Client information and Love Counseling & Consulting Policies

Please read this form carefully so that you understand these policies and your responsibilities as well as options. Once you have read this, please ask any questions you may still have and then sign agreeing that you understand and will abide by these policies.

Informed Consent

What you share with me during your treatment is confidential, meaning that without your written permission, I cannot share your information with others. However, there are limits to confidentiality and occasions when I am legally or ethically required to make a report:

1. Reasonable suspicion of physical or sexual abuse, or neglect to a child, elderly person, or dependent adult.
2. Serious threats to harm oneself.
3. Serious threats to harm others.

Risks and Benefits of Treatment

There are risks and benefits associated with mental health treatment. Risks of receiving treatment may include being asked to recall or talk about material that is painful or upsetting. Sometimes, problems or symptoms may seem worse, but with continued engagement in the therapeutic process, benefits may include improvement of symptoms, relationships, and life experiences. There are no guarantees that treatment will work, and as with most things, what you put into treatment, you'll get out of it.

Financial Policies

Fees for the session are due at the beginning of the session. If you are using your insurance to pay for your session, know that you will be responsible for any copay or portion that your insurance does not cover. Your insurance may not cover all services, and in the case that a claim is denied, you understand that you will be responsible for the fee. If you choose not to use insurance, you will be solely responsible for the session fee.

Session fees may be paid in cash, VISA or MasterCard, or checks made payable to Love Counseling & Consulting. Please be aware that there will be a $20 fee for returned or bounced checks.

If you are not able to pay for your portion of the session fee at the time of the session, please notify me so that we can make arrangements for repayment. I reserve the right to refuse service for clients who accumulate bills over $50. Once the bill is paid, sessions may resume. If you are not working on repaying your bill, it may be sent to a collection agency and you will be charged extra for their service. I will not regularly send you bills or reminders of moneys owed. You will be responsible for ensuring your fees are paid.

Cancelation Policy: I prefer that you give 72 hours notice if you need to cancel your session. If you miss a session or cancel with less than 24 hours notice, you will be responsible for half of your session fee. Please be advised that your insurance will not pay this fee. It will be your responsibility to pay in full.

If you request or require written reports from me, you will be charged the regularly hourly fee for the service. Your insurance will not pay for written reports. Phone calls between you and me lasting less than 5 minutes will not be billed, however, calls lasting more than 5 minutes will be billed per minute according to the hourly rate. Again, that fee will likely be your responsibility to pay as your insurance will typically not cover it.

Appointments

Sessions will generally start on the hour and will last approximately 50-55 minutes unless otherwise stated. Group, family, and couples sessions may last longer and be billed at a different rate than individual therapy. You will be notified of any changes ahead of time.

If you are late to your appointment, your session will still end 50-55 minutes after the original start time. In order to respect other clients who may be scheduled after you, I will not push back your end-time if you are late.

If you are going to be late, please call to notify me. If you are more than 15 minutes late and do not call to notify me, I am not obligated to keep your appointment.

If you have a regular time slot, but miss two sessions in a row or repeatedly miss sessions, I am not obligated to hold that time slot for you for future sessions. You will still be able to make an appointment, but it may not be during your desired time slot. Please be advised that if you continually skip or cancel your sessions, I reserve the right to terminate treatment services. In that event, I will gladly furnish you with referrals to other mental health resources.

Emergencies

Emergencies require immediate attention or care and cannot wait until your scheduled session or regular business hours. **I am not available for emergencies. If you find that you are experiencing an emergency, please call 911 or go to your nearest emergency room.** Once you leave my office, I am not responsible for your safety or welfare and I am not required to check in with you between scheduled sessions. If you are a danger to yourself or others, please call the National Suicide Prevention Lifeline at 1-800-273-8255 or 911 or go to your nearest hospital or emergency room.
Whether I am contacted for emergent or non-emergent matters, I will typically try to respond by the next business day.

Managed Care and Treatment Planning

Whether you are using your insurance benefits to pay for your sessions or not, we will follow a treatment plan and regularly take time out of our sessions to review and update it to ensure that we are working toward the goals you identified at the outset of treatment. If you are using your insurance to pay for sessions, we may need to check your status to ensure that the service will be covered to prevent any additional charges to you, personally. Sessions may occasionally need to be canceled or rescheduled if authorization from your insurance has not yet been given for services. This is to minimize out-of-pocket expenses for you.

Record-Keeping

In accordance with standard guidelines, Love Counseling & Consulting will maintain your treatment records in a private, secure format and location for 7 years after the date you are last seen. Records for minors must be held for 7 years past their 18th birthday (until age 25). If you would like your records to be transferred to another provider, please contact me to make those arrangements. If you would like your records to be held for longer than the standard, please arrange for another provider or service to hold them. You have the right to access your records, with the exception of process notes (the notes made by the psychotherapist), but there may be a fee for copies of records requested.

Other Policies

Please respect others who use this office by not eating during sessions and by arriving clean and without odor. If you smoke, please do not smoke for at least 30 minutes prior to the session. Please ensure that when you come to sessions, you wear clothing that is laundered and appropriate.
Love Counseling & Consulting shares this office with other organizations/professionals, but their practices are independent. Love Counseling & Consulting is not a partner with, and does not have any legal association with any other organization or mental health professional.
Cell phones can be distracting and can interfere with the therapeutic process. Please do not take calls or respond to emails or texts during the session unless there is an emergency.
If you have children who will not be a focus of the treatment session, please arrange for childcare. They may not be left unattended on or around the premises and are not permitted in the office unless the therapist has requested they attend, or if they are the focus of therapy.

_____	_____	____/_____/____
Print Name	Signature	Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Privacy is a very important concern for all those who come to this office and who work here. It is also complicated, because of the many federal and state laws and our professional ethics. Because the rules are so complicated, some parts of this notice are very detailed, and you may need to re-read them or ask questions to understand them. If you have any questions, I be happy to help you understand our procedures and your rights.

Contents of this notice of privacy practices

A. Introduction: To our clients

This notice will tell you how we handle your medical information. It tells how we *use* this information here in this office, how we *disclose* (share) it with other health care professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family. If you have any questions or want to know more about anything in this notice, please ask our compliance officer for answers or explanations.

B. What we mean by your medical information

Each time you visit us or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the tests or treatment you got from us or from others, or about payment for health care. All this information is called "PHI," which stands for "protected health information" which means its privacy must be protected. This information goes into your medical or health care records in our office.

In this office, your PHI is likely to include these kinds of information:

- Your history: Things that happened to you as a child; your school and work experiences; your marriage, relationships, and other personal history.
- Your medical history of problems and treatments.
- Reasons you came for treatment: Your problems, complaints, symptoms, or needs.
- Diagnoses: These are the medical terms for your problems or symptoms.
- A treatment plan: This is a list of the treatments and other services that we think will best help you.

- Progress notes: Each time you come in, we write down some things about how you are doing, what we notice about you, and what you tell us.
- Records we get from others who treated you or evaluated you.
- Psychological test scores, school records, and other evaluations and reports.
- Information about medications you took or are taking.
- Legal matters.
- Billing and insurance information

There may also be other kinds of information that go into your health care records here.

We use PHI for many purposes. For example, we may use it here:

- To plan your care and treatment.
- To decide how well our treatments are working for you.
- When we talk with other health care professionals who are also treating you, such as your family doctor or the professional who referred you to us. When we do this, we will ask for your consent. Almost always, we will also ask you to sign a release-of-information form, which will explain what information is to be shared and why.
- For teaching and training other health care professionals or for medical or psychological research. If we do this, your name will never be shown, and there will be no way they can find out who you are. Before we do this we will ask for your consent and ask you to sign an authorization, so that you will know what information will be shared and why.
- To show that you actually received services from us, which we billed to you or to your health insurance company.
- For public health officials trying to improve health care in this area of the country.
- To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is used for, you can make better decisions about what other persons or agencies should have this information, when, and why.

C. Privacy and the laws about privacy

We are required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Omnibus Final Rule of 2013, as well as applicable Hawaii State laws. HIPAA requires us to keep your PHI private and to give you this notice about our legal duties and our privacy practices.

This form is not legal advice. It is just to educate your about your rights and our procedures. It is based on current federal and state laws and might change if those laws or court decisions change. If we change our privacy practices, they will apply to all the PHI we keep. We will obey the rules described in this notice.

D. How your protected health information (PHI) can be used and shared

Except in some special circumstances, when we use your PHI in this office or disclose it to others, we share only the *minimum necessary* PHI needed for those other people to do their jobs. The laws give you rights to know about your PHI, to know how it is used, and to have a say in how it is shared. So now we will tell you more about what we do with your information.

Mainly, we will use it here and disclose (share) your PHI for routine purposes to provide for your care, and we will explain more about these below. For other uses, we must tell you about them and ask you to sign a written Release of Information form**.** However, the HIPAA law also says that there are some uses and disclosures that don't need your consent or authorization which we will explain below in section 3. However, in most cases we will explain the PHI and who it will go to and ask you to agree to this by signing a release-of-information form.

1. Uses and disclosures with your consent

We need information about you and your condition to provide care to you. In almost all cases, we intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called "health care operations." You have to agree to let us use and share your PHI in the ways that are described in this Notice of Privacy Practices. To agree, we will ask you to sign a separate consent form before we begin to treat you. If you do not consent to this, we will not treat you because there is a risk of not helping you if we don't have some information.

a. The basic uses and disclosures: For treatment, payment, and health care operations

Here we will tell you more about how your information will be used for these purposes.

For treatment. We use your information to provide you with psychological treatments or services. These might include individual, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of our services.

We may share your PHI with others who provide treatment to you. If you are being treated by a team, we can share some of your PHI with the team members, so that these providers will work best together. The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, and so we all can decide what treatments work best for you and follow a treatment plan.

If we want to share your PHI with any other professionals outside this office, we will need your permission on a signed release-of-information form. For example, we may refer you to other professionals or consultants for services we cannot provide. When we do this, we need to tell them things about you and your conditions. Later we will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, we can also share your PHI with them. We can do this only when you give your permission by signing a release-of-information form. This is so that you will know what information is being shared and with whom. These are some examples so that you can see how we use and disclose your PHI for treatment.

For payment. We may use your information to bill you, your insurance, or others, so we can be paid for the treatments we provide to you. We may contact your insurance company to find out exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we met, your progress, and other similar things. Insurers may also look into a few of our patient records to evaluate the completeness of our record keeping.

For health care operations. Using or disclosing your PHI for health care operations goes beyond our care and payment for services. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies, so they can study disorders and treatment and make plans for services that are needed. If we do, your name and all personal information will be removed from what we send.

b. Other uses and disclosures in health care

Appointment reminders. We may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work, or you prefer some other way to reach you, we usually can arrange that. Just tell us.

Treatment alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

Other benefits and services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Research. We may use or share your PHI to do research to improve treatments—for example, comparing two treatments for the same disorder, to see which works better or faster. In all cases, your name, address, and other personal information will be removed from the information given to researchers. We will discuss this with you, and we will not use your PHI unless you give your consent on an authorization form. If the researchers need to know who you are, we will discuss the research project with you, and we will not send any information unless you sign a special release-of-information form.

Business associates. We hire other businesses to do some jobs for us. In the law, they are called our “business associates.” Examples include a copy service to make copies of your health records, and a billing service to figure out, print, and mail our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contracts with us to safeguard your information just as we do.

2. Uses and disclosures that require your consent

If we want to use your information for any purpose besides those described above, we need your permission on a release-of-information form. If you do allow us to use or disclose your PHI, and then change your mind, you can cancel that permission in writing at any time. We will then stop using or disclosing your information for that purpose. Of course, we cannot take back any information we have used here already or disclosed to anyone with your permission.

As a Licensed Marriage and Family Therapist and Certified Substance Abuse Counselor, I maintain your privacy according to the strictest guidelines. The HIPAA rules are described below, but we will almost always discuss these with you and ask you to sign a release of information so that you are fully informed.

3. Uses and disclosures that don't require your consent or authorization

The HIPAA laws let us use and disclose some of your PHI without getting your consent or authorization in some cases. Here are some examples of when we might do this. We will almost always notify you if any of these situations occur.

a. When required by law

There are some federal, state, or local laws that require us to disclose PHI:

- We have to report suspected abuse [or neglect] of children [elders, frail/disabled persons, etc.] to a state agency.
- If you are involved in a lawsuit or legal proceeding, and we receive a subpoena, discovery request, or other lawful process, we may have to release some of your PHI. We will only do so after making reasonable attempts to tell you about the request and will suggest that you talk to your lawyer.
- We have to disclose some information to the government agencies that check on us to see that we are obeying the privacy laws, and to organizations that review our work for quality and efficiency.

b. For law enforcement purposes

We may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

c. For public health activities

We may disclose some of your PHI to agencies that investigate diseases or injuries.

d. For matters relating to deceased persons

We may disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

e. For specific government functions

We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment. We may disclose your PHI to workers' compensation and disability programs, to correctional facilities if you are an inmate, or to other government agencies for national security reasons.

f. To prevent a serious threat to health or safety

If we come to believe that there is a serious threat to your health or safety, or that of another person or the public, we can disclose some of your PHI. We will only do this to those people who can prevent the danger.

If it is an emergency, and we are unable to get your agreement, we can disclose information if we believe that it is what you would have wanted and if we believe it will help you. When we do share information in an emergency, we will tell you as soon as we can. If you don't approve, we will stop, as long as it is not against the law.

4. Uses and disclosures where you have an opportunity to object

We can share some information about you with your family and anyone else you choose, such as close friends or clergy. We will ask you which persons you want us to tell, and what information you want us to tell them about your condition or treatment. You can tell us what you want, and we will honor your wishes as long as it is not against the law.

5. An accounting of disclosures we have made

When we disclose your PHI, we will keep a record of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures. We may charge you a reasonable fee if you request more than one accounting in any 12-month period. If the records were sent as electronic medical records, we will always record that, and there will be no charge for an accounting.

E. Your rights about your protected health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, rather than at work, to schedule or cancel an appointment. We will try our best to do as you ask, and we don't need an explanation. Sending your information in emails has some risk that these emails could be read by someone else. You may just accept the risk of using emails just for simple messages like changing appointments, and not use it for any PHI or sensitive information, or you may request communication in a more secure forma than email. We ask that you be thoughtful before you put

any information in an email and not use email for anything you want kept private. By signing the separate consent form, you agree to this use of email. Please note that anything you send us electronically becomes a part of your legal record, even if we do not place it in the chart. Be mindful of this, and please do not forward us emails from third parties or others in your life. It is better to print those out and bring them in to discuss them.

2. You have the right to ask us to limit what we tell people involved in your care or with payment for your care, such as family members and friends. You can ask us face to face, and we may then ask for your written permission. We don't have to agree to your request, but if we do agree, we will honor it except when it is against the law, when there is an emergency, or when the information is necessary to treat you.
3. You have the right to prevent our sharing your PHI with your insurer or payer for its decisions about your benefits or some other uses, if you paid us directly ("out of pocket") for the treatment or other services and are not asking the insurer to pay for those services unless we are under contract with your insurer (on their panel of providers).
4. You have the right to look at the PHI we have about you, such as your medical and billing records. In some very unusual circumstances, if there is very strong evidence that reading this would cause serious harm to you or someone else, you may not be able to see all of the information.
5. You can get a copy of these records, but we may charge you a reasonable cost-based fee. If your records are in electronic form, not on paper, you can ask an electronic copy of your PHI. Generally we do not recommend that you get a copy of your records, because the copy might be seen accidentally by others. We will be happy to review the records with you or provide a summary to you, or work out any other method that satisfies you.
6. You have the right to add to (amend) your records to explain or correct anything in them. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records or to include your own written statements to correct the situation. You have to make this request in writing.
7. You have the right to a copy of this notice. If we change this notice, we will post the new one in our waiting area, and you can always request a copy from us.
8. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, contact us. We will do our best to resolve any problems and do as you ask. You have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington, DC 20201, or by calling 202-619-0257.
9. We will not in any way limit your care here or take any actions against you if you complain or request changes.

You may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

F. If you have questions or problems

If you have any questions or problems our health information privacy policies, please contact us. My signature below shows that I understand my rights regarding protected health information.

_____	_____	____/____/____
Signature of client or legal representative	Printed name	Date

_____	_____
Printed name of legal representative	Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	____/____/____
Signature of therapist	Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Consent to Treatment

I, _____, acknowledge that I have had all my questions about treatment answered fully and to my satisfaction.

I seek and consent to take part in treatment with the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand and agree to play an active role in the therapy processes.

I understand that no promises have been made to me about the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. If I do, I will have to pay for the services I have already received. I understand that I may lose other benefits or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 72 hours (3 business days) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that my health insurance company or other third-party payer may be given information about my diagnose(s) and life functioning, as well as the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____	_____	____/____/____
Signature of client or legal representative	Printed name	Date

_____	_____
Printed name of legal representative	Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	____/____/____
Signature of therapist	Date

❑ Copy accepted by client or ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Consent for Electronic Communications

1. Risk of using email/texting:
   The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:
   1. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   2. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
   3. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
   4. Employers and on-line services have a right to inspect emails sent through their company systems.
   5. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   6. Email and texts can be used as evidence in court.
   7. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.
2. Conditions for the use of email and texts:
   Therapist cannot guarantee, but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by therapist's intentional misconduct. Clients/Parents/Legal Guardians must acknowledge and consent to the following conditions:
   1. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
   2. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
   3. Email and texts may be printed and filed into the client's medical record.
   4. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
   5. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
   6. Provider is not liable for breaches of confidentiality caused by the client or any third party.
   7. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

_____	_____	_____/____/_____
Client Name	Client Signature	Date
_____	_____	_____/____/_____
Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____/____/_____	
Therapist's Signature	Date	

Financial Information Form

I truly appreciate your choosing to come to me for treatment. As part of providing high-quality services, I need to be clear with you about our financial arrangements.

My hourly rates are as follows:
$160/ hour for individual therapy
$180/ hour for couple or family therapy
$125/ group therapy session

Other services such as phone calls, writing reports, performing assessments/evaluations, etc. will be billed per minute at the individual session rate and may not be covered by your health insurance.

An hour is considered 50-55 minutes of therapy.

If you have health insurance, it may pay for a part of the cost of your treatment here. To find out if this is so, I need the information requested below in sections D, E, F and G. I will explain any part of this form that is not clear to you.

A. Please select one or more of the following options:

1. ❑ I intend to use any insurance benefits available to pay for part of the services I receive here. (Please complete sections E, F, and G of this form.)
2. ❑ I decline to use the health insurance I have with _____ (company). (Please select options 4, 5, or 6 below.)
3. ❑ I have no health insurance coverage.
4. ❑ I intend to use a health savings account (HSA), flexible savings account (FSA), or similar. (Please discuss this with me so that I can supply you with the forms you will need.)
5. ❑ I will use a credit card to pay my copays or other fees. (Please discuss this with me so that I can supply you with the information and forms you will need.)
6. ❑ I will pay by cash or check at each visit.
7. ❑ Another organization/agency/payer will be paying for my treatment. (name of payer _____).

B. If you ask me to, I can submit claims to your health insurance plan or managed care organization (MCO) for you, but you must authorize me to receive any payments the insurer makes. Because I have a contract with your plan, I am “in network” and must charge you only the fee that the insurer and I have agreed to. You will pay me the full fee until your payments reach the yearly deductible of your health insurance. After that, you will pay me only the copayment or “copay” for each time we meet.

C. The use of health insurance or another payer to pay for all or part of therapy involves many considerations. The major concerns include these:

- When an insurance company pays for part of your treatment, the company has a right to review your records, limit treatment, and deny claims for payment.
- Not all services may be covered, including phone meetings, videoconferencing, and any services the company decides are not “medically necessary.” If you request and agree to services that are not covered, you will be expected to pay for them.
- If your insurance changes, you agree to provide me with an update as soon as possible. If you become eligible for additional or different insurance such as Medicare, you must inform me.
- This office will submit claims in a timely manner and will provide an update to you if the insurance company or MCO denies the claim.

D. Please give us this information as it appears on your insurance policies or cards.

Your name: _____ Date of birth: ___/___/___ Age: _____

Home phone #: _____ Cell #: _____

Home street address: _____

City: _____ State: _____ Zip:_____

Policy holder's name: _____ Date of birth: ___/___/

Relationship to the patient: ❑·Spouse ❑·Child ❑·Other: _____

Name of the insurance company: _____ Health plan: _____

Policy #: _____Group #: _____FECA #: _____ Effective date: ___/___/____

Reciprocity number: _____ Phone number of plan: _____

Address to send claims: _____

Any other information on the card? _____

E. If you or the policy holder (if different from you) have a second kind of health insurance, please fill in the numbers and names for it.

Policy holder's name: _____ Date of birth: ___/___/____

Relationship to the patient: ❑·Self ❑·Spouse ❑·Child ❑·Other: _____

Name of the insurance company: _____ Health plan: _____

Policy #: _____Group #: _____FECA #: _____Effective date: ___/___/____

Reciprocity number: _____ Phone number of plan: _____

Address to send claims: _____

Any other information on the card? _____

F. Release of information and assignment of benefits:

I, the client (or the policy holder), by my signature below authorize the release by this office of any information obtained during evaluations and treatment that is necessary to support and process any insurance claims, determine medical necessity, support any clinical or financial audits, or requests for additional sessions. I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the clinician or organization above. Medicare regulations may apply.

I understand that I am responsible for all charges, regardless of insurance coverage or other payments. I understand that I will be responsible to pay a cancellation fee if I fail to cancel my appointment <u>at least 24 hours in advance.</u>

A photocopy of this assignment is to be considered as good as the original.

_____ _____ ___/___/___

Client's (or policy holder's) signature Printed name Date

My signature indicates my agreement to and accuracy of all of the statements above

Please bring your (or the policy holder's) health insurance card(s) with you to your first session.

Consent to Release Confidential Information

When completed, this form authorizes the Love Counseling and Consulting LLC to release/ receive/ exchange protected health information about you or from your clinical record to/ from/ with the person(s) or organization(s) designated.

I authorize Love Counseling and Consulting LLC to release and/or exchange the following information:

(check all that apply)

- ○ Complete copy of file or chart
- ○ Diagnosis/ testing/ assessment results
- ○ Psychotherapy notes
- ○ Attendance and progress in treatment
- ○ Clinical issues as they arise in treatment
- ○ Other information:_____

  _____

  _____

This information should be released to, received from, and/or exchanged with:

Name of person(s)/ organization/ agency: _____

Relationship to Client: _____

Contact information: _____

I am requesting my provider to release/receive/exchange this information for the following reason(s): Coordination of services, supervision, program effectiveness, treatment compliance, attendance, and progress.

-OR-

Other: _____

This authorization shall remain in effect until date signed or (fill in expiration date) _____.

You have the right to revoke this authorization, in writing, at any time by sending written notification to my office address. However, your revocation will not be effective if Love Counseling and Consulting LLC has already contacted the designated individual(s) or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and Love Counseling and Consulting LLC is not responsible for recipient(s) use of the information once released.

_____	_____	____/____/____
Signature of client	Printed name	Date
_____	_____	____/____/____
Signature of parent/guardian	Printed name	Date

No Secrets Policy

If you are participating in family or couple therapy sessions, or if others are otherwise involved in your care, there may be occasions when information is shared with me, the therapist, which you or others involved in treatment are not aware of. This document serves as notice for all involved in treatment that the therapist does not keep secrets from, or for, anyone involved in treatment.

If you are receiving family or couple therapy, you are treated as a unit rather than as individuals, and while I may agree to see or speak to individuals outside of the presence of the rest of the treatment unit, if information is shared with me, I will not promise to keep it from the rest of the group if I believe that it is important for them to know.

At times, something important may be shared with me that is difficult to share with others and requires planning and preparation. This is understandable and is a part of the therapeutic process. If the person is actively preparing to make a disclosure, I will hold the information for a reasonable amount of time. However, family and couple therapy cannot proceed in a productive manner when important issues are left unaddressed, so if the person refuses to share the important information, I may elect to share it myself, or may terminate treatment altogether.

By signing below, you understand and agree to respect others involved in the treatment unit by agreeing to the timely sharing of information that is important and deemed necessary for the treatment unit to be aware of.

Signature of client	Printed name	Date
Signature of client	Printed name	Date
Signature of client	Printed name	Date
Signature of client	Printed name	Date
Signature of client	Printed name	Date
Signature of client	Printed name	Date