

OFFICE POLICIES, GENERAL INFORMATION & CONSENT FOR TREATMENT FOR PSYCHOTHERAPY SERVICES

Welcome to the Abundant Living Counseling and Consultation, PLLC and thank you for choosing us. Please carefully read the following information because it will help you utilize our services most effectively. Feel free to ask any questions. This document contains important information about our professional services, business policies, and the current legal and ethical requirements for Licensed Clinical Mental Health Counselors and associates (including Interns and Supervisors of either license).

HIPPA CONSENT FORM: I have read the Abundant Living Counseling and Consultation, PLLC "Notice of Policies & Practices to Protect the Privacy of your Health Information" (also known as "HIPPA Consent") form posted in the office and understand that it describes how psychological and medical information about me may be used or disclosed and how I can gain access to this information. In addition, I understand that I am welcome to a copy of this HIPPA Consent form if I simply request it from my Abundant Living Counseling and Consultation, PLLC therapist.

CONFIDENTIALITY: The information you share with us is confidential; that means that information about you does not leave our office without our consent or authorization. Exceptions to this policy are outlined more fully in the HIPAA Consent Form. Briefly, information may be disclosed only by if the following criteria are met or are necessary:

- Diagnosis and date of service shared with your insurance company (if insurance is billed for treatment purposes)
- Mandated reporting of physical or sexual abuse of children
- Threats of suicide or homicide
- Cases where you have signed a release of information for information to be disclosed
- Information released as outlined in the HIPPA Consent Form

In addition to the above, we sometimes consult with professional colleagues to improve the quality of care we provide. Your signature on this form constitutes advance consent for this practice. We do not use names or other identifying information when discussing "cases" with other professionals. They are also bound to keep this information confidential. We follow HIPPA procedures re: transportation of files. Records containing information about your visits are stored in a locked file cabinet.

CULTURAL COMPETENCE: Abundant Living Counseling and Consultation, PLLC prohibits discrimination based on race, color, national origin, age, disability, sex, marital status, familial status, parental status, religion, sexual orientation, political beliefs, or because all or part of an individual's income is derived from any public assistance program.

OFFICE HOURS/EMERGENCIES:

* **Office Hours:** Evening and weekend appointments are scheduled by appointment only.

* **Outside of session:** If there is an emergency while you are an Abundant Living Counseling client where your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he/she will do whatever he/she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. He/she may also contact the person whose name you have provided as your emergency contact on the Personal Data sheet. We are not available for after-hours emergencies. If you feel that you cannot safely wait for us to return your call, you should call your physician, go to or call the local emergency room, or call 911. You can reach Presbyterian Behavioral Health Access at (704) 384-4255 or Carolinas Medical Center—Behavioral Health Center Emergency Room at (704) 358-2800.

* **Inside session:** Your therapist may also disclose your PHI (Protected Health Information) to others without your consent if you are incapacitated or in an emergency. For example, if you are in session with your therapist and begin to experience an anxiety attack, your therapist will not assume that it is anxiety-based and may call for emergency medical treatment to ensure that nothing more serious is happening for you medically.

FINANCIAL ASPECTS OF CONTRACTING PSYCHOTHERAPY SERVICES:

* **Insurance Reimbursement:** We will file insurance claims for you and provide a receipt for payment for personal tax purposes. If your insurance plan has an unmet deductible or the claim is denied for service, you are responsible for payment. We encourage you to contact your insurance company to answer questions you may have about the extent to which our fees are reimbursable. We ask that you authorize payment of medical benefits directly to Abundant Living Counseling and Consultation, PLLC. We may use and disclose medical information about you so that the services received may be billed and payment may be collected. Please also understand that we may tell your health plan about the treatment you will receive in order to obtain prior approval and determine whether your plan will cover the proposed treatment.

* **Co-Pay:** Your co-pay of is due at the time of service. Payment can be made by cash, money order, debit or credit card. It is your responsibility to ensure that your co-pay amount is accurate. If you owe more than paid, you will be billed accordingly likewise you will be refunded any amount over paid.

Non-eligible Services

Your insurance company will not pay for disability evaluations, court order evaluation, and completions of forms for attorneys or employers, court appearances, copies of records, letters or any other type of reports. Your initial evaluation does not cover information needed for disability or court ordered evaluations. If you are seeking disability or court ordered services, please let your therapist know prior to your appointment. Full payment in advance is required for these charges. Paperwork charges are \$60.00 for complex paperwork and \$20.00 for simple paperwork. Court appearances start at \$500.00 and will increase depending on hours spent in court and client scheduling time loss. Please discuss cost of these and other services with your provider.

Disability Claims

If you are requesting assistance in completion of a disability claim, please make note of the following:

1. Your provider does not “give disability”. They can only report symptoms and response to treatment to the company that handles your disability insurance.
 2. If you are disabled to work, our goal is to help you return to work. You may have to see a therapist and psychiatrist to help with issues which are preventing you from being able to work.
 3. We do not back date disability.
 4. If regularly scheduled appointments are not kept, we will notify your disability carrier.
 5. Disability paperwork requests take up to 10 business days to complete.
 6. We require 3 months of treatment history to provide most accurate disability information. Please plan for consistent treatment so we can share most accurate information regarding your condition.
 7. We do not complete forms for service animals. You will be referred back to your primary physician.
- ***Disability/Leave-from-work/and other forms** will be completed for \$50.00
***Disability/Leave-progress summary or other report** will be completed for \$150.00

***Payments Due at Time of Service:** Clients are expected to pay the standard fee per 50-minute session at check in. Please notify your therapist before your session if any problem arises re: your ability to make timely payments. Payments may come by cash, money order or credit/debit card.

LATE CHARGES/CANCELLATION POLICY: **Effective 01/2021**

*As a courtesy to you, we will confirm your appointment 1-2 days prior. Please do not rely on this as the only means of remembering your appointment as there could be technical circumstances that may prevent a call or text from going out.

***Late arrivals:** If you arrive more than 15 minutes late for your scheduled appointment, your appointment may be cancelled to avoid inconveniencing other patients.

***Cancellation policy:** If you give **24 hours’ notice** to your therapist that you do not plan to attend your previously scheduled session, your therapist can take you off his/her calendar without owing a session fee. However, giving less than 24 hours’ notice, or “no-showing” for your appointment will result in **you being charged a \$50.00 late cancellation/no show fee.**

While we do appreciate the 24-hour notice, we would like you to attend all scheduled appointments as you will gain the most benefit from the consistency. If more than 3 cancellations are made, you will be at risk of losing your set scheduled appointment time.

SERVICES ASSOCIATED WITH LEGAL ISSUES AND/OR COURT PROCESS:

***Fees & Payment re: legal services:**

Requested documentation and court appearances including travel time, are \$150.00 per hour. You should discuss with your therapist before sending a subpoena, because he/she will not often agree to appear in court and may be expected to refuse to give a professional opinion in court. The client or parent whose attorney issues the subpoena must pay \$500 in advance of a court appearance, which will be refunded if she is notified in a timely manner that the appearance is not needed.

THE PROCESS OF THERAPY/EVALUATION:

* **Visits** with therapist are approximately 50 minutes. During your initial visit, your therapist will obtain information from you to assist in making a diagnosis, developing a treatment plan and making recommendations for return visits. You may also be referred to a psychiatrist or your primary care physician for medication evaluation if the therapist determines medication may be helpful in addition to therapy.

* **Participation** in therapy can result in several benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly to ensure that your therapy is progressing toward your original goal(s).

* **Risks:** During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as interpersonal relationships, may result in changes that were not

originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a positive decision for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift; but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

*** Theoretical Orientation:** During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, existential, family systems, developmental (adult, child, family), psychodynamic, or psycho-educational therapy.

BOUNDARIES WITHIN THERAPY:

*** Phone Calls/Voicemail & Emergencies:**

Given that we spend majority of our time in sessions, we are often not available by phone. When we are unavailable, the phone is answered by voicemail. We monitor our voicemail frequently. We will make every effort to return your call within 24 hours, except for weekends and holidays. You may also contact us via email at thughes@abundantlivingcandc.com as we check email a few times a day. Text messages can also be sent to 980-999-3212. Please allow therapist time to return your call and/or text messages.

*** Termination:** Your Abundant Living Counseling therapist requests a two-week notice before therapy is terminated to process gains made during treatment, as well as issues to be addressed in the future either by him/her or another therapist.

*** Dual Relationships:** The phrase “dual relationship” is used by the NC State Board of Examiners of Licensed Clinical Mental Health Counselors to describe when a therapist is not only serving a client in counseling, but also have a second point of contact, such as serving on a board together, or attending the same book study, etc. Not all dual relationships are unethical or avoidable. Some non-sexual dual relationships are unavoidable and rare examples can be clinically beneficial. Therapy never involves sexual or any other dual relationships that impair your therapist’s objectivity, clinical judgment and therapeutic effectiveness; this could be exploitative in nature. Your therapist will assess carefully before entering non-sexual and non-exploitative dual relationships with clients, discuss with each client the potential benefits and difficulties that may be involved in relationships and will discontinue the dual relationship if he/she finds it interfering with the effectiveness of the therapeutic process. In addition, if you encounter your therapist in any public setting, he/she will never approach you or even acknowledge you unless you first initiate contact so that he/she may protect your confidentiality and the nature of your professional relationship.

GRIEVANCES:

If you are dissatisfied with any aspect of our work, please talk with us about it. If you think you have been treated unfairly or unethically, and we cannot resolve the problem, you can contact the NC Board of Licensed Clinical Mental Health Counselors, P.O. Box 77819, Greensboro, NC 27417, for clarification of clients’ rights as I’ve explained them to you or to lodge a complaint. All grievances will be attended to within 5-10 business days.

I have carefully read, understand, and agree to comply with the above Office Policies, General Information, and Consent for Treatment for psychotherapy services with Abundant Living Counseling and Consultation, PLLC.

Client’s Printed Name

Client’s Signature

Date

Guardian’s Printed Name

Guardian’s Signature

Date

Therapist Name

Therapist Signature

Date



Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and 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 I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. 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 I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the North Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the North Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- **For Treatment** – I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- **For Payment** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- **For Operations** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- **Right to Treatment** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- **Right to Confidentiality** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of \$1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- **Right to Amend** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- **Right to a Copy of This Notice** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- **Right to Choose Someone to Act for You** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- **Right to Choose** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- **Right to Terminate** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- **Right to Release Information with Written Consent** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of North Carolina Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client Signature

Date

Client Printed Name

Legal Guardian Signature

Date

Legal Guardian Printed Name

Tanya M. Hughes, MA, LCMHC

Date