therapy requires a very active effort on the client's part in order to be most successful. You will have to work on the things we discuss during session outside of treatment as well.

The first few sessions will be focused on information gathering, culminating with identifying what your goals for treatment include and an individualized treatment plan. If you have any questions about this process, at any point in time, ask your therapist for further information.

Sessions are 45-55 minutes in duration and are scheduled ahead of time. You will be expected to pay for each session at the time it is held. Therapy sessions begin at the arranged appointment time and will end on time. If you are unable to attend an already scheduled session, please contact your therapist at least 24 hours in advance or you will be subject to the full session fee of $125.00.

If at any point you have questions or are unhappy with your treatment, please let us know so we may work to rectify your concerns. You will be taken seriously and treated with respect for any concerns that may arise. You may also request that we refer you to another practice at any time and we will be happy to accommodate your request.

OHCW is a safe space regardless of race, ethnicity, color, gender, gender identity, sexual orientation, age, religion, disability, national origin or source of payment. You have the right to ask questions about any aspect of therapy and about your therapist's specific training and experience.

INSURANCE

It is your responsibility to verify that you have the appropriate insurance coverage to be seen at OHCW. Any time beyond the 45-55 minute contracted session will be charged to the client. If your insurance coverage changes at any time, please notify OHCW immediately to ensure that your sessions are billed to the appropriate insurance company. Any costs that your insurance does not reimburse, you will be billed for. If there are other services you should require beyond what is contracted by insurance, including but not limited to: report writing, telephone conversations with other professionals with your permission, preparation of records or treatment summaries, you will be responsible for paying an appropriate fee for the professional time. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time. Please ask us for a fee schedule if any of this applies to your situation.

CONFIDENTIALITY

Conversations between you and your therapist will almost always remain confidential. Here are the exceptions to that rule:

- Personal safety – if you are expressing thoughts to harm yourself.
- Others' safety – if you are expressing thoughts to harm someone else.
- Abuse/neglect – if you disclose any actual or suspected child/elder abuse or neglect. All therapists at OHCW are mandated reporters and must report any actual or suspected child/elder abuse or neglect to the proper authorities.
- Signed consent – if you sign a consent form giving us permission to disclose your confidential information.

In regard to people under 18 years of age, specific content will remain confidential though parents/guardians do have the right to general information, themes of treatment, diagnosis and the therapeutic relationship in order to make informed decisions about treatment.

If a child's parents have joint custody, both parents must consent to treatment in order for this patient to be seen at OHCW.

PROFESSIONAL RECORDS

OHCW is required to keep appropriate records of the therapeutic services provided to you. Although therapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and a mention of the topics discussed. You have the right to a copy of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request. Your records are maintained in a secure location in the office.

CONTACTING OHCW

Therapists are not always immediately available by telephone as they do not answer the telephone while meeting with a client. If you are in an emergency situation, please dial 911 or go to your nearest emergency room. If you have a question or a concern that is not urgent, please leave us a message on the voicemail and your call will be returned within 24 business hours.

NOTICE OF PRIVACY PRACTICES

Our privacy practices are attached in an additional document. Please review it carefully. If you do not sign this form agreeing to what is in our privacy practices, we cannot treat you. If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

You do not need to bring the above pages to your appointment as they are for your record only. Please bring the completed pages below to your initial appointment with your clinician.

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Acknowledgement of Receipt of Privacy Notice and Oak Hill Counseling and Wellness, LLC Policies & Procedures Federal law requires that all patients be given a copy of the privacy notice. The Privacy Notice describes in detail how patient health information is used and shared with others. All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example by e-mail or facsimile mail.

I HAVE BEEN GIVEN A COPY OF THE PRIVACY NOTICE.
Name (print)____________________________________ Date___________________
Signature_______________________________________ Date of Birth____________

When patient is a minor, or is unable to give consent, the signature of a parent, guardian, or personal representative is required.
Signature of Representative________________________ Date___________________
Name (print) ____
Relationship to Patient____

CONSENT TO TREATMENT
Your signature below indicates that you have read the Clinical Services Agreement and agree to its terms.
Name (print)____________________________________ Date__________________
Signature_______________________________________ Date of Birth___________

When patient is a minor, or is unable to give consent, the signature of a parent, guardian, or personal representative is required.
Signature of Representative________________________ Date___________________

CONSENT TO BILL INSURANCE
Your signature below indicates that you authorize OHCW to provide information to your insurance carrier concerning your treatment. I assign Oak Hill Counseling and Wellness, LLC all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by my insurance.
Name (print)____________________________________ Date__________________
Signature_______________________________________ Date of Birth___________

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Request/authorization to release Confidential Records and/or Information

This form allows your clinician to communicate with other key professionals. I hereby authorize:

Name/Facility: ____
Address: ____
Phone number: ____
Email Address: ____

To **obtain/release** (circle one or both) the records/information about:

If you circle obtain, OHCW can receive information about the patient named below. If you circle release, then OHCW can release information to the person named above. If you circle both, then both parties can release and discuss information about the patient named below.

Patient Name: _________________________________ Date of Birth: ________________
To the provider, ___________________________________, at Oak Hill Counseling and Wellness, LLC, for the purpose(s) of:

- ☐ Further mental health evaluation, treatment, or care
- ☐ Treatment Planning and coordination of care
- ☐ Substance use information
- ☐ Other: ____

Information should be sent to the postal address/fax/email/phone number in the letterhead at the top of this form. I have had it explained to me and fully understand that this request/ authorization to release records and information, including the entire nature of the records, their content, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may rescind this consent at any time within 90 days, except to the extent that action based on this consent has already been taken.

____ _________________
Signature of patient/parent/guardian/representative Date

____
Printed name of signatory above/Relationship to patient

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Insurance/Payment Information

Patient Name: ____________________________________ SSN: _________________________
Address: ____
DOB: ________________________ Gender: ________________ Marital Status: ____________

Responsible Party:

- ☐ Same as patient
- ☐ Other Party

Name: ____
Phone number: ____
Address: ____

Payment Type:

- ☐ Insurance
- ☐ Private Pay

Insurance Company: ____
Address: ____
Phone number: ____
Subscriber number: _______________________ Group number: ___________________________
Copayment: _________________

Subscriber:

- ☐ Patient
- ☐ Other party

Subscriber Name: ___________________________________ DOB: _______________________
Address: ____
Phone number: ____
Employer: ____

Relationship to patient:

- ☐ Self
- ☐ Spouse
- ☐ Parent/Guardian

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Intake Packet

Name: ____ DOB: _________________

Address: _________________________________ Phone: ___________________________

Email address: ____

Emergency contact name: ____

Phone number: ______________________________ Relationship to self: _____________

Referral source: ____

If the patient is a minor, please fill out the following:

Parent/Guardian 1

Name: __________________________________ *Phone:* __________________________

Address: ________________________________ *Employer:* ________________________

Parent/Guardian 2

Name: __________________________________ *Phone:* __________________________

Address: ________________________________ *Employer:* ________________________

Primary Care Physician (PCP): ____

Address: __________________________________ *Phone:* _________________________

Do you wish to notify your PCP that you are in treatment?

- Yes (If yes, please complete a release listed above for this provider.)
- No

Current medications (medical and psychiatric) and dosages: __________________________

____

____

____

____

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Please indicate why you are seeking treatment at this time (low mood, poor sleep, changes in appetite, thoughts of self-harm, etc.), when your symptoms began and the frequency of your symptoms: ____
____
____
____
____

History of treatment: ____
____

External Stressors: ____
____

Primary Supports: ____
____

Whom do you live with? ____
____

Do you work? What do you do? ____
____

Are you in school? What are you studying ____
____

Family history of mental health or substance use: ____
____

Do you use substances? If so, what ones and how often? ___________________________________
____

Current/past medical issues: ____
____

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Significant life events: ____
____
____
____

Hobbies/interests: ____
____

Current/past legal involvement: ____
____

In looking at the information you've completed above, what are the three things that you would like to focus on most in treatment?

1. ____

2. ____

3. ____

Is there anything else we need to know?

____
____
____
____
____
____
____
____
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