INFORMED CONSENT AND OFFICE POLICIES AND PROCEDURES (2014)

WELCOME TO MY OFFICE

I hope that you will find your time here to be worthwhile. This document contains important information about my professional services and business policies. It will outline what you can expect from our meetings and how we can most effectively work together.

Please read it carefully and feel free to ask me any questions you may have. When you sign that you have received and understood this document, it will represent and agreement between us.

WHAT IS PSYCHOTHERAPY AND HOW DOES IT WORK?

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the counselor and client and the particular problems you may bring forward. There are many different methods I may use to deal with the issues that we identify as treatment goals. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation period, I will be able to offer you some first impressions of what our work will include. During this evaluation time, we can both decide if I am the best person to provide you with the services you need in order to meet your treatment goals. If you ever have questions about my procedures, we should discuss them whenever they arise.

Typically we will schedule one 55 minute session per week at a time we agree on, although some sessions may be longer or more frequent if needed. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation.

BENEFITS AND RISKS OF THERAPY

Increasingly, people are becoming aware of the importance of emotional well-being and how professional mental health services can contribute to leading a happy, full, and rich life. The purpose of psychotherapy is to enable individuals to cope more effectively, solve their problems, and reach their goals. Therapy may lead to increased self-understanding, better relationships, solutions to specific problems, and significant reduction in feelings of distress. There are no guarantees, however, of what you will experience, and specific results of therapy cannot be guaranteed.

Although psychotherapy may lead to significant benefits, there are some risks to consider. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger and frustration. Other risks may include an increased awareness of painful emotions, discomfort in processing these emotions, and changes in your relationships with others. We can always discuss these issues if they arise for you as part of therapy.

CONFIDENTIALITY

In general, the law protects the privacy of all communications between a patient and psychologist and I will only release such information with your written permission. However, there are some limits to confidentiality. I am obligated to release information *without* your permission in the following circumstances:

1. If I believe that a minor, elderly person or dependent adult is being abused, I am legally obligated to take action to protect them from harm and must file a report with the appropriate state agency.
2. If a patient threatens to harm him/herself or I deem a patient gravely disabled, I am required to take protective actions that may include hospitalization for the patient and/or contacting authorities, family members or others who can help provide protection.

3. If I believe that a patient poses a serious danger of violence to others, I am required by law to take protective actions that may include notifying the potential victim(s), contacting the police, or seeking hospitalization for the patient.
4. A judge may order my testimony if he/she determines that the issues demand it.

I may occasionally find it helpful to consult other professionals about a case and a release of information is not required for such instances. During a consultation, I do not use the identifying information of my patient. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Client will be charged an appropriate fee for any time spent in preparing information requests.

COORDINATION OF TREATMENT

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist regarding your treatment at Oakwoods Center. If you prefer to decline consent, no information will be shared.

_____ You may inform my physician(s) _____ I decline to inform my physician(s)

PHYSICIAN NAME: _____

CLINIC: _____

ADDRESS: _____

EMAIL ADDRESS: _____

I give permission to communicate with my physician and/or psychiatrist via email.
_____ Yes _____ No

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS

I consent that _____ may be treated as a client at Oakwoods Center.

CONSENT TO COMMUNICATION VIA EMAIL

I, _____, consent to the use of email to communicate with my therapist or between Oakwoods Center staff or with other necessary professionals, for billing and treatment issues, given that all appropriate steps will be taken to ensure confidentiality.

TELEPHONE CALLS, MESSAGES, AND EMERGENCIES

I strive to promptly return calls, but there can be unavoidable delays. My contact number has voicemail that I monitor frequently. I usually return calls within 24 hours, with the exception of weekends and holidays. Please inform me if you have any special instructions about how you would like to be contacted.

If you are unable to reach me and feel that you cannot wait for me to return your call, contact your primary care physician, psychiatrist or the nearest emergency room. You may call 911 or the Joliet

Crisis Center at 815-722-3344. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact if necessary.

PROFESSIONAL FEES, BILLING AND PAYMENTS

My rate for a 55 minute session is $_____. Extended sessions will be billed an additional charge. Full payment is due at the time of each visit, unless we agree otherwise or unless you have insurance coverage which requires other arrangements.

Fees for report writing are additional. I charge for all time out of the office on your behalf, such as hospital visits, school staffings, or court testimony. Insurance frequently does not cover expenses outside of therapeutic sessions and you will be responsible for any non-covered expenses.

Personal checks, cash and credit/debit cards (Visa and MasterCard) are accepted. Any bank charges incurred by this office for a check refused for due to non-sufficient funds will be added to the outstanding balance. If the balance for which you are responsible is not paid within 90 days, your account may be turned over to a collection agency.

If you are having financial problems that keep you from paying in a timely manner, let's discuss it. We can make special arrangements if necessary.

INSURANCE REIMBURSEMENT

You should be aware that most insurance companies require the release of clinical information, including, dates of service, diagnoses, treatment plans, and outcome. Submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality or privacy. Only the minimum necessary information will be communicated to the carrier. In rare cases, however, the insurance company may request additional information or copies of the entirI hCW e record. This information will become part of the insurance company files. Although all insurance companies claim to keep such information confidential, you should be informed that I have no control over what they do with the information once it is in their hands.

With your consent, my office will file insurance claims with your primary insurance carrier on your behalf. Please remember that professional services are rendered and charged to the client, not the insurance company. My relationship is with you, not your insurance company and it is the responsibility of the insured to follow the guidelines under the insurance policy. Failure to follow the policies of your insurance company may result in a reduction of benefits. If you have questions about your coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. You are responsible for paying any fees or portion of fees not covered by your insurance.

CANCELLATION POLICY

Your appointment is held exclusively for you. If you are unable to keep your appointment, you are required to provide 24-hour notice or you may be charged a missed session fee of $_____. There is no insurance reimbursement for a missed appointment.

Printed Name(s) _____

Signature(s)_____ **Date:**_____

HIPAA NOTICE OF PRIVACY PRACTICES / CLIENT RIGHTS

I have received a copy of the HIPAA Notice of Privacy Practices and the Client Rights, and they have been explained to me.

Signature(s)_____ **Date:**_____

HIPAA 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 INFORMATIION. PLEASE REVIEW IT CAREFULLY.

The Oakwoods Center has been, and will always be, totally committed to maintaining clients confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services:
Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT
We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources.

PAYMENT
Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS
We may need to use information about you to review our treatment procedures and business activity; such information maybe used for certification, compliance and licensing activities.

Other uses or disclosures of your information, which do not require your consent:
There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to:

- Information you, your child or children, report about physical or sexual abuse. By Illinois state law, we are obligated to report such information to the Department of Children and Family Services.
- Information that informs us that you are in danger of harming yourself or others.
- Information to remind you of, or to reschedule, appointments or treatment alternatives.
- Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law, such as a subpoena or court order.

CLIENT RIGHTS

RIGHT TO RELEASE YOUR MEDICAL RECORDS

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

RIGHT TO INSPECT AND COPY YOUR MEDICAL AND BILLING RECORDS

You have the right to inspect and obtain a copy of your information contained in our medical records. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

RIGHT TO ADD INFORMATION OR AMEND YOUR MEDICAL RECORDS

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request within 60 days, or some cases, within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release.

RIGHT TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

RIGHT TO COMPLAIN

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services, or you may contact one of the agencies listed below. An individual will not be retaliated against for filing such a complaint.

IL Guardianship & Advocacy Commission
http://www.illinois.gov/sites/gac/Pages/default.aspx
866-274-8023

Equip for Equality
20 N. Michigan Ave. Suite 300, Chicago, IL 60602
312-341-0022, http://www.equipforequality.org/

RIGHT TO RECEIVE CHANGES IN POLICY

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.