**INFORMED CONSENT**

Thank you for choosing New Transitions Counseling. Today’s appointment with Steve Robinson, MA, LPCC will take approximately 45 – 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Steve has earned a Bachelor’s Degree in Psychology from the University of Maryland, UC and a Master’s Degree in counseling from Heidelberg University. He is licensed by the State of Ohio as a Licensed Professional Clinical Counselor. He has over 10 years of clinical experience in treating adolescents, adults, and couples using individual and couples’ therapy. Steve practices standard cognitive-behavior therapy, Reality therapy, and solution focused therapy for most conditions; although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: shared with our, a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, mental/verbal or sexual abuse; then, by Ohio State Law, I am obligated to report this to the Department of Children and Family Services, as well as the abuse of an elder or a disabled individual and animal abuse/neglect to the Humane Society c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself (suicidal or self-harm) or others (homicidal thought or plans), e) information necessary for case supervision or consultation and f) or when required by law/subpoenaed by court.

If an emergency for which the client or their guardian feels immediate attention is necessary and I am unable to return your call, the client or guardian understands that they are to contact their localemergency room in the community (911 or call/text (988) for those services. Also contact pre-selected family members or reliable friends to assist you with your situation, including your mental state and transportation. Steve Robinson, MA, LPCC will follow those emergency services with standard counseling and support to the client or the client's family.

**Signature(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_**

**FINANCIAL/INSURANCE ISSUES:**

As a courtesy, we will bill your insurance company, HMO, responsible party or third-party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $150.00 after insurance payments, we have the option to interrupt services until payment is made. I understand if I have an unpaid balance with New Transitions Counseling and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred in collecting my account, and possibly including reasonable attorney fees if so, incurred during collection efforts.

In order New Transitions Counseling or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that New Transitions Counseling and the designated external collection agency are authorized to (I) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Our hourly fees are $100.00 per every **50-**minute clinical hour. Our diagnostic assessment is $120.00. We also charge for other professional services based on your needs. These services will be billed in 15 increments based on the $100.00 hourly rate. These include telephone calls, phone calls to educational settings, letter writing to authorized contacts, FMLA paperwork, assessment testing and results, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify. Because of the extra time involved, we will charge $150.00 per hour for preparation and attendance at any legal proceeding. This payment is required in advance of the hearing based on an approximate time of need. (Example 3 hours would equal $450.00 in advance.) Any time not spent will be reimbursed back to the paying client.

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed a $75.00 no show/no cancel fee. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested.

**Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_**

**COORDINATION OF TREATMENT:** It is important that all health care providers work together. Many insurance companies require this cooperation for continuity of care and payment reimbursement.

**Social Media:** The American Counseling Association (ACA) advises therapists and their clients to avoid social connectedness with any platform of social media on personal pages. This includes but is not limited to Facebook, X, Instagram, Tik Tok, Snapchat and any other sites. If clients ask me to conduct such searches or review their websites or profiles and it is deemed helpful, I will consider it on a case-by-case basis and only after discussing possible impacts to our professional relationship and your privacy.

Friending: I do not accept friend or contact requests from current or former clients on any social networking sites.

**Inclement Weather and Cancellations**: In the event of a weather emergency, New Transitions Counseling Facebook page will be used to announce closures and cancellations. An attempt at phone calls informing you of these closures will be made.

**Benefits and Risks:** As with any intervention, there are both benefits and risks. Under professional discretion, all reasonable care and consideration will be taken to guard the client and this professional relationship from harm and danger. Understand that this process will require hard work on the part of the client and therapist; there are no “quick fixes,” miracle cures, or guarantees of desired resolution. The clients may experience what seems to be a worsening of circumstances, as self-exploration and changes occur. The client is always encouraged to address these concerns as we move toward restoration and healthy adaptive functioning. Psychotherapy often leads to a significant reduction in feelings of distress, increased satisfaction in personal relationships, greater personal awareness and insights, increasing skills for stress management, and resolutions to specific problems. Everyone is unique and there are no guarantees of outcome.

Therapy is voluntary for the client, with freedom to continue, alter, or discontinue services at any time. I recommend that clients commit to a minimum of six sessions. If at any point I feel that the client would be better serviced by a specialized referral service, I will discuss this with the client and provide supportive care in the transition to these treatments.

**Consent to Treatment:** Your signature below indicates you have read all the information in our intake packet and agree to treatment by our agency and to abide by our policies during our professional relationship.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:**

Any information that is relayed to me by a minor within the counseling setting may be disclosed to parents/guardians if, in my professional judgment, it is appropriate or necessary. While parents or guardians have a legal right to know what treatment modalities are being utilized and what charges are incurred during the course of therapy with their child, it is not conducive to the therapeutic relationship, or in the child’s best interest, to disclose all information that the child may share in confidence.

I/We consent to treatment at New Transitions Counseling. At times, it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children. **It is mandatory for treatment of** **children that we have proof of custody even if shared parenting is ordered**. Failure to provide legal documents may result in the rescheduling of your appointment.

**Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Registration Form
Patient Demographic Information

|  |  |
| --- | --- |
| **Patient Name:** | **Social Security #:** |
| **Street Address:** | **Date of Birth:** |
| **City, State, Zip Code:** | **Home Phone:** |
| **Gender:** | **Work Phone:** |
| **Email Address:** | **Mobile Phone:** |
| **Primary Physician:** | **Psychiatrist (if any):** |
| **Emergency Contact Person:** | **Emergency Contact Phone:** |
| **How did you hear about us?** | **Marital Status:** |

**Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)**

|  |  |
| --- | --- |
| **Responsible Party:** | **Home Phone:** |
| **Street Address:**  | **Work Phone:** |
| **City, State, Zip Code:** | **Mobile Phone:** |
| **Relationship to Patient:** | **Responsible Party SSN:** |

**INSURANCE INFORMATION**

(Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PAIENTS IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

**PRIMARY INSURANCE:**

\*Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Insured’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured SS No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE:**

Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Insured’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured SS No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*REQUIRED FIELDS -PLEASE COMPLETE FOR BILLING

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Questionnaire**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_

**Current medications:**
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Medical history:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Why are you seeking counseling?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do any immediate family members have a history of alcohol or drug abuse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, do you understand the need to stop using all tobacco products immediately? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or any family member have a history of gambling, playing lottery, scratch offs, etc.? If so, list the addiction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, how often and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you using any form of illegal drugs? \_\_\_\_\_\_\_\_\_ If yes, which drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been convicted of any type of drug or alcohol related crime within the past 10 years? \_\_\_\_\_\_\_\_
If yes, what was the charge and punishment (sentence) passed down? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you understand that providing non-functional or unreachable phone numbers &/or addresses will in all likelihood result in treatment discontinuation at this facility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it your statement that you have answered all questions in a truthful and honorable manner? \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature** **Date**

CLIENT RESPONSIBILITIES

No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $75 if I fail to give at least 24-hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of $75 if I fail to show for my appointment.

3. I understand that if these charges are an out-of-pocket expense, and that my insurance carrier will not cover these charges, that I am fully responsible for paying the cost of these out of pocket expenses.

4. I understand that the therapy session will last 50 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I agree to the above stated terms and stipulations regarding the services I receive from this therapist.

5. I understand if my balance is $150 or more, my therapist has the option to discontinue services until my balance is under the allowable amount of $150.

6. I understand it is **my responsibility (or the parent/guardian for a child client)** to schedule all appointments. This is not limited to but includes cancellations, no shows and if you have been referred to another clinician. No exceptions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

CLIENT RIGHTS

**Right to request how we contact you**

It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

**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. To request access to your billing or health information, contact the office manager. Under limited circumstances 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 circumstances, 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. To receive information regarding disclosures made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

**Right to request restrictions on use 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 233 N. Michigan Ave Suite 240 Chicago Ill 60601 PH 312-886-2359. An individual will not be retaliated against for filing such a complaint.

**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 Kim Boyer.

**Initials**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.**

**Effective date: April 14, 2003**

New Transitions Counseling has been and will always be totally committed to maintaining client’s 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 allow 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. Information maybe used for certification, compliance and licensing activities.

**Other uses or disclosures of your information which does 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 and/or your child or children report about physical or sexual abuse: then by Ohio State Law, we are obligated to report this to the Department of Children and Family Services; if you provide 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 and finally 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.

**Initials**: \_\_\_\_\_\_\_\_\_\_\_

**NEW TRANSITONS COUNSELING**

**TELEHEALTH TREATMENT CONSENT**

**Information and Informed Consent for Telemental Health Treatment**

Telemental health is live two-way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

**Client Understanding**

I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telemental health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.

I understand that telemental health is performed over a secure communication system that is almost impossible for anyone to access. I understand that any internet-based communication in not 100% guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interceptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/or my emergency contact.

I understand that this form is signed in addition to the **Notice of Privacy Practices** and **Consent to Treatment** and that all office **policies and procedures** apply to telemental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead if time for re-contact.

I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

I understand my therapist will advise me about what telemental health platform to use and they will establish a video conference session.

**Client Consent**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ] I hereby give my informed consent for the use of telemental health in my care.**

**[ ] I DECLINE telehealth services.**