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Office Policy Agreement & Consent for Treatment

As a Licensed Clinical Social Worker, I am governed by various laws and regulations and by the code of ethics of my profession. The ethics code requires that I make you aware of my specific office policies and procedures, how these policies and procedures may affect you, as well as your patient rights. I welcome any questions you may have about this document and will address them during your intake appointment. This document contains important information and serves as your informed consent for treatment. By signing this form, you are acknowledging your understanding, agreement, and consent to the terms and conditions of this Treatment Agreement.

SCHEDULING

All sessions are scheduled by appointment. They are generally 50 minutes long and occur on a weekly basis at an agreed upon, regularly scheduled time. Please arrive on time as you use up your own treatment time when you arrive late and sessions generally end on time to accommodate other clients who have scheduled appointments after you.

CANCELLATION POLICY

Consistency is an essential part of the counseling process. When you make an appointment, this time is reserved specifically for you and is not available to other clients. If you are unable to keep a scheduled appointment, you must notify me at least 24 hours in advance or you will be charged for the full fee amount of the canceled or missed appointment. For this reason, you are required to provide updated credit card information for me to keep securely on file. In the event that you do not provide 24 hours advance notice before canceling or not showing up for an appointment, I will charge your credit card on file for my regular session fee amount. Please be advised that most insurance companies do not reimburse for missed sessions. By signing this Treatment Agreement, you are agreeing to full payment of any canceled or missed sessions without 24 hours advance notice.

When 24 hours advanced notice has been given and if my schedule permits, you may be offered a make-up session prior to your next regularly scheduled

appointment. If a pattern emerges of you being frequently unable to keep weekly appointments, I will evaluate whether you are able to commit to therapy at this time and I reserve the option of suspending or discontinuing treatment with you. In the rare occurrence that an emergency situation forces me to cancel your scheduled appointment, I will make every effort to provide you with as much advance notice as possible and schedule permitting, to reschedule our session.

TELEPHONE AND EMAIL CONTACT

I may be contacted by phone (847-431-6639) and email (jessicadubinlcsw@gmail.com) with the understanding that email is intended for non-urgent and general purposes since complete confidentiality cannot be ensured by this means of communication. Please do not send text messages, unless otherwise agreed upon, as I do not respond to texting. Also, please be aware that any text message, email, or other written correspondence that I receive from you becomes a part of your clinical record. Due to the nature of my work, I am often not immediately available by phone or email. I monitor my voicemail and emails frequently and will make every effort to return your call or email within 24 hours. When I will be unavailable for an extended period of time such as during a scheduled vacation, I will offer you contact information for another therapist you may call if necessary.

In the event of an emergency, you may always call 911. You may also call me any time for an emergency. If I cannot respond as quickly as you need, please call or go to the nearest emergency room if you require immediate attention.

SOCIAL MEDIA POLICY

As policy, I will not accept friend and contact requests from current or former clients on any social networking sites such as Facebook, LinkedIn, etc. I will also not follow any current or past clients on any social media sites such as Twitter, Instagram, blogs, etc.. Connecting to clients on these sites can compromise confidentiality and also our therapeutic relationship. If I happen to notice that you are following me on Twitter, etc., I may bring this up during a session to discuss any impact that it may have on our therapeutic relationship.

FEES & BILLING

Full payment of the agreed upon fee-for-service is expected at the time of each scheduled appointment. I accept payment by cash, credit card or check. My fee is reevaluated annually and generally increases by a nominal amount. I will provide

you with notice of any increases in fees. If you are experiencing a true financial hardship, I will consider working together on a sliding-scale basis or try my best to refer you to a more suitable referral or therapy source.

INSURANCE REIMBURSEMENT

I am an in-network provider with BlueCross and BlueShield PPO of Illinois. If your preference is to pay out-of-pocket or you are seeking services with out-of-network insurance, I can provide you with the necessary receipts and other documentation you need in order to receive reimbursement through your out-of-network benefits. Most insurance plans offer out-of-network benefits for mental health treatment, but it is necessary that you contact your insurance company to determine exactly what coverage you are entitled to through your specific insurance policy including information about your deductible. Be advised that you (not your insurance company) are directly responsible for the full amount of all fees associated with my services at each session and you will later be reimbursed by the insurance company (if using out-of-network insurance) for any covered expenses. By signing this Treatment Agreement, you are acknowledging that you are responsible for the full payment of our agreed upon fee-for-service.

If you wish to receive reimbursement for psychotherapy services through your insurance company, I am required to provide information relevant to the services I provide you. I will make every effort to only release the minimum information about you that is necessary for the purposes requested. Please be aware that although insurance companies claim to keep your protected health information (PHI) confidential, I do not have control over how they will store or use your information. By signing this Treatment Agreement, you are acknowledging that I can provide the required information to your insurance carrier.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your clinical record. Your clinical record may contain information such as a diagnosis, intake information, consent to treatment, treatment plan, phone and electronic contact, and treatment notes. Treatment notes are brief summaries of our individual sessions outlining important issues, facts, or any treatment recommendations discussed. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may request in

writing to examine and/or receive a copy of your clinical record. These are professional records that can be misinterpreted and/or upsetting to untrained readers. For this reason, I strongly recommend that you review them in my presence or upon your written consent, have them sent to another mental health professional to review with you.

CONFIDENTIALITY & NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protection with regard to the use and disclosure of your clinical records (also known as your Protected Health Information or PHI) used for the purpose of treatment, payments, and health care operations. I will make every effort to safeguard the privacy of information concerning our work together. It is unethical for me to disclose any information regarding your treatment with me, with a few exceptions.

- You may authorize me to release records or other information to individuals of your choosing (insurance companies, family members, other providers, etc). This may only be done with your expressed written consent.
- In order to provide the best possible clinical care for my clients, I seek professional supervision and consultation. During professional supervision or consultation, I will make every effort to avoid revealing the identity of my client. Any other professional with whom I discuss clinical information with is also legally bound to keep the information confidential.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Contract.
- If I am providing treatment for conditions directly related to worker's compensation claim, I may have to submit such records, upon appropriate request, to Chairman of the Worker's Compensation Board on such forms and at such times as the chairman may require.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- In certain legal proceedings, confidential information may be disclosed by court order. This is a rare occurrence and would not happen without your knowledge.
- Treatment of Couples: In the treatment of couples, both clients must consent the release of treatment records. When consent is not given, records will only be release with a court order.

- Treatment of Minors: Clients under 18 years of age who are not emancipated should be aware that the law may allow both parents the right to examine their treatment records. Privacy in psychotherapy is very important to the success of treatment and I will likely ask parents to respect the need for confidentiality in their child's therapy relationship. Under most circumstances, some parental involvement in a child's treatment is essential to successful therapy outcomes. When children are age 12 or older, I will request that an agreement be made between my client and parent(s) to share general information about treatment progress and compliance with scheduled appointments. Other communication about what is shared in session between the child and me will require the child's authorization. An exception to this agreement would be if I feel that the child may be in danger or is a danger to someone else, in which case, parents will be notified of the concern. I will do my best to discuss these kinds of concerns with the child beforehand if this type of disclosure to a parent becomes necessary.

There are some situations in which I am legally obligated to take actions in an attempt to protect others from harm. In this rare and unusual event, I may be required to reveal some information about a client's treatment.

- If a client communicates an immediate threat of serious physical harm to an identifiable victim, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If a client threatens to harm herself/himself, I may be obligated to seek hospitalization for her/him, or to contact family members or others who can provide protection.
- In the event that a client discloses information that provides evidence of current abuse including neglect of a minor child, or a disabled or elderly adult, the law requires that I report this to the appropriate state agency.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your clinical records and disclosure of Protected Health Information (PHI). These rights include: requesting to amend your clinical record; requesting to place restrictions on what information from your clinical records is disclosed to others; requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which Protected Health Information disclosures are sent; having any complaints

you make about my policies and procedures recorded in your records; requesting a paper copy of this Psychotherapy Services Contract including this Notice of Privacy Practices; and refusing or ending treatment at any time for any reason.

NOTE

We will work together at establishing your goals and will regularly evaluate your treatment progress to ensure that you are getting what you need and want. Throughout our time together, I encourage you to share what you find helpful and what, if anything, may be getting in the way. I want you to feel free to share with me what I can do to help!

I HAVE READ THIS POLICY AND AGREE TO ABIDE BY IT.

Signature:_____

Date:_____