Updated
05/10/2019

Inspirit Counseling

Client-Counselor Service Agreement

Welcome to Inspirit Counseling. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. These rights and responsibilities are described in the following sections.

Goals of Counseling

There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the relationships you have with your loved ones along with establishing a reliable support system. Others may be more immediate goals such as decreasing anxiety and depression symptoms, establishing helpful coping skills in stressful situations, developing healthy relationship or changing behavior. Whatever the goals for counseling, they will be established according to your needs and motivation to achieve them. The counselor may make suggestions on how to reach that goal but you decide where you want to go.

Risks/Benefits of Counseling

Counseling is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be the most successful, you will have to work on things we discuss outside of sessions.

However, there are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

Appointments

Appointments will ordinarily be 50-60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide us with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you may be required to pay for the session [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible the cancelation fee. In addition, you are responsible for

coming to your session on time; if you are late, your appointment will still need to end on time.

Confidentiality

We will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. Your counselor may consult with a supervisor or other professional counselor in order to give you the best service. During this time, your name or other identifying factors will be withheld to protect your confidentiality. Counselors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If we receive a court order or subpoena, we may be required to release some information. If you place your mental status at issue in litigation initiated by you, the defendant, may have the right to obtain the psychotherapy records and/ or testimony. In couple or family therapy or when different family members are seen individuals, confidentiality and privilege do not apply between the couple or among family members, we will use clinical judgment when revealing such information. We will not release records to any outside partly unless it is authorized by all adult family members who are part of the treatment. 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. Most of the provisions explain when the law requires disclosure were described to you in the notice of Privacy Practices that you will receive within this packet.

When disclosure is required by law are where there is a reasonable suspicion of child, dependent or elder, abuse or neglect ; and where a client presents a danger self, to other, to property or is gravely disabled (form more details see also Notice of Privacy Practices form)

Confidentiality and Group Therapy

The nature of group counseling makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that we cannot guarantee that other group members will maintain your confidentiality. However, we will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. We also have the right to remove any group member from the group should it be discovered that a group member has violated the confidentiality rule.

Confidentiality and Technology

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via Skype, telephone, email, text or chat. Due to the nature of online counseling, there is always the possibility that unauthorized persons may attempt to discover your personal information. I will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in counseling sessions. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology used in your counseling sessions.

Record Keeping

We will keep records of your counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to

confidentiality discussed in the Confidentiality section. Should you wish to have your records released, you will be required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically or in a paper file and stored in a locked cabinet in the office.

Professional Fees

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash or credit card. Please keep in mind if we have a returned check, that it is an additional fee of $30.00. You will be provided with a monthly statement. If, after 30 days no contact or payment is made you will be mailed a past due letter. On the event after 30 days, there is still no contact or payment made, your account will be sent to a collection agency to secure payment. Counselor reserves the right to discontinue treatment on past due accounts.

If you anticipate becoming involved in a court case, it is recommend that we discuss this fully before you waive your right to confidentiality. If your case requires our participation, you will be expected to pay for the professional time required.

Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate unless indicated and agreed otherwise.

Fees are subject to change at counselor's discretion.

Fee Schedule

90791 psychiatric diagnostic evaluation (Intake) – $200.00
90834 psychotherapy 45 minutes – $135.00
90837 psychotherapy clinical hour (50-60 minutes) – $165.00
90847/90846 family psychotherapy with/without patient present– $150.00
90839- emergency session - $165.00
90887- consultation fee - $60.00
Therapist fee or legal proceedings, etc.- $165.00 per/hour
Cancellation fee- Subject to therapist's discretion.

Please note: Nebraska law states that the custodial parent has ultimate financial responsibility for payment, regardless of the divorce decree. The custodial parent, not this office, is responsible for settling any financial issues with the noncustodial parent.

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting us know if/when your coverage changes.

Please note that there are differing rates that are charged to your insurance company based on our network status with that insurance company. This can change the cost of your co-pay/ coinsurance depending on your individual premium. It is your responsibility to be aware of your own individual premium and coverage regarding mental health services.

You should also be aware that most insurance companies require you to authorize Inspirit Counseling to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information which will become part of the insurance company files. By signing this Agreement, you agree that we can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover counseling fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee to be covered by the patient. Either amount is to be paid at the time of

the visit by check, cash or credit card. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services.

Clients who carry insurance should remember that professional services rendered can be charged directly to the clients and are not required to submit to insurance companies. At this time we are submitting charges to insurance companies on your behalf for your convenience. Your insurance company will send you an EOB (explanation of benefits). If this arrangement is not satisfactory to either party, you will be provided a statement copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose.

If we are not a participating provider for your insurance plan, you will be supplied with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, we will refer you to a colleague.

Legal

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 should be noted that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries lawsuits, etc.) that records can be requested and used in the court proceedings. Please be sure to discuss this with your therapist in the event that you anticipate that our records will be subpoenaed to court. Please be aware that that you will be responsible for any fees or therapists' time out of the office to attend court.

Emergencies

Should you find yourself in the need of immediate care between sessions, the office number 308-430-1944 is available Monday- Friday 8am- 5pm. If you are feeling unsafe and if it is after hours or if you are unable to get through to a provider on that number please utilize the Local Crisis Response Team by dialing 911 or by going to your local emergency room.

Termination

As set forth above after the first couple sessions we will assess if our services will be of benefit to you. We do not accept clients who, in our opinion we cannot help, in such cases we will give you a number of referrals that you can contact. If at any point during psychotherapy, we find that we are not effective in helping you reach you therapeutic goals, we would be obliged to give you a number of referrals that may assist you. If you request it and authorize it in writing, your goals and progress will be discussed with another psychotherapist that may better assist you in reaching your goals. If at any time during treatment if you wish therapist to consult with another therapist regarding your treatment, therapist will comply after the proper releases have been signed. You have the right to terminate treatment at any time. If you do this, therapist will provide you with referrals if needed.

Dual Relationships

Dual relationship is a situation where multiple roles exist between a therapist, or other mental health practitioner, and a client. In our small communities, these cannot be avoided. A professional therapeutic relationship never involves sexual or any other dual relationship that impairs my objectivity, clinical judgment, or therapeutic effectiveness or that can be

exploitative in nature. Due to the small communities that we practice, you may bump into another person that you know in the waiting room or your therapist in the community. We will not acknowledge knowing or working therapeutically with you without your permission.

Minors

Inspirit Counseling provides services for minors. A minor in the state of Nebraska is any youth under the age of 19. Parents and/or guardians are responsible for having their children attend counseling at their scheduled time. No minor should attend counseling without a parent and/ or guardian present unless a plan of action is in place prior to treatment, however, parent and/ or guardian are still responsible for payment at time of service. Counselor reserves to right to discontinue treatment for unaccompanied youth.

Contact Information

We are often not immediately available by telephone. We do not answer the phone when we are with clients or otherwise unavailable. At these times, you may leave a message on the confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. Text messages and email are accepted but please be aware of the information you include in these messages as your confidentiality cannot be protected. By signing this agreement you were made aware that Inspirit Counseling cannot guarantee confidentiality if you choose to contact your provider via text or email message. If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital or call 911.

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.

*Protected Health Information (PHI)

PLEASE REVIEW IT CAREFULLY

05/10/2019

Privacy

Inspirit Counseling (IC) is required by state and federal law to maintain the privacy of your protected health information (PHI). PHI includes any identifiable information about your physical or mental health, the health care you receive, and the payment for your health care.

IC is required by law to provide you with this notice to tell you how it may use and disclose your PHI and to inform you of your privacy rights. IC must follow the privacy practices as set forth in its most current Notice of Privacy Practices.

This notice refers only to the use/disclosure of PHI. It does not change existing law, regulations and policies regarding informed consent for treatment.

Changes to this Notice

IC may change its privacy practices and the terms of this notice at any time. Changes will apply to PHI that IC already has as well as PHI that IC receives in the future. The most current privacy notice will be posted in IC facilities and programs and will be available on request. Every privacy notice will be dated.

How Does IC Use and Disclose PHI?

IC may use/disclose your PHI for treatment, payment and health care operations without your authorization. Otherwise, your written authorization is needed unless an exception listed in this notice applies.

Uses/Disclosures Relating to Treatment, Payment and Health Care Operations

The following examples describe some, but not all, of the uses/disclosures that are made for treatment, payment and health care operations.

For treatment - Consistent with its regulations and policies, IC may use/disclose PHI to doctors, nurses, service providers and other personnel (e.g., interpreters), who are involved in delivering your health care and related services. Your PHI will be used to help make a determination on your application for IC services, to assist in developing your treatment and/or service plan and to conduct periodic reviews and assessments. PHI may be shared with other health care professionals and providers to obtain prescriptions, lab work, consultations and other items needed for your care. PHI will be shared with IC service providers for the purposes of referring you for IC services and then for coordinating and providing the IC services you receive.

To obtain payment - Consistent with the restrictions set forth in its regulations and policies, IC may use/disclose your PHI to bill and collect payment for your health care services. IC may release portions of your PHI to the Medicaid or Medicare program or a third party payor to determine if they will make payment, to get prior approval and to support any claim or bill.

For health care operations - IC may use/disclose PHI to support activities such as program planning, management and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare), audits, training and credentialing of health care professionals, and certification and accreditation (e.g., The Joint Commission).

Appointment Reminders

IC may use PHI to remind you of an appointment or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses/Disclosures Requiring Authorization

IC is required to have a written authorization from you or your personal representative with the legal authority to make health care decisions on your behalf for uses/disclosures beyond treatment, payment and health care operations unless an exception listed below applies. You may cancel an authorization at any time, if you do so in writing. A cancellation will stop future uses/disclosures except to the extent IC has already acted based upon your authorization.

Exceptions

- For guardianship or commitment proceedings when IC is a party

- For judicial proceedings if certain criteria are met
- For protection of victims of abuse or neglect
- For research purposes, following strict internal review
- If you agree, verbally or otherwise, IC may disclose a limited amount of PHI for the following purposes:
    - **Clergy** – Your religious affiliation may be shared with clergy
    - **To Family and Friends** – IC may share information directly related to their involvement in your care, or payment for your care
- To correctional institutions, if you are an inmate
- For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities
- If required by law, or for law enforcement or national security
- To EOHHS and/or its agencies, such as MassHealth, DCF, DDS, DYS, DTA and DPH for functions including service delivery, eligibility and program management.
- To avoid a serious and imminent threat to public health or safety
- For public health activities such as tracking diseases and reporting vital statistics
- Upon death, to funeral directors and certain organ procurement organizations

Your Rights

You, or a personal representative with legal authority to make health care decisions on your behalf, have the right to:

- Request that IC use a specific address or telephone number to contact you. IC is not required to comply with your request.
- Obtain, upon request, a paper copy of this notice or any revision of this notice, even if you agreed to receive it electronically.
- *Inspect and copy PHI that may be used to make decisions about your care. Access to your records may be restricted in limited circumstances. If you are denied access, in certain circumstances, you may request that the denial be reviewed. Fees may be charged for copying and mailing.
- *Request additions or corrections to your PHI. IC is not required to comply with a request. If it does not comply with your request, you have certain rights.
- *Receive a list of individuals who received your PHI from IC (excluding disclosures that you authorized or approved, disclosures made for treatment, payment and healthcare operations and some required disclosures).
- *Ask that IC restrict how it uses or discloses your PHI. IC is not required to agree to a restriction.

*** These requests must be made in writing**

Record Retention

Your individual records relating to IC provided care and services will be retained at a minimum for 20 years from the date you are discharged from inpatient care and/or from the applicable community services. After that time, your records may be destroyed.

To Contact IC or to File a Complaint

If you want to obtain further information about DMH's privacy practices, or if you want to exercise your rights, or you feel your privacy rights have been violated, or you want to file a complaint, you may contact: DHHS 200 Independence Avenue S.W. Washington DC 20201.

You also may contact your therapist at their contact information given to you at the beginning of treatment

No one may retaliate against you for filing a complaint or for exercising your rights as described in this notice.

You also may file a complaint with the **Secretary of Health and Human Services**, Office for Civil Rights, U.S. Department of Health and Human Services, JFK Federal Building, Room 1875, Boston, MA. 02203.

Inspirit Counseling
308-430-1944
inspiritcounseling16.com

General information

Patient Name:_____Preferred Name:_____

Legal Guardian/Parent Name:_____

DOB:_____

Physical Address:_____City:_____State:_____ Zip:_____

Mailing Address:_____City:_____State:_____ Zip:_____

Cell (for text reminders):_____Alternative Phone_____

Email:_____Marital Status:_____

Birth Sex:_____Gender Identity:_____Sexual Orientation:_____

Race:_____ Languages:_____

Employment

☐ Full Time ☐ Full Time Student ☐ Part Time Student ☐ Unemployed

Primary Care Provider Release

Would you like to sign a release of information for us to consult with your Primary Care Provider?

☐ Yes ☐ No ☐ Not Applicable

Insurance

Insurance Name:_____ Insurance Primary ID Number:_____

Insured Name_____Insured Date of Birth:_____

Insured Address:_____ City:_____State:_____ Zip:_____

Insured Phone Number_____

Responsible Party for Billing

Name:_____Address:_____City:_____

State:_____ Zip:_____Phone_____Relationship to Patient_____

Emergency Contact:_____Emergency Contact Phone_____

Inspirit Counseling

Acknowledgement of Receipt of Informed Consent including Office Policies, HIPAA Notice of Privacy Practices General Information and Agreement for Psychotherapy Services

- I acknowledge that I have received a copy of the notice of office policies and general information for Inspirit Counseling. My signature below indicates that I agree to abide by those policies and that I consent to receive treatment services. You may request a copy of this agreement.
- I acknowledge that I have received a copy of the HIPAA notice regarding privacy practices for Inspirit Counseling.

_____
Patient Name (please print)

_____ _____
Signature of patient/parent/guardian Date

_____
Relationship to Patient

_____
Witness

Consent of Treatment

I_____consent to treatment for myself or my ward. If client is a minor, I further represent that I am the legal guardian of the client and possess full legal rights to give consent for medical treatment

_____ _____
Signature of patient/parent/guardian Date

_____
Signature of Witness

Inspirit Counseling

Billing and Fee Information

Fee information:

Behavioral health services are considered medical treatment and are covered by most insurance companies. Although we will submit claims to your insurance company on your behalf, any co-payments and fees not covered by your insurance are due at the time of your appointment.

Cancellation:

If you need to cancel or reschedule a session, we ask that you provide us with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you may be required to pay for the session [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible the cancellation fee.

Informed consent:

Our professional code of ethics and state laws require that personal information discussed with any therapist and information provided on paperwork must be kept confidential. Written case records are kept in locked files. This means that information may only be shared for professional purposed with your written consent and request. However, therapist is legally required to report the following situations

1. Medical emergencies that require information for the handling of the emergency for example names of medications, medical conditions, emergency contact person.
2. Potential harm, danger, or threat of death to one's self or another person. This situations requires that the police and or the intended victims be advised.
3. Disclosure of abuse or neglect of a child, elderly person or vulnerable adult
4. Records that are court ordered by a judge/court

Please refer to the HIPAA Notice provided to you for further details on the use of protected information.

Office billing and Insurance Policies

I understand that I am responsible for the full amount of my bill for services
I authorize use of this form or copy of this form on all my insurance submissions
I authorize the release of reciprocal information to my insurance company
I authorize direct payment from my insurance company to this service provider.

_____ _____

Signature of patient/parent/guardian Date

_____

Signature of Witness

Inspirit Counseling
Animal Assisted Therapy Consent
(This form is optional)

I_____ recognize that Inspirit Counseling utilizes animal assisted therapy in the form of a canine to assist in therapeutic interventions. I give Inspirit Counseling permission to have canine present during my or my ward's session as my counselor sees fit. I recognize that animals need to be treated in a certain way and will comply with therapist and/or canine when a break needs to be utilized.

_____ _____

Client Printed Name Date

_____

Signature of patient/parent/guardian

_____

Witness Signature

☐ Form declined

Inspirit Counseling
Essential Oils Release Form
(This form is optional)

I_____ understand that my therapist is recommending essential oils for my treatment as a supplemental approach to traditional therapy. I understand that there are no formal evidence based results that prove that essential oils are successful as they are not psychotropic medication. I also understand that essential oils are not covered by my insurance company and I agree to pay the cost of the oils out of pocket with the understanding that there are no returns or refund policy.

_____
Patient Printed Name

_____ _____
Signature of patient/parent/guardian Date

_____
Witness Signature

☐ Form Declined

Inspirit Counseling

Telehealth Consent Form

(this form is optional)

I, _____ (please print) agree to receive behavioral health services

through a HIPAA-compliant telehealth platform with Inspirit Counseling.

Telehealth services means that my session with the provider will happen through an internet connection utilizing special audiovisual software, where the provider and myself are in different locations.

I also understand that:

- I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away
- I may have to travel to see a particular health care provider in person if I decline the telehealth service
- The same confidentiality protections/limitations that apply to my other behavioral health care also apply to the telehealth service. Further, I can inquire about this at any time.
- I will have access to all behavioral health treatment information resulting from the telehealth service as provided by law and according to Inspirit Counseling policy
- The information from the telehealth service cannot be released to anyone else without my written consent
- I will be informed of all people who will be present at all sites during my telehealth service
- I may exclude anyone from any site during my telehealth service
- I may be informed that the telehealth service is not in my best interest, per the professional opinion of my provider, and be provided a minimum of three references for more appropriate care
- I may be asked by my provider to seek face-to-face services, to assist with my safety or the safety of others, under certain circumstances at the professional judgment of the provider.
- I will present myself in appropriate dress and refrain from engaging in socially inappropriate/illegal behaviors while having a session with the provider

I have read this document carefully, and my questions have been answered to my satisfaction. I am aware that I may ask for clarification of these items at any time.

_____ _____

Signature of Client/Guardian Date

_____ _____

Witness Date

☐ Form Declined