Above It All Counseling Group, LLC

Consent for Treatment

I agree to take part in psychotherapy/counseling at Above It All Counseling Group, LLC. I understand that developing a treatment plan and regularly reviewing our work and goals is in my best interest. I agree to play an active role in the process.

I understand that psychotherapy/counseling has potential risks and benefits. I understand that no promises or guarantees have been made to me as to the results or success of treatment.

I also understand that I may withdrawal from treatment at any time. Withdrawal of consent can be in any form: verbal, active resistance, repeated noncompliance, or any other unwillingness to continue participating in treatment. If I withdraw consent I will be responsible for paying for the services that I have already received.

My signature below shows that I understand and agree with all of the above statements. The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions. If the client is a minor or has a legal guardian appointed by the court, the client's parent(s) or legal guardian(s) appointed by the court, the client's parent(s) or legal guardian(s) must sign this consent and provide copies of Court/Custody Papers (if applicable).

I UNDERSTAND THAT I AM RESPONSIBLE FOR FINDING A NEW THERAPIST IF I FAIL TO SHOW UP FOR TWO CONSECUTIVE APPOINTMENTS, WITHOUT PROVIDING A 24 HOUR NOTICE. WE WILL NOT CONTINUE TO PROVIDE SERVICE AFTER TWO NO-SHOWS. I HAVE READ AND AGREE TO THE ABOVE POLICY TERMS.

X (Client / Parent / Guardian Signature) Date

Notice of Privacy Practices Receipt and Acknowledgment of Notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of **Above It All Counseling Group, LLC Notice of Privacy Practices**.

I understand that I may request a hardcopy of Above It All Counseling Group, LLC Notice of Privacy Practices or may access an electronic copy via Above It All Counseling Group's, Website: **www.Aboveitallcounseling.com/forms**

I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Above It All Counseling Group, at **Above It All Counseling Group at 89-B Trolley Rd, Suite #205, Summerville, SC 29485, 843-900-8960**

X (Client / Parent / Guardian Signature) Date

X (Signature of Personal Representative – **if applicable**) Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate,etc.).*_____

Above It All Counseling Group, LLC

Coordination with Primary Care Physician or Psychiatrist (if applicable)

It may be beneficial for our practice confer with your Primary Care Physician or Psychiatrist (if applicable) with regard to your mental health treatment. In addition, some Managed Care Plans require that we notify your physician/ psychiatrist by telephone or in writing concerning mental health services, unless you request that notification not be made. This information will not be released without your consent, except in an emergency.

Please check one of the following:

_____**I do** authorize Above It All Counseling Group, LLC to contact my Primary Care Physician or Psychiatrist whose name and address are shown below to discuss the diagnosis, treatment plan, and prognosis while under Above It All Counseling Group, LLC care. In addition, Above It All Counseling Group, LLC is authorized to obtain information from my Primary Care Physician or Psychiatrist concerning my medical diagnosis and treatment.

_____**I do not** authorize Above It All Counseling Group, LLC, to contact my Primary Care Physician or Psychiatrist whose name and address are shown below to discuss the diagnosis, treatment plan, and prognosis while under Above It All Counseling Group, LLC care. I am providing Above It All Counseling Group, LLC with the name and address of my Primary Care Physician or Psychiatrist for informational purposes only.

Name of Primary Care Physician:_____Phone #:_____

Name of Psychiatrist (if applicable):_____Phone #:_____

X (Client Signature) Date

X (Client / Parent / Guardian Signature) Date

Above It All Counseling Group, LLC

Consent for E-Mail and Electronic Means of Communication

As a covered entity under the HIPAA Privacy and Security Rules, we take your privacy and right for confidentiality seriously. Although it is convenient, email and other forms of electronic communication is not a secure medium because third parties can view and store confidential information. Therefore, email and other forms of electronic communication are *not* to be considered completely confidential forms of communication, and using email runs the risk of breaching your confidentiality.

RISKS OF USING E-MAIL & OTHER FORMS OF ELECTRONIC COMMUNICATION TO COMMUNICATE WITH ABOVE IT ALL COUNSELING GROUP, LLC Transmitting client information by e-mail has a number of risks that clients need to consider before using e-mail to communicate with your therapist. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by unintended recipients.
- E-mail senders can easily type in the wrong email address.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies or e-mail may exist even after sender or recipient has deleted his or her copy.
- Employers and on-line services have a right to archive & inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-Mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

TYPES OF PERMISSIBLE E-MAIL OR ELECTRONIC COMMUNICATION THAT CLIENT AGREES TO SEND AND/OR RECEIVE the types of information that can be communicated via e-mail with Above It All Counseling Group, LLC includes (please check which items you consent to): Appointment scheduling requests and appointment reminders Billing and insurance questions and patient education

☐ Use of e-mail for general client information only. **I agree not to use e-mail for clinical or psychiatric emergencies, other time sensitive matters, or for non-general clinical information**.

If you are an active client of Above It All Counseling Group, LLC and experiencing an urgent, clinical emergency and the office is closed, you may call emergency services at 911. Our office hours are 9am – 6 pm, Monday through Friday or please leave us a voice mail message if you have updated information.

If you feel that you have a **life-threatening emergency, call 911 or go to the nearest emergency room**. In addition, contact the **National Suicide Prevention Hotline # 1-800-273-8255 or 1-800-784 2433** to be connected to a skilled, trained counselor at a crisis center 24/7.

As part of our commitment in delivering the best care and service to you, we recently upgraded our electronic record system. We are pleased to now offer the option of receiving electronic text message, email, or telephone appointment reminders.

As a reminder, appointments not cancelled within 24 hours are subject to a **$20.00** administrative fee.

Please complete the following sections to begin receiving automated appointment reminders:

Please Complete: [Print]

Client Name:_____

Email Address:_____

Phone #:_____

Please choose only one:

_____Electronic Text Message

_____Email Message

_____Telephone Message

_____None

Above It All Counseling Group, LLC

FINANCIAL POLICY

If you are not insured, payment in full is expected at time of service. Our services are charged as follows:

- **Comprehensive Clinical Assessment / Diagnostic Interview - $150.00**
- **Individual Therapy (45-60 minutes) - $110.00**
- **Family Therapy - $125.00 per hour**
- **Couples / Marital Therapy - $125.00 per hour**

First Appointment: Please arrive for your initial appointment 15 minutes early so that all paperwork may be completed before you see the clinician. Please bring your current insurance card with you EACH VISIT. On follow-up visits, you will be asked to verify demographic/insurance information so that our records remain up-to-date. Please be prepared to pay for the current visit as well as any past balances on your account. Payment for services will be required at the time of service. For your convenience, we accept CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS, AND DEBIT.

Insurance Claims: We can provide you with a receipt for clinical services rendered that you may submit to your insurance company for reimbursement.

Collections: Accounts will be sent to collections after 90 days if not paid as agreed. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, our practice has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require our practice, as allowed by law, to disclose confidential information about you. You agree that if we must collect on your account that you will be responsible for the costs of collection, including attorneys' fees. In most collection situations, the only information our practice would release regarding a client's treatment is his/her name, the type of services provided, and the amount due [If such legal action is necessary, these costs will be included in the claim].

An administrative fee of **$42** will be applied for **all returned checks with insufficient funds.**

Missed Appointments and Late Cancellations: Please be mindful that your appointment time is reserved **exclusively** for you and be considerate of others – if you miss your appointment or cancel at the last minute, we will be unable to provide care for another client in your place, and have no way of recovering lost revenue due to "no-shows" or last-minute cancellations.

Above It All Counseling Group charges a *$20 administrative fee for missed appointments or appointments cancelled / rescheduled with less than 24 hours advance notice (*Note: excludes the case of emergency situations). This fee is non-refundable and is **not** covered by your insurance or EAP.

REVIEW OF PSYCHOLOGICAL / MEDICAL FORMS; DISABILITY CLAIMS, FORMS, REPORTS, & LETTER COMPLETION (COMPLETED OUTSIDE OF APPOINTMENT TIMES): $40 - $100 BASED ON NUMBER of pages / LENGTH OF TIME REQUIRED TO COMPLETE
TELEPHONE CONSULT / AFTER-HOURS CONSULT WITH CLINICIAN - $30 (PER 15 MINUTES OR PORTION THEREOF)
E-MAIL CONSULT WITH CLINICIAN - $40 PER ISSUE / E-MAIL
COURT APPEARANCE / COURT TESTIMONY - $150 / Hour

I understand that I am financially responsible for all payments and missed appointments, or appointments cancelled without 24-hour notice. I confirm that information I provided is accurate and complete, to the best of my knowledge.

I understand that I am responsible for payment before services are rendered; I will be financially responsible for payment in full. I am also responsible for informing Above It All Counseling Group, LLC of any changes in my address, phone number, and emergency contact information.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I have had the opportunity to discuss the above and acknowledge that I have read and fully understand and agree with the terms, policies, and conditions outlined in Above It All Counseling Group, LLC consent forms. I hereby acknowledge that any questions I may have had were answered.

X (Client / Parent / Guardian Name – **PLEASE PRINT** Date

X (Client / Parent / Guardian Signature) Date

Above It All Counseling Group, LLC
Standard Authorization Mental Health Treatment

I, _____[Name of Patient/Client], whose Date of Birth is_____ ,
Authorize Above It All Counseling Group, LLC to disclose to and/or obtain from: _____

_____

the following protected health information (as that term is used in HIPAA) [Insert Name of Primary Care Physician, Psychiatrist, Practice, or Organization]:

Description of Information to be Disclosed (Client should check each item to be disclosed)

_____ **Description of Care / Services Provided, Fees, & Charges Owed, & Other Information as is necessary to submit a claim to my insurer(s) and be paid**
_____ **Client initials to indicate agreement for All information checked**

	Assessment		Verbal Communication		Progress in Treatment		Discharge Summary
	Diagnosis		Medication Management Info		Treatment Plan or Summary		Other
	Current Treatment Update		Participation in Treatment		Demographic Information		Other

Purpose The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. IT IS NOT THE PURPOSE OF THIS AUTHORIZATION TO AUTHORIZE THE RELEASE OF PSYCHOTHERAPY NOTES, AS DEFINED BY HIPAA. IF I WISH OR HAVE A NEED TO AUTHORIZE THE RELEASE OF PSYCHOTHERAPY NOTES, I WILL EXECUTE A SEPARATE AUTHORIZATION AUTHORIZING THE SAME. If the purpose is other than marketing, sale of information, research or as specified above, please specify:

Research: If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Above It All Counsesling. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires on (i) 180 days following last treatment, or (ii) as otherwise indicated the following date:

Conditions: I further understand that Above It All Counseling Group, LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. I will be given a copy of this authorization for my records, and acknowledge receiving a copy.

X (Client / Parent / Guardian Signature) Date

X (Signature of Personal Representative – **if applicable**) Date

** If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*_____

X (Signature of Staff Witness) Date