Amy L. Luzar, LISW-S
19910 Malvern Rd.
Shaker Hts., OH 44122 Rm. 221
amy@amyluzar.com
(216) 973-9976

CLIENT INFORMATION:

Name of Client:

Age: Date of Birth:

Responsible Party Name:

Responsible Party Full Address (please include zip code):

Client Full Address (if different from responsible party):

Responsible Party (best way to reach you) phone number:

Responsible party email address:

Teen Cell: Teen Email:

Client School and Current Grade:

Emergency Contact for Client:

Emergency Contact Phone Number:

How did you hear about my practice?

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FEES AND BILLING INFORMATION - Please read carefully

Payment is accepted at the time of each appointment and can be made by Zelle, Cash, Check, or Credit Card, including HSA or FSA cards (credit cards will include a 3% processing fee). Please let me know your preferred payment method. *Please note that missed appointments and appointments cancelled without 48-hour notice are charged full fee.*

Therapy is provided on a private-pay basis, which means I require payment in full at the time of service and do not accept reimbursement from insurance companies. I know how important finances are in making the decision to seek my services. To assist you, I offer receipts to clients seeking potential out-of-network reimbursement for the cost of therapy.

It will be your responsibility to manage the mechanics of your insurance claim. I do not accept direct assignment of payment from insurance carriers. Any reimbursement will go directly to you.

Since I do not have access to anyone's insurance policy benefits, the best way to find out information about out-of-network benefits is to call your insurance company and ask the following questions:

1. Does my policy include reimbursement for out of network mental health treatment?
2. Is there a separate deductible for services that are out of network?
3. Once a deductible is met, how much of the session fee is covered?

If another party is responsible for paying all or part of your charges, it is necessary for that individual to also complete the Professional Services Agreement (proceed to the next page).

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PROFESSIONAL SERVICES AGREEMENT

The Ohio Counselor and Social Work Board regulations require that all clients are fully informed regarding the costs for professional services. I ask that you read this material carefully, and sign below to signify your acceptance of these terms. Payment is expected in full at the time of the office visit.
Please note that my rate is subject to change, and I will provide notice of any changes.
An initial phone consultation is offered at no charge.

SERVICE	FEE
Office visit 45-50 min	190.00
Office visit 55-60 min	225.00
Family and Couples Therapy 55-60 min	225.00
Group Therapy 60 minute	135.00
Extended Office Visit	Office visit rate pro rata
Other professional time (see below)	Office visit rate pro rata

Credit card payments a 3% processing fee will be applied.

Other professional services include report writing, telephone conversations totaling more than 15 minutes in a week, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $400 per hour for preparation and attendance at any legal proceeding. To maintain neutrality, I will not testify for either party who are in couples therapy.

CANCELLATION AND LATE POLICIES – Forty-eight hours (two full business day) cancellation notice is required for appointment times reserved. Should you cancel with less than 48-hour notice, I will do my best to fill the appointment hour. If I am unable to, you will be billed the fee for the time reserved. If you will be arriving late for your appointment, please contact me to let me know and note that the session will still end at the regularly scheduled time.

PRIVACY RIGHTS
It is important to know that you have rights and responsibilities regarding disclosure of your Personal Health Information (PHI) by any healthcare provider or agency. Carefully read the Notice of Privacy Practices (NPP) that can be downloaded from the forms page: https://amyluzar.com/office-forms. At our first meeting, I will review the NPP with you and answer your questions.

TELE-MENTALHEALTH INFORMED CONSENT

I hereby consent to participate or for the minor client to participate in tele-mental health with Amy Luzar, LISW-S as part of my psychotherapy or that of my minor child. I understand that tele-mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to tele-mental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with tele-mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-mental health services are not appropriate, and a higher level of care is required.

6) I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at the preferred phone number I have provided on the client information form to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols I need to know your location in case of an emergency. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

As a convenience to me, I hereby request that Amy Luzar, LISW-S communicate with me regarding my treatment via electronic communications (e-mail or text message). I understand that this means Amy Luzar, LISW-S will transmit via electronic communication my protected health information (PHI) which will include information about my appointments, diagnosis codes and CPT (type of service) codes that are necessary for the purpose of creating invoices and receipts.

Amy Luzar, LISW-S uses the email address amy@amyluzar.com which is HIPAA compliant; however, for scheduling and general emails, it is not encrypted. Invoices and receipts will only be sent via email. Text messaging is neither HIPAA compliant nor encrypted. I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Amy Luzar, LISW-S shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Amy Luzar, LISW-S to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Amy Luzar, LISW-S to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Amy Luzar, LISW-S, I may revoke this authorization by providing written notice to Amy Luzar, LISW-S 19910 Malvern Rd. Shaker Hts., OH 44122 or fax at (216) 991-5472.

I agree that Amy Luzar, LISW-S may communicate with me electronically unless and until I revoke this authorization by submitting notice to Amy Luzar, LISW-S in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically and give consent to participate or for the minor client to participate in tele-mental health with Amy Luzar, LISW-S as described above.

ACCESS TO RECORDS

As outlined in the HIPAA Notice of Privacy Practices available on my website, you have certain rights to your Health Insurance Portability and Accountability Act (HIPAA) – defined Protected Health Information. In addition, you are entitled to review or receive any other of your records that I keep, unless I believe that seeing them would be emotionally damaging.

I generally recommend that records are reviewed together so that any questions about them can be answered. Alternately, I may be able to prepare a summary for you or to send them to a mental health professional of your choice who can review them with you.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during your professional relationship with Amy Luzar, LISW-S.

CONSENT TO TREAT

Signature is required for clients 18 and over

I have read and understand the information provided and accept full financial responsibility for fees incurred within the framework of this agreement. I understand the information contained in this form and all my questions have been answered to my satisfaction.

I authorize Amy Luzar, LISW-S to provide me treatment and psychotherapy services and will be financially responsible for payment of services at the time service is rendered.

Your name (Please print):

Your Signature Today's date:

PERMISSION TO TREAT MINOR

Parent/Guardian signature is required for client under 18

I have read and understand the information provided and accept full financial responsibility for fees incurred within the framework of this agreement. I have received and read the Notice of Privacy Practices, I understand the information contained in this form and all my questions have been answered to my satisfaction.

I authorize Amy Luzar, LISW-S to treat my dependent child. I attest that I do have legal custody of this minor. This authorization for treatment is effective for a period of 12 months from today or until terminated.

Parent/ Guardian name (Please Print):

Parent/Guardian Signature: Today's date: