Counseling Agreement & Consent to Treat

I have entered into this agreement because I am aware that the information from these sessions have a therapeutic, not legal, purpose and require an emotionally safe and confidential atmosphere to be present for optimal success in counseling. I will not use information from these sessions to cast a negative light on others involved in counseling with me. I understand that this agreement does not prohibit disclosure in the case of criminal offenses, including suspected child abuse or neglect or potential harm to myself or others.

I also understand that, in the case of couples and family counseling, secrets will not be kept by the therapist from members participating in the counseling, as it will undermine the success of counseling, and the therapist reserves the right to pass on information that furthers therapeutic goals.

I am aware that sessions are limited to 50 minutes, and will try to provide new disclosures and goals early in the session so that there may be satisfactory attention and resolution reasonable to the time that is available.

INFORMED CONSENT FOR TREATMENT

I, _____ acknowledge I have reviewed and understand my rights and responsibilities as a client in the therapeutic relationship. *I consent to participate in, or allow my child to participate in, counseling treatment provided by Laura Pryor LIMHP, LPC. *I understand the practice of counseling is not an exact science and that results cannot be guaranteed. I am aware I may stop treatment at any time. *I understand Laura Pryor LIMHP, LPC is not affiliated with Alternative Counseling and any grievances towards Laura Pryor should be brought directly to her attention. ***I understand I am financially responsible for all evaluation and treatment charges not covered by insurance. Charges may include insurance deductibles, co-insurance or out- of-pocket expenses, and late cancellation or no-show fees (see financial policy).** *I understand Laura Pryor meets with a group of mental health therapists to staff client concerns and gain feedback for the benefit of the clients Laura Pryor works with and for her professional development. The information discussed in the consultations remains confidential within the group and is not discussed in any other setting.

My signature below indicates I have read, understand and agree with the above statements.

_____

Responsible Party's Signature or Representative of Client Date

_____

Responsible Party's Relationship to Client (parent, power of attorney, healthcare surrogate, etc.)

Understanding Your Health Information and Your Rights

As part of your counseling here, a record will be made of each visit and any other important exchange of information on your behalf. This record may include your symptoms, diagnosis, treatment plan and other impressions. Your information is used by insurance companies to verify that the services billed for were actually provided. Although your health record belongs to the healthcare provider, you do have certain rights with regard to your health information. Those rights include the following:

• The right to expect that your information will be kept secure and used only for legitimate purposes.
• The right to understand how your information may be used and disclosed.
• The right to ask questions about any health privacy issue and get clear and prompt answers.
• A limited right to know who has seen your health information and for what purpose.
• A right to see, and to keep a copy of all your health records (except psychotherapy notes). Your request must be in writing and you may be charged a reasonable copying fee.
• A right to ask for correction or inclusion of a statement of disagreement for anything in your records that you feel is in error. Your request must be in writing and include supporting documentation.
• A right to authorize or refuse additional uses of your health information, such as for fundraising, marketing or research.
• A right to request extra protections for health information you consider especially sensitive, and to request that I communicate with you by alternative means.

My Responsibilities: I also have certain responsibilities. These include:

• Maintaining the privacy of your record.
• Providing you with a copy of this Notice.
• Abiding by the terms of this Notice.
• Notifying you if I am unable to agree to a requested amendment or restriction.
• Accommodating reasonable requests you may have to communicate health information by alternative means. If my information practices change, I may change this notice. If so, the change will be effective for information gathered both before and after the effective date of such change.

Disclosures for Treatment, Payment and Healthcare Operations: Your health information will not be used or disclosed without your authorization, except as described in this Notice. Your information may be used for treatment, payment and healthcare functions without your permission. However, if state law requires me to obtain written permission, I will do so. I will use or disclose your health information for treatment. For instance, I may provide your physician or other healthcare provider with copies of reports that may help in determining your future treatment or coordinate treatment. You information may also be disclosed for payment purposes. I will use or disclose your health information for payment. In order to bill your insurance company, your bill may contain information that identifies you, your diagnosis, procedures and dates and times of service. Your dates of services and charges may be disclosed for collection purposes as well. I will use or disclose your information for healthcare operations and internal business practices.

Other Disclosures That May Be Made Without Your Authorization: Family members, personal representatives or another person responsible for your care may be informed about your location and general condition and health information relevant to that person's involvement in your care or payment related to your care. Some services of my practice are provided through contractual arrangements with business associates, such as the front office staff, cleaning services, computer and accounting services. These business associates must use appropriate safeguards to protect your health information. In Worker's Compensation situations, I may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law. When required or permitted by law, I may disclose your health information to public health or legal authorities responsible for preventing or controlling disease, injury or disability or performing other public health functions. In addition, I may disclose your health information in order to avert a serious threat to health or safety. I may disclose your health information for military and veterans' activities, national security and intelligence activities and similar special governmental functions, as required or permitted by law. Some disclosures are required by law. These may include a valid subpoena, court order or other binding authority. Your health information may be disclosed to appropriate health oversight agencies, public health authority or attorney involved in health oversight activities. If you believe your privacy rights have been violated, you can file a complaint with me or with the Secretary of Health and Human Services. I will not retaliate against you for filing a complaint.

I acknowledge I have received a copy of this Privacy Notice: Signed _____ Date _____

Laura Pryor
mental health therapist

Financial Policy

This statement is to inform you of Laura Pryor's financial policy. I am committed to providing you with the highest quality mental health care. My financial policy is intended to facilitate excellent service to you, while minimizing administrative costs.

All charges incurred are your responsibility regardless of your insurance coverage. I must emphasize that as your provider, my relationship is with you, the client, not with your insurance company. As a courtesy to you, I will help you process all your insurance claims. In order for me to help, you must provide current and accurate insurance information.

Financial Agreement

I understand and agree:

- Laura Pryor performs services necessary for the well being of the clients regardless of insurance benefits.
- My co-pay, deductible, or self-pay fee is due at the time of service.
- If there is a remaining balance upon payment by the insurance company, I will pay it in full at that time.
- A **$25** fee will be added for any return or insufficient fund checks written to Laura Pryor.
- I am responsible for the payment of all treatment fees on my account. If my insurance company fails to pay within 90 days, I will be responsible for the full amount.
- **I require a 24-hour notice for cancellations.** When scheduling your appointment with me, keep in mind that this is your agreement that I will hold this time exclusively for you. Because this time is reserved by you, I will bill you **$100** for any appointments that are not kept (a no show) and **$55** for appointments canceled within 24 hours of your scheduled appointment time.
- Payment for late cancellation, fail to arrive charges, and return checks are due at the time of your next session.

I understand **insurance** fees are billed at contracted in/out-network rates:

- Initial Diagnostic Interview: $210
- 50 Minute Session: $180-$160

I understand insurance will not be billed/cover **cash** fees:

- 30 Minute Session: $90
- 50 Minute Session: $160
- Late Cancel: $55
- Fail to Arrive: $100

Signature _____Date:_____