Amy L. Luzar, LISW, LLC
19910 Malvern Road
Shaker Heights, OH 44122
(216) 973-9976
amy@amyluzar.com

CLIENT INFORMATION:

Name of Client:

Age: Date of Birth:

Responsible Party Name:

Responsible Party's Full Address (please include zip code):

Client's Full Address (if different from responsible party):

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

Responsible party's email address:

May I use this email address to communicate re practical/business matters?

Occupation/Place of Employment:

Teen Cell:

Teen Email:

Client School:

Who referred you to my practice?

Please continue to next page.

Amy L. Luzar, LLC
Payment and Health Insurance - Please Read Carefully

As a Fee for Service practice, payment is expected for each session at the time it is held, unless we agree otherwise. I accept checks, cash, credit cards, and HSA cards.

The easiest electronic payment method I've found is Zelle. It is direct bank to bank and there are no-fees. You simply sign up via your bank website - look for a link that says “send money” and select "Zelle." If you are using your bank’s app, go to “payments” and if Zelle is an option, it will say “pay using Zelle.” Go through the agreement checklist the first time. It’s all set up for you moving forward. **Use the email** amy@amyluzar.com **to send**.

I also use Ivy Pay to accept payment; it works with credit, debit, HSA and FSA cards. It is HIPAA-secure, keeps therapy information confidential, and facilitates the payment process. Your mobile number is entered, after which you will receive a text message with a prompt to enter your payment information.

Out of Network Provider and Health Insurance

Please Read Carefully. My office handles health insurance differently than many healthcare providers. By choice, **I have not contracted with any insurance companies, and consequently am an “out of network” provider.** If you are relying upon your health insurance to cover or defray the cost of my services, please check your policy provision for out of network providers.

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.

Though I am not affiliated with insurance companies, I can provide you with periodic billing summaries if you need them for insurance or health care spending accounts.

If another party is responsible for paying all or part of your charges, it is necessary for that individual to also complete a copy of my Office Billing forms. Please have that individual complete the New Client Form and Professional Services Agreement.

Please continue to next page.

Amy L. Luzar, LLC
PROFESSIONAL SERVICES AGREEMENT

The Ohio Counselor and Social Work Board regulations require that all clients are fully informed regarding the costs of 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 and can be made with check, cash and credit card.**

Office visits are 50 minutes. Extended time office visits are billed pro rata. Please note that my rate is subject to change and I will provide notice of any changes.

SERVICE	FEE
Office visit 50 min	150.00
Office visit 60 min	175.00
Initial Consultation Session is typically 60 minutes	
Extended Office Visit	Office visit rate pro rata
Other professional time (see below)	Office visit rate pro rata

Other professional time: Telephone consultation (over 10 minutes) and other services you request of me including participation in meetings or phone conferences with your permission, report or letter writing.

Court-related professional services (Including travel time)	200.00 per hour billed pro-rata

Twenty four (24) hour notification is requested for all cancellations of appointment time reserved. Please note missed appointments and appointments cancelled within 24-hour notice are charged full fee.

I have read and understand the above, and accept full financial responsibility for fees incurred within the framework of this agreement. I have received and read the Privacy and Confidentiality Notice Form.

Consent to Treat - Signature is required for clients 18 and over

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 A Minor - Parent/Guardian signature is required for client under 18

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 Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

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 minimally 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. 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 as described above.

Patient Name: _____ Date _____

Signature of Patient (if patient is 18 over) or Parent/Guardian:

_____ Date _____

Tele-mental Health Informed Consent

I, _____, hereby consent to participate in tele-mental health with, _____ , as part of my psychotherapy. 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 located 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 telemental 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 _____ 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.

Tele-mental Health Informed Consent cont.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. 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.

In case of an emergency, my location is: _____
and my emergency contact person's name, address, phone: _____
_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian _____Date _____

Signature of therapist _____ Date _____