

Limitless Counseling Services (LCS) LLC  
2670 N. Columbus Street Suite G Lancaster, Ohio 43130  
Phone: (740) 901-1231 Fax: (740) 901-3021

**NOTICE  
CLIENT INFORMATION AND POLICY STATEMENT**

**NEW CLIENTS.** The following is important information about treatment, confidentiality, and office policy. It also contains summary information about the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). Please read it carefully and if you have any questions, your therapist will discuss them with you. HIPAA is a federal law that provides privacy protection and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. This Notice of this Agreement, which explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. You and your counselor can discuss any questions you have about these procedures in your first or second session. When you sign this document, It will represent an agreement between you, your counselor, and Limitless Counseling Services LLC. You may revoke this agreement in writing at any time. That revocation will be binding on us unless: we have taken action in reliance on it; if there are obligations imposed on us by your health insurer; in order to process or substantiate claims made under your policy or if you have not satisfied any financial obligations you have to us.

**CONFIDENTIALITY AND EXPECTATIONS TO CONFIDENTIALITY.** Federal and Ohio law require that issues discussed with a therapist be confidential. The information you reveal will not be discussed by the therapist with anyone, other than the exceptions listed below, without a signed authorization from you.

**LEGAL REQUIREMENTS.** The release of confidential materials may be legally required of your therapist in the following situations:

1. If your therapist believes you present a clear and substantial risk of harm to yourself (suicide) or others (homicide).
2. Suspected child or elder abuse or neglect.
3. Instances where the court subpoenas records.
4. If you file a complaint or lawsuit against your therapist or Limitless Counseling Services (LLC)

**42 CFR STATEMENT.** Staff shall not convey to a person outside of the program that a client receives services from Limitless Counseling Services LLC or disclose any information identifying a client as an alcohol or other drug services client unless the client consents in writing for the release of information, the disclosure is allowed by a court order, or the disclosure is made to a qualified personnel for a medical emergency, research, audit or program evaluation purposes. Federal laws and regulations do not protect any threat to commit a crime, any information about a crime committed by a client either at the program or against any person who works for the program. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or Local authorities.

**SUPERVISION.** If your therapist is under formal supervision, they will meet regularly for consultation and direction, and therefore, the supervisor will be familiar with you, your concerns, and the content of

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sessions. You can request a meeting with the supervisor at any time for any reason; including to discuss treatment and diagnosis issues.

**Your therapist/counselor does not require supervision.**

Your therapist/counselor \_\_\_\_\_ OH license # \_\_\_\_\_  
is supervised by \_\_\_\_\_ OH license # \_\_\_\_\_.

**STAFF.** Your therapist may at some time practice with other mental health/behavioral health/addiction professionals and administrative staff. Protected information may be shared with these individuals for clinical and administrative purposes, such as scheduling, billing, and quality assurance. Any staff who may come in contact with Protected Health Information (PHI) are bound by the same laws of confidentiality.

If you learn at any time during your therapy that information may be requested from your therapist by a third party, e.g. physicians, lawyers, schools, or other mental health/behavioral health/addiction professionals, you need to inform your therapist as soon as possible. In such cases, you can waive your privilege of confidentiality by signing an authorization form. If at any point the therapist believes it would be useful to confer with other professionals, you will be asked to grant permission and to sign an authorization form.

**APPOINTMENTS.** Usually are scheduled bi-weekly to monthly; weekly when possible for at-risk clients. Because ongoing therapy is a negotiated process between you and your therapist, you will not be automatically rescheduled. Both you and your therapist need to evaluate the progress of your therapy periodically to determine the need for further appointments. It is your right to discontinue treatment any time you feel it is in your best interest to do so. It is the therapists' ethical responsibility to end therapy when it is reasonably clear that you are not benefiting from treatment.

**CANCELATIONS.** If you find it necessary to cancel a scheduled appointment, a 24 hour notice is required. When less than a 24 hour notice is given, you may be responsible for a missed appointment fee. The minimum fee is \$25 and will not be covered by insurance. If you find you must cancel within 24 hours due to an unexpected circumstance your therapist can choose to waive the cancellation fee. If you fail to miss three (3) appointments without calling in advance to cancel within 24 hours you will be dismissed from the practice; in order to allow your therapist to meet the needs of all clients appropriately.

**EMERGENCIES AND AFTER HOUR CARE.** If known ahead of time, you must discuss any expectations you have for emergency treatment with your therapist and agree to develop and follow a written step-by-step plan. You should also be aware that you will be charged for after-hours care, whether on the phone or in person. If the need for crisis arises without warning, you may call and leave your therapist a voicemail message which is accessed daily. If your crisis needs immediate attention, please call 24 hour crisis line at **740-687-8255** or go to the nearest hospital emergency department.

It is assumed that our clients are self-responsible, autonomous, functioning individuals, or in care of functioning adults, and not in need of day to day supervision. As private practitioners, we cannot assume

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responsibility for client's day to day functioning as can institutions nor can we be available 24 hours a day for crisis care.

**PROTECTED HEALTH INFORMATION RECORDS.** You should be aware that, pursuant to HIPAA, your therapist will keep Protected Health Information (PHI) about you in two separate categories. One set constitutes your **medical record** and the other is the **therapist psychotherapy notes**.

**MEDICAL RECORD.** Includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that are set for treatment, your progress towards these goals, your medical and social history, psychological testing, your treatment history, and past records that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself or others, you may examine and/or receive a copy of your medical record if you request it in writing and the request is signed by you and dated no more than 60 days from the date of submission. If we refuse your request for access to your medical record, you have the right for review, which we will explain at that time. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. You will be assessed a copying fee of \$5.00 as well as postage fee if mailing is required.

**THERAPIST PSYCHOTHERAPY NOTES.** These notes are for the therapists own use and are designed to assist them in providing you with the best treatment possible. While the contents of psychotherapy notes vary for client to client, they can include the contents of conversations, analysis of those conversations, and their impact on your therapy. They also contain particularly sensitive information that you may reveal that is not required to be included in your medical record. These psychotherapy notes are kept separate from your medical record. While insurance companies can request and receive a copy of your medical record they cannot receive a copy of your psychotherapy notes, nor require your authorization to release them as a condition of coverage. Your insurance company cannot penalize you in any way for your refusal.

**PATIENT/CLIENT RIGHTS.** HIPAA provides you with several new or expanded rights with regard to your medical record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your medical record is disclosed to others; requesting an accounting of disclosures of PHI; determining the location to which protected information disclosures are sent; having any complaints you make about agency policies and procedures records in your records; and the right to a paper copy of the agreement and our privacy policies and procedures. Your therapist will be happy to discuss any of these rights with you. Your rights are as follows:

1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy.
2. The right to receive services in the least restrictive, feasible environment.
3. The right to be informed of one's own condition.
4. The right to be informed of available program services.
5. The right to give consent or to refuse any service, treatment or therapy.
6. The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it.

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7. The right or freedom from unnecessary or excessive medication, unnecessary physical restraint or seclusion.
8. The right to be informed and the right to refuse any unusual or hazardous treatment procedures.
9. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies or photographs
10. The right to consult with an independent treatment specialist or legal counsel at one's own expense.
11. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations.
12. The right to have access to one's own client record in accordance with program procedures.
13. The right to be informed of the reason(s) for terminating participation in a program.
14. The right to be informed of the reason(s) for denial of a service.
15. The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, sex, national origin, disability or HIV infection, whether asymptomatic or symptomatic, or AIDS.
16. The right to know the cost of services
17. The right to be informed of all client rights.
18. The right to exercise one's own rights without reprisal.
19. The right to file a grievance in accordance with program procedures.
20. The right to have oral and written instructions concerning the procedure for filing a grievance.

If you have any complaints about professional services from a counselor, social worker, and/or family therapist, please contact:

The State of Ohio Counselor, Social Worker, and  
Marriage and Family Therapist Board  
77 South High Street, 24th Floor  
Columbus, Ohio 43215  
Phone: (614) 446-0912  
[www.cswmft.ohio.com](http://www.cswmft.ohio.com)

Ohio Chemical Dependency Professionals Board  
Vern Riffe Center  
77 South High Street, 16<sup>th</sup> Floor  
Columbus, OH 43215  
Phone: (614) 387-1110  
[www.ocdp.ohio.gov](http://www.ocdp.ohio.gov)

**PAYMENTS.** Payment at each session is expected. As a general rule, health insurance pay a portion of fees submitted. Until we have written documentation from your insurance company that your insurance deductible is met, we ask that you pay full fee at each visit. After your deductible is met, we ask that you pay the amount that is not covered by your insurance (copay) at the time of each session. If necessary, special payment arrangements can be made with your therapist. Credit cards accepted are Master Card, Visa, and Discover. There will be a \$40.00 returned check fee for each returned payment. Return check fees must be resolved before any appointments can be arranged.

In cases of divorce and blended families, we look to the custodial/residential parent or adult to make payments regardless of any court ordered agreements. The custodial/residential parent or responsible party will need to get reimbursement from other responsible parties.

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Regarding billing statements, you are responsible for paying the “now due” amount on each statement. You will only be billed for your unpaid co-pay amounts, and any deductible your insurance reports you are responsible for. After sixty (60) days past due you will be billed a late fee of 10% of the amount due. An additional 10% will be assessed for each 30 days thereafter. After your last visit with your therapist, we expect you be current in having paid your co-payments, deductibles, and missed appointment fees. **For those required to complete mandated treatment, a letter of completion will not be submitted until all fees are paid in full.** After reasonable efforts to collect from you have been made, we reserve the right to turn your account over to a collection agency. This is a measure of last resort on our part and is made only when we think a client has not made a good faith effort to pay on their account.

### PRIVATE PAY

It may be to your advantage to not use your insurance benefits due to the following reasons:

- **Privacy:** If your insurance company should ask for your complete medical record we have no control over how this information is used and who has access to it. Therefore, we cannot guarantee confidentiality once your information is turned over to your insurance company.
- **Control:** You have complete control over all information about you, who has it and what is done with that information (except for standard confidentiality exceptions related to safety and legal subpoenas.)
- You receive no psychological diagnosis.
- You have control over the frequency of your session and how long you feel/believe that you need to be in therapy.

### INSURANCE

If you have health insurance, part of your therapy expenses may be covered. **You should contact your insurance company to obtain precertification or provide notification of services.** Your health insurance policy is a contract between you and your insurance company. When you call them please ask the following questions about your outpatient behavioral health care coverage:

1. Is your therapist a provider for your plan? If yes, how do I pre-certify visits? If no, how much does the policy pay for out-of-network visits?
2. How many visits are allowed per year?
3. What is the insurance company’s usual and customary fee?
4. What is my deductible and has any of it been met?
5. Do I have a co-payment amount per session?

It is important that you understand that any dispute with your insurance company is your responsibility. You should be also aware that your contract with your insurance company requires that we provide them any information relevant to the service provided to you. We are required to provide the clinical diagnosis. Sometimes we are required to provide additional information such as treatment plans or summaries, or copies of your entire medical record. This information will become part of the insurance companies files and will probably be stored in a computer. Though all insurance companies claim to keep such information as confidential, we have no control over what they do with your information. This agency will provide you

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with a copy of any report we submit if you request it. By signing this agreement, you agree that we can provide requested information to your carrier.

**FEES**

Description of Service	Fee
Initial Evaluation	\$145.00
Treatment in Lieu of Conviction Substance Abuse Evaluation	\$325.00
<b>Individuals</b>	
Individual session (60 minutes)	\$125.00
Individual session (45 minutes)	\$115.00
Individual session (30 minutes)	\$62.50
<b>Urinalysis</b>	
12 panel	20.00

Psychological testing is not currently available at Limitless Counseling Services LLC rather can be referred out to a provider as/if needed or upon request.

Those choosing to self-pay (without using insurance benefits) will pay \$90 at the time of each session.

**RECORDS CUSTODIAN** In the event of your therapist's absence, incapacitation, or death, a records custody has been identified as required by law. **4757-5-09(I)** This person would be responsible for maintaining the records for the required 7 years after the date of the last session and would be knowledgeable about the transfer and custody of records.

**SESSION ETIQUETTE** We make the best effort to begin and end each session on time, but you may need to wait in situations where the client before you needs additional time. Your patience is appreciated and you will be given the same professional priority. When you arrive, it is not necessary to sign in. Please have a seat in the waiting area and your therapist will come to meet you. If providing regular or random urinalysis is a part of your treatment plan, please wait to use the restroom in case this is requested. Additionally, if you are under the influence for your scheduled appointment, you may be rescheduled. If you are impaired to the point in which you could pose a danger to yourself or others if you were to operate a motor vehicle, we will help you in contacting your emergency contact or support person to provide transportation from our agency.

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**NOTICE  
CLIENT INFORMATION AND POLICY STATEMENT SIGNATURE PAGE**

\_\_\_\_\_ YES      \_\_\_\_\_ NO

I have received a copy of Limitless Counseling Services (LCS) LLC client information and policy statement including a summary of information from the Health Insurance Portability and Accountability Act (HIPAA).

\_\_\_\_\_ YES      \_\_\_\_\_ NO

I agree that Limitless Counseling Services (LCS) LLC can provide the requested information to my health insurance carrier.

In addition: I understand that I am solely responsible for all financial charges regardless of potential reimbursement by an insurance company, or any other third party. I agree to be treated by Limitless Counseling Services (LCS) LLC under terms of the Limitless Counseling Services (LCS) LLC Client Information and Policy Statement including the Health Insurance Portability and Accountability Act (HIPAA).

Client Printed Name: \_\_\_\_\_

Client/Responsible Party Signature: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

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**CONSENT FOR TREATMENT**

I hereby do give consent for Ann Kennedy LISW-S at Limitless Counseling Services (LCS) LLC permission to provide treatment services for a behavioral health and/or substance abuse condition. Though I expect the care given to meet the customary standards, I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees haven been made to as the result of such treatment and examination.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**PARENT/LEGAL GUARDIAN CONSENT FORM**

I give Ann Kennedy LISW-S at Limitless Counseling Services (LCS) LLC permission to treat my child/legal guardian to (name) \_\_\_\_\_ DOB \_\_\_\_\_.

Beginning on this date \_\_\_\_\_ and any following dates as needed.

If there is a court ordered custody document, I agree to provide a copy of this to the office immediately.  
\_\_\_\_\_ (initials)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_



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CLIENT INFORMATION SHEET

CLIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

AGE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

GENDER: \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_ TRANSGENDERED \_\_\_\_\_ OTHER: \_\_\_\_\_

PREFERRED PRONOUNS: \_\_\_\_\_ HE/HIM/HIS \_\_\_\_\_ SHE/HER/HERS \_\_\_\_\_ THEY/THEM/THEIR \_\_\_\_\_ OTHER  
(PLEASE DESCRIBE/DEFINE): \_\_\_\_\_

SEXUAL ORIENTATION: \_\_\_\_\_ HETEROSEXUAL \_\_\_\_\_ HOMOSEXUAL \_\_\_\_\_ BI-SEXUAL  
\_\_\_\_\_ OTHER: \_\_\_\_\_

RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_ PRIMARY LANGUAGE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS): \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

STATUS: \_\_\_\_\_ FULL-TIME \_\_\_\_\_ PART-TIME \_\_\_\_\_ STUDENT \_\_\_\_\_ RETIRED \_\_\_\_\_ DISABLED \_\_\_\_\_ HOMEMAKER  
\_\_\_\_\_ UNEMPLOYED \_\_\_\_\_ OTHER: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ REASON: \_\_\_\_\_

ANY CURRENT LEGAL OR PENDING CHARGES: \_\_\_\_\_ YES \_\_\_\_\_ NO IF YES, PLEASE EXPLAIN: \_\_\_\_\_

PRIMARY CARE PROVIDER (PCP) NAME: \_\_\_\_\_

PCP PHONE: \_\_\_\_\_

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**INSURANCE INFORMATION**

**PRIMARY**

INSURANCE COMPANY: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_  
PLAN #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
POLICY HOLDER NAME: \_\_\_\_\_ POLICY HOLDER DOB: \_\_\_\_\_  
POLICY HOLDER SSN: \_\_\_\_\_

**SECONDARY**

INSURANCE COMPANY: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_  
PLAN #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
POLICY HOLDER NAME: \_\_\_\_\_ POLICY HOLDER DOB: \_\_\_\_\_  
POLICY HOLDER SSN: \_\_\_\_\_

YOUR INSURANCE MAY REQUIRE PREAUTHORIZATION FOR SERVICES. HAVE YOU CALLED TO INQUIRE?  
\_\_\_ YES \_\_\_ NO AUTHORIZATION NUMBER: \_\_\_\_\_ # OF SESSIONS \_\_\_\_\_

IS YOUR THERAPIST A NETWORK PROVIDER? \_\_\_ YES \_\_\_ NO \_\_\_ I DON'T KNOW.

**MEDICATIONS/MEDICAL CONDITIONS**

NAME	STRENGTH/DOSE	FREQUENCY	REASON/MEDICAL CONDITION

**ALLERGIES**

Any allergies to food, medications, etc.? If so, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I agree that the information given above is accurate and true to the best of my knowledge. I understand that it is my responsibility to obtain the initial authorization from my insurance company. If I fail to do so, I understand that I would full fee for services. I also understand that it is my responsibility to notify Limitless Counseling Services (LCS) LLC immediately of any change in my behavioral health benefits. I have also read and understand the insurance section of the policy statement for Limitless Counseling Services (LCS) LLC.

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

Responsible Party (if different from client) Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_