McCameyCounseling

Informed Consent & Statement of Understanding

CLIENT INFORMATION:

Name: _____DOB: _____
Address: _____ City:_____
State: _____ Zip: _____ Home phone: _____ Cell Phone: _____
SS# _____ Email: _____
Place of Employment: _____ Driver's License # _____
Job Title: _____ Business Phone # _____
Name of Spouse/Partner (guardian of child): _____ D.O.B_____
Place of Employment: _____ Job Title: _____
In case of emergency, whom should we contact? _____
Phone #: _____ Relationship to client? _____
Party responsible for payment of services: _____
Referred by: _____
I want to receive appointment reminder text messages/emails but am aware they will be unencrypted:
Yes_____ No_____ Texts only_____ Emails only_____

At McCamey Counseling, *we are considered an "out-of-network provider" for insurance plans. This means that we collect payment from you directly at the time of your appointment. Following your appointment, we can provide you with a form called a "Superbill" that you can then use to collect your benefits from your insurance company. We can discuss the benefits of seeing an out-of-network provider at the time of your initial appointment, as well as how confidentiality is affected by billing to an out-of-network provider versus not reporting or collecting from your insurance company.*

CLIENT'S PRIMARY CARE PHYSICIAN:

Name: _____ Physician Phone # _____

Confidentiality: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law. You have the right to confidential mental health care *except* in cases where the therapist believes you might cause harm to yourself, to someone else, or if abuse or neglect of a child, elderly person, or disabled person is suspected. In these cases, the therapist has a duty by law to file a report with the appropriate authorities. Also, therapists are required to testify when commanded to do so by a court ordered subpoena. If you run into me, your therapist, outside of the office, I will not acknowledge you. I do this to ensure your right to confidentiality. However, if you want to greet, visit with, or introduce me to your friends or family as a friend or your therapist, that is up to you. I want you, the client, to take the lead in these situations.

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Initials

Dual Relationships: I will avoid a therapeutic relationship with a personal friend, education or business associate and will avoid the development of a personal, education or business relationship with a therapy client. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking websites.

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Initials

Emergencies: Medical and/or psychiatric emergencies should be directed to 911 if life or safety is threatened. I will return your call as soon as possible during regular working hours and no later than the next working day. After hours and on the weekend, please leave a message and I will get back to you the next business day. If I cannot be reached and this is a life-threatening emergency, please go to the nearest ER; do not wait for me to return your call.

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Initials

Telephone / Internet Counseling: Whether in crisis or not, a client may occasionally want to discuss an issue on the phone or by email. For this service there is a minimum $35.00 fee, which includes up to 15 minutes of Internet or telephone conversation. If it goes beyond that period of time, the client will be billed at a rate of $35.00 per 15-minute increments in addition. Lengthy e-mails (read / responded) will be charged a minimum fee of $35.00. Please do not assume that any e-mail sent will be read immediately as there are times I am not available to check my e-mail. Health insurance companies do not reimburse for this type of contact; therefore, the client will be personally responsible for the fee.

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Initials

Scheduling of Appointments: Please conscientiously keep all scheduled appointments. If it is necessary to cancel an appointment, you must give at least 24 hours notice. Monday appointments must be cancelled before noon on the preceding Friday. **You will be charged $125 for missed appointments or appointments canceled without 24 hours advanced notice.** If you miss an appointment and do not contact the office about the reason, your next appointment is automatically cancelled. ***If you arrive late for your appointment, your session cannot be extended into the next client's time.*** This policy is designed to respect the time management and scheduling for all other clients and therapists impacted within the office.

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Initials

FYI about Health Insurance & Confidentiality of Records: There may be a chance that services will be a reimbursable medical expense under your insurance company's "out of network" coverage policy. If you wish to seek reimbursement from your insurance coverage for services, I will provide you with a receipt detailing information the insurance company requires for reimbursement. Please consider what the ramifications of submitting such a claim to your insurance company might be. In order for your therapy to be considered a covered medical expense, your therapist (or "provider" in insurance parlance) must give you a mental illness diagnosis according to the DSM (Diagnostic and Statistical Manual of Mental Disorders). When this information is submitted to your insurance company, it becomes part of your permanent medical record. Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Your therapist has no control over, or knowledge of, what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access. Medical data have been reported to be legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position. Take this into consideration when deciding to use your health insurance to help pay for services.

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Fee Policy for Services: I provide individual, couples and family therapy for the fee of $125 per session. Group therapy is $50 per session (this is not family therapy). I charge $125 per hour for reports, letters, and other documentation. Any services I provide beyond your therapy session are charged to you directly at my hourly rate of $125 (charged in 15-minute increments). Court preparation and appearances begin at $300 per hour. Fees for other services provided upon request. All fees are due and will be collected at the time of your appointment. Any returned checks are subject to a $40 charge. Should your account be referred for collections, you agree to pay 6% interest plus a *$25* collection fee and reasonable attorney fees and/or court costs. If legal action becomes necessary, the cost of bringing the procedure will be included in the claim. If a client wants me to speak, meet, or correspond in any way with any other person to include but not limited to an attorney, probation officer, CPS worker, physician, etc., the client will be billed for the therapist's time. **Payment is due at the beginning of your session. You may pay by cash, check or credit card.**

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Initials

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of client records be requested unless otherwise agreed upon.

Should I be subpoenaed to testify in court regarding an issue with a client, this will necessitate that I clear my schedule to be "on call" for the court appearance. The charge for this is a minimum nonrefundable fee of $1200, payable in advance, regardless of whether I actually testify or appear in court. The first $1200 applies to a maximum of four hours of my time at an out-of-office courtroom rate of $300 per hour. Expenses I may incur such as parking, travel time, telephone calls, and time spent preparing documents will be charged at an appropriate rate and are in addition to the $1200 minimum fee. If I am required to be on call beyond the first four hours for a court appearance, an additional $1200 minimum fee will be incurred, even if I must remain (on call) one minute, one hour, or all four hours beyond the first four. In other words, a $1200 minimum fee will be charged for any portion of a four-hour time slot in which I am required to be "on call" to testify in court, whether I actually testifying or not. The client is responsible for these fees, not the court. Therefore, the client (or parents of a minor client) will be billed in advance.

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Initials

Other documents to review, complete, and sign prior to first appointment:

Cancellation Policy

Credit Card Authorization

HIPAA Notice

AUTHORIZATION AND RELEASE:

I have read the above Statement of Understanding & Informed Consent carefully; I understand and agree to comply. I fully understand that I am financially responsible for all charges whether or not paid by the insurance company. By signing this form, I agree that I have read and understand these policies, give full consent for the completion of evaluation and provision of treatment as necessary, by the above named therapist, until otherwise notified. I also agree that I am financially responsible for any fees that are accrued for me or members of my family, including dependents who may or may not be over the age of 18, while under the care of my therapist. I further acknowledge that I have received notice of HIPAA policies.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS.

_____ _____

Patient/Guardian Signature Date

_____ _____

R. Mason McCamey, MS, LPC Date
McCamey Counseling

McCameyCounseling

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 INFORMATION.

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health information and how we may disclose your health information.

- Treatment means providing, coordinating, or managing health and related services by one or more healthcare providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit.
- Health Care Operations includes business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request.

- The right to inspect and copy your information;
- The right to request corrections to your information;
- The right to request that your information be restricted;
- The right to request confidential communications;
- The right to report of disclosures of your information; and
- The right to a paper copy of this notice.

This notice is effective as of June 1, 2016, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about the violations of the provisions of this notice and procedures of our office. We will not retaliate against you for filing a complaint. I acknowledge receipt of this notice:

Client Name: _____

Guardian Name (if different from client): _____

Client/Guardian Signature: _____ Date: _____

Credit Card Authorization

FORM MUST BE COMPLETED OR A $35 DEPOSIT IS REQUIRED WITH EACH VISIT

McCamey Counseling requires a credit card to guarantee payment of any outstanding balances. This will greatly improve office efficiency in that I will no longer have to generate and mail a bill, and you will no longer have to write and mail a check. A similar payment method is used to check into a hotel or to rent a car. A copy of the charge will be emailed to you. This will not compromise your ability to dispute a charge and any concerns should be addressed with your therapist as soon as possible. You may pay by check or cash at the time of your appointment and your credit card will not be charged.

I authorize Mason McCamey, MS, LPC/McCamey Counseling to charge outstanding balances on my account to the following credit card:

Type of Card	VISA MASTERCARD AMERICAN EXPRESS DISCOVER		
Card Number	__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __		**Exp:** __ __ / __ __ __ __
Security Code	__ __ __ __	**Billing Zip Code**	__ __ __ __ __

Name on Card	
Receipt Email	

FORM MUST BE COMPLETED OR A $35.00 DEPOSIT IS REQUIRED WITH EACH VISIT

WHEN PAYING BY CHECK: When you provide a check as payment, you authorize Mason McCamey, MS, LPC/McCamey Counseling to use the information from your check to withdraw the amount from your account or to process the payment as a check transaction. Information from your check will be made to withdraw funds from your account as soon as the same day you make payment.

Understand that in the event that your check payment is returned for insufficient funds, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. By using your check, you acknowledge and accept this policy and its terms and conditions of check exchange.

Signature: _____ Email: _____

McCameyCounseling

Declaration of Agreement

Regarding Missed or Cancelled Appointments
Without 24-Hour's Notice

Though it is generally alright to cancel via a text message or email, phone calls are preferred. If you do email or text, unless you receive confirmation of receipt of the message, the session has not been officially cancelled.

I understand and agree to the following:

It is my responsibility to notify my therapist at **214.906.4422** at least 24 hours prior to the scheduled appointment, if I am unable to keep that appointment.

In the event I do not inform the office of the cancellation, I agree to pay a **$125 missed appointment fee**, which is the same as the standard appointment charge.

If I am more than 15 minutes late for my appointment, this is considered a **missed appointment without notice** due to the fact your appointment cannot go over into the next client's time. This will also result in a **$125 missed appointment fee**.

Client/Guardian Name:

_____

Client/Guardian Signature:

_____

Provider: R. Mason McCamey, MS, LPC

Date: _____