ASSOCIATES IN BEHAVIORAL COUNSELING
Minor Registration Form

TODAY'S DATE: _____ Client # _____

How did you hear about us? ( ) Yellow Pages ( ) Health Source Booklet ( ) Internet Search ( ) Insurance ( ) Friend
( ) Family ( ) Professional, _____ ( ) Other, _____
Name of Person Specify

PATIENT NAME: _____
First Middle Last

ADDRESS: _____
Street City State Zip

HOME PHONE: ___-___-____ PARENT CELL: ___-___-____ SOCIAL SECURITY #: ___/___/____

CELL PHONE: ___-___-____ DATE OF BIRTH: ___/___/____

AGE: _____ SEX: F / M STUDENT: _____ FT___ OR PT___ GRADE: _____ SCHOOL: _____

TEACHER: _____ ANY SPECIAL SERVICES?: _____

PLACE OF EMPLOYMENT: _____ POSITION: _____

RESPONSIBLE PARTY 1: _____
ADDRESS: _____

RELATION TO CHILD: _____
( ) Sole Custody ( ) Joint Custody ( ) Legal Guardian
Percentage of bill you are responsible for: _____%

RESPONSIBLE PARTY 2: _____
ADDRESS: _____

RELATION TO CHILD: _____
( ) Sole Custody ( ) Joint Custody ( ) Legal Guardian
Percentage of bill you are responsible for: _____%

PRIMARY CARE PHYSICIAN: _____ PHONE: _____ FAX: _____
Other Treating Providers:
Name: _____ Address/Phone: _____

Name: _____ Address/Phone: _____

EMERGENCY CONTACT
Name: _____ Home #: _____
Relationship: _____ Cell #: _____ Work #: _____

MUST BE FILLED IN EVEN IF YOU GAVE THE OFFICE A COPY OF YOUR CARD

PRIMARY INSURANCE

INSURANCE CO: _____ ID#: _____

POLICY HOLDER: _____ SSN OF POLICY HOLDER: ___-___-____

GROUP #: _____ POLICY HOLDER'S D.O.B.: _____

ADDRESS IF DIFF FROM PATIENT: _____

EMPLOYER: _____ DEDUCTIBLE: $_____ OFFICE COPAY: _____

PHONE #: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE

INSURANCE CO: _____ ID#: _____

POLICY HOLDER: _____ SSN OF POLICY HOLDER: ___-___-____

GROUP #: _____ POLICY HOLDER'S D.O.B.: ___/___/____

ADDRESS IF DIFF FROM PATIENT: _____

EMPLOYER: _____ DEDUCTIBLE: $_____ OFFICE COPAY: _____

PHONE #: _____ RELATIONSHIP TO PATIENT: _____

ASSOCIATES IN BEHAVIORAL COUNSELING

Outpatient Services Contract

Patient Name	Patient #	Date of Birth

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one session per week at a time we agree on, although some sessions may be more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

The hourly fee is $XXX (see fee schedule below). In addition to weekly appointments, I charge for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding.]

ASSOCIATES IN BEHAVIORAL COUNSELING

Outpatient Services Contract

Patient Name _____ Patient # _____ Date of Birth _____

Common Service	Fee Ph.D.	M.A.	Common Service	Fee Ph.D.	M.A.
Initial Diagnostic Evaluation, 60 min	200.00	170.00	Family Therapy	160.00	140.00
Individual Psychotherapy, 16-37 min	85.00	65.00			
Individual Psychotherapy, 38-52 min	150.00	130.00	**Court Testimony w/travel or Deposition	250.00/hr.	
Individual Psychotherapy, 53-60 min	175.00	155.00	**Written Reports	200.00/hr.	
Play Therapy, 16-37 min	110.00	90.00	**Same Day Late Cancellation	Full Session Fee	
Play Therapy, 38-52 min	175.00	155.00	**Missed Appointment- No Notice Given	Full Session Fee	
Play Therapy, 53-60 min	200.00	180.00	**Monthly Fee for Mailed Statements on Services in Arrears	5.00	

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care

Patient Name _____ Patient # _____ Date of Birth _____

plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.]

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 9 AM and 7 PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by an answering service [machine, voice mail, or by my secretary, that I monitor frequently, or who knows where to reach me]. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also discuss with them a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss. [At the end of your treatment, I will

Patient Name _____ Patient # _____ Date of Birth _____

discuss a summary of our work together with your parents, and we will discuss it before I meet with them.]

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [elderly person or disabled person] is being abused, I must [may be required to] file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am [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 the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

_____ _____
ABC Witness Date

ASSOCIATES IN BEHAVIORAL COUNSELING

Consent for Treating a Minor Child

Patient Name _____ Patient # _____ Date of Birth _____

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's progress notes. (Notes made by therapist about the content of each session.)

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will discuss with you a treatment summary that will include what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed

ASSOCIATES IN BEHAVIORAL COUNSELING

Consent for Treating a Minor Child

Patient Name _____ Patient # _____ Date of Birth _____

(if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Abbreviated Contract Draft

- If you decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship.
- You are waiving your right to access to your child's progress notes.
- I will inform you if your child does not attend the treatment sessions.
- At the end of therapy, I will discuss with you a summary of your child's treatment including a general description of goals, progress made, and potential areas that may require intervention in the future.
- If necessary to protect the life of your child or another person, I have the option of disclosing information to you without your child's consent.
- You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).
- You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.
- If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will not include recommendations concerning custody or custody arrangements.
- If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

_____ _____

Signature of Parent or Guardian 1 Signature of Parent or Guardian 2

_____ _____

Date Date

_____

ABC Witness

ASSOCIATES IN BEHAVIORAL COUNSELING

Patient's Rights And Responsibilities

Patient Name _____ Date of Birth _____ Patient # _____

Please initial each box indicating that you have read and understood the information contained herein.

☐ **CONSENT TO PSYCHOTHERAPY TREATMENT-**The patient consents to participate in the services offered and provided by the mental health care provider as defined in Indiana Law. This would include only those services the provider is qualified to provide within the scope of the provider's license, certification, and training. Psychotherapy is not a guaranteed treatment or cure. Effectiveness depends on the relationship and cooperation between the patient and therapist.

☐ **CONFIDENTIALITY-** Protected Health Information (PHI) will never be disclosed without prior expressed written consent, except as required by law to report possible abuse, or the patient is at risk of self-harm, or harm to someone else or when subpoenaed by order of the Court. HIPAA protects patients from unauthorized disclosure of PHI except as required to obtain payment from third-party payers or guarantors; conduct normal healthcare operations such as quality assessments or provider certifications. ***** I have been provided the opportunity to read the Notice of Privacy Practices. I understand that I may ask for a copy to be provided to me at any time.**

☐ **REQUESTS FOR PATIENT RECORDS-** Standard policy requires the request be made in writing and preferably in person and on a valid Release Form. When this is not possible, a valid photo ID with signature must be submitted with the written and signed request. With regard to situations involving legal guardianship, power of attorney or unsubstantiated parental rights of a patient record, legal documentation providing entitlement to obtain PHI is required, NO EXCEPTIONS.

☐ **EMERGENCIES-** WHEN A PATIENT LIFE IS AT RISK CALL 911 OR GO IMMEDIATELY TO THE NEAREST HOSPITAL. Our providers do not carry admission privileges, so it is not necessary we be contacted in such a situation. However, if you should need to update your ABC therapist after seeking help for your emergency, you may contact them during normal business hours. If your therapist is not available or not scheduled to work on that day, you may leave a message regarding your update.

☐ **PAYMENT OR SCHEDULING INQUIRIES-** Your therapist is a highly qualified mental health professional, trained to provide you with the highest level of care as it pertains to your mental health needs. HOWEVER, your therapist does not have knowledge or understanding of your insurance benefits, nor does she or he have the authority to arrange a payment agreement for you. Your therapist cannot address your scheduling needs, or "fit you in" because these services are performed and managed by the administrative staff. If you have concerns regarding scheduling or insurance coverage, your admin staff is educated and trained to provide assistance in every aspect of this part of the mental health industry. If you need to discuss a payment or claim dispute, the Financial Administrator is always happy to work with you.

☐ **MINOR PATIENTS-** Parents are encouraged to communicate with your child's therapist regarding progress in therapy; however your child's therapist may not prompt your involvement unless it is deemed pertinent to do so. In such cases, and with the involvement of the minor who holds the privilege of confidentiality (see Consent for Treating Minor Child), general trends, observations, concerns and verification of attendance will be discussed, as well as, recommendations for further treatment.

☐ **PARENTAL RESPONSIBILITIES-** We LOVE our little patients and provide care for MANY! Therefore for the safety and security of everyone involved, **parents may NOT leave the clinic for the duration of their minor child's therapy session.** Parents must maintain responsibility for the appropriate behavior of minor children while at the clinic. Please do not leave children unattended in the reception area for any unnecessary length of time. **Additionally, Mom and Dad, please instruct your little one to remain in the reception area while you are in brief consult with his or her therapist.** Please understand that patients are in session beyond the reception area door and should be entitled to quiet, uninterrupted care with their therapist. As such, please make necessary accommodations for the care of minors who need supervision. Admin staff is not equipped to provide this. Minors may not be left unattended in the reception area while their parents attend their own therapy session.

☐ **PUNCTUALITY-** Counseling sessions are typically 30, 45, or 60 minutes long. If you are more than 15 minutes late, you may be asked to reschedule. At times, however, your therapist may be running behind, in which case, you will be given the opportunity to wait or reschedule. Our policy requires a 24 hour cancellation notice or a fee will be applied. This fee is the responsibility of the patient and NOT the insurance company. To avoid being charged for missed appointments, please call the office promptly when appointments cannot be kept.

☐ **CONTACT BETWEEN SESSIONS-** If you need to provide information to your therapist between sessions, you may leave it on voicemail or admin staff will relay your message. Therapy concerns or questions should be addressed at your next appointment. However, if brief telephone communication with your therapist is necessary between appointments, be patient... understand your therapist may not be available to return your call the same day or week, as it was not a scheduled or expected communication. Be as descriptive as possible regarding the timeframe you need this consult, so we can make every effort to triage your needs.

☐ **TERMINATION-** The counseling relationship may be terminated by the therapist or patient at any time she/he feels the relationship is no longer productive. This includes, but is not limited to non-payment of services, inconsistent attendance i.e., 3 or more missed appointments, 3 or more cancellations, or if the client is not progressing in therapy or cooperating with the recommended treatment plan. In cases where the therapist has terminated treatment, an explanation, as well as, referral instructions will be provided. A final session will be offered to close the patient record.

_____
Signature of Patient or Responsible Party 1
Date _____

_____
Signature of Patient or Responsible Party 2
Date _____

ASSOCIATES IN BEHAVIORAL COUNSELING
*Notice of Privacy Practices

Patient Name _____ Patient # _____ Date of Birth _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all health records and other individually identifiable health information used or disclosed by us in any form be kept confidential.

This notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, obtain payment, maintain health care operations, and for other purposes permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you including demographics, diagnosis, treatment plan and goal, and mental health history that may identify you and relate to your past, present or future physical or mental health, condition, and related health care services.

Uses and Disclosures of PHI: Your PHI may be used and disclosed for the purpose of providing health care services to you, your dependents or others for whom you've obtained or sought care, to obtain payment for your health care services, to support the operation of this office, to obtain insurance benefits and authorization for treatment, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your mental health care and related services. This includes coordination or management of your health care with third parties such as primary care physicians, home health agencies, insurance companies, employee assistance programs, law enforcement officials, judicial entities, or other parties involved in providing care to you.

Payment: Your PHI will be used as needed to obtain payment for our health care services.

Health Care Operations: We may use or disclose, as needed, your PHI in order to support the business activities of the office, including but not limited to, quality assessment activities, employee review, training of students, licensing of providers, conducting and arranging for any other business activities required to provide care including, but not limited to, contacting you to confirm, remind, or cancel appointments.

We may also use or disclose your PHI in the following situations without your consent: as required by law, public health issues required such as: communicable diseases, health care oversight, abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, criminal activity, military activity, national security, workers comp, inmates, required uses and disclosures under the law. We must make disclosures to you and when required by the Secretary of Department of Health and Human Services to investigate or determine our compliance with the sections 164.500.

- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

ASSOCIATES IN BEHAVIORAL COUNSELING
*Notice of Privacy Practices

Patient Name _____ Patient # _____ Date of Birth _____

Other permitted and required uses and disclosures will be made only with consent, or with the opportunity to object, unless required by law. You must sign an authorization before a release of your PHI in any uses or disclosures not described in this Privacy Notice.

I will also obtain an authorization from you before using or disclosing:

- PHI in a way that is not described in this Notice.
- Psychotherapy notes.

You may revoke this authorization at any time in writing, except to the extent your therapist or the clinic has taken an action in reliance on the use of disclosure indicated in the authorization previously given.

Your Rights With Respect to PHI: You have the right to inspect and receive a copy of your PHI. Under federal law, however, you may not inspect or obtain a copy of the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, administrative action or proceeding and PHI that is subject to law that prohibits access to PHI. We may choose to assess a fee for reproduction or submission of PHI. This fee will not exceed the allowable amount as set forth by Indiana Law 760 IAC 1-71 which states:

$1.00 per page for pages 1-10
$0.50 per page for pages 11-50
$0.25 per page for pages 51 and higher
OR
$20 labor fee for pages 1-10
$0.50 per page for pages 11-50
$0.25 per page for pages 51 and higher

Provider or clinic may charge the actual cost of mailing the PHI. Provider or clinic may charge an additional $10 if the request is for copies to be provided within two working days, only if the provider/clinic chooses to honor this request. Provider or clinic may charge an additional fee of $20 for certifying a patient's PHI.

A request to inspect or receive a copy of PHI must be submitted in writing and must be accompanied by proof of the right to receive such PHI such as: picture identification, signature for comparison to original file, custodial documentation clearly stating parental, guardian, or power of attorney rights to obtain PHI. We reserve the right to thoroughly investigate any request which we believe to be inaccurate, false, or detrimental to the care or well-being of our patient. In such an event, we will notify you of our need to investigate to obtain accurate proof and documentation. Upon verification and confirmation of your right to PHI, we will release the requested PHI within 30 days, not including weekends, holidays, or days when the clinic is not in operation.

You have the right to request a restriction of PHI. This means you may ask us not to use or disclose any part of your PHI for purposes of treatment, payment, or healthcare operations. You may also request any part of your PHI not be disclosed to family members or friends who

may be involved in your care or for the specific restriction requested; and to whom you want the restriction to apply. The clinic and/or therapist will notify all parties involved to ensure the request has been noted.

You Have a Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

You Have a Right to Be Notified if There is a Breach of Your Unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

The clinic and/or therapist are not required to agree to a restriction you request. If the clinic and/or therapist believe it is in your best interest to permit use and disclosure of PHI, the restriction will not be granted. You then have the right to terminate care with your therapist and seek another healthcare professional.

You have the right to a paper copy of the Privacy Act Policy notice, upon request even if you have agreed to accept this notice alternatively.

You have the right to request your therapist to amend your PHI. If we deny your request of amendment you have the right to file a statement of disagreement with us to become a part of your PHI records, and we may prepare a rebuttal to your statement and provide you a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you through public posting, or by mail, of any changes. You have the right to object or withdraw from treatment as provided in this notice.

You have the recourse if you feel your privacy protection has been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, and violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Associates in Behavioral Counseling
Robyn N. Eubank, Privacy Officer
708 W. White River Blvd.
Muncie, IN 47303
(765)288-1110

For more about HIPAA, or to file a complaint:

Department of Health and Human Services
Office of Civil Rights, Region V
233 N. Michigan Ave, Suite 240
Chicago, IL 60601
(312)886-2359

ASSOCIATES IN BEHAVIORAL COUNSELING
*Notice of Privacy Practices

Patient Name	Patient #	Date of Birth

Patient Signature	Date

Signature of Parent, Guardian or Power of Attorney	ABC Witness

* A copy of this notice will be provided upon request

ASSOCIATES IN BEHAVIORAL COUNSELING

Social Media Policy

Patient Name _____ Date of Birth _____ Patient # _____

This document outlines our office policies related to use of Social Media. Please read it to understand how we conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, we encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when we need to update this policy. If we do so, we will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING

We do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

FOLLOWING

Our primary concern is your privacy. Please note that we will not follow you on Twitter. We use Twitter for private use only and do not follow current or former clients on blogs or Twitter. Our reasoning is that we believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy our personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share, please bring them into our sessions where we can view and explore them together, during the therapy hour.

INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact us. These sites are not secure and we may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with us in public online if we have an already established client/therapist relationship. Engaging with us this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

If you need to contact your therapist between sessions, the best way to do so is by phone.

USE OF SEARCH ENGINES

It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If we have a reason to suspect that you are in danger and you have not been in touch with us via our usual

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means (coming to appointments or by phone) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if we ever resort to such means, we will fully document it and discuss it with you when we next meet.

GOOGLE READER

We do not follow current or former clients on Google Reader and we do not use Google Reader to share articles. If there are things you want to share with your therapist that you feel are relevant to your treatment whether they are news items or things you have created, we encourage you to bring these items of interest into your sessions.

BUSINESS REVIEW SITES

You may find our psychology practice on sites such as Yellowbook.com, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our listing on any of these sites, please know that our listing is NOT a request for a testimonial, rating, or endorsement from you as our client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence."

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with us about your feelings about our work, there is a good possibility that we may never see it.

If we are working together, we hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy wherever and with whomever you like. Confidentiality means that we cannot tell people that you are our client and our Ethics Code prohibits us from requesting testimonials. But you are more than welcome to tell anyone you wish about your therapist or how you feel about the treatment provided to you, in any forum of your choosing.

If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

LOCATION-BASED SERVICES

If you used location-based services on your mobile phone, you may wish to be aware of the

ASSOCIATES IN BEHAVIORAL COUNSELING

Social Media Policy

Patient Name _____ Date of Birth _____ Patient # _____

privacy issues related to using these services. We do not place our practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at our office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from our office or if you have a passive LBS app enabled on your phone.

EMAIL

We do not use email for client related services as email is not completely secure or confidential. All emails are retained in the logs of your and our Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. Also any emails that we would receive from you and any responses that would be sent to you would become a part of your legal record. So, in order to avoid a possible breach in your confidentiality we do not give out our email address to clients and ask clients to not use the email to contact us.

TEXT MESSAGING

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

WEBSITES

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

CONCLUSION

Thank you for taking the time to review our Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to your therapist's attention so that you can discuss them.

_____ _____

Signature of Patient Date Signed

_____ _____

Signature of Parent, Guardian or Legal Representative of client under 18 or client under guardianship/medical representative

Signature of ABC Witness

ASSOCIATES IN BEHAVIORAL COUNSELING

Outpatient Services Contract

Patient Name	Patient #	Date of Birth

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one session per week at a time we agree on, although some sessions may be more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

The hourly fee is $XXX (see fee schedule below). In addition to weekly appointments, I charge for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding.]

ASSOCIATES IN BEHAVIORAL COUNSELING

Coordination of Care Notification

Ph: 765-288-1110
Fax: 765-288-4044

Communication between Behavioral Health Providers and your **Primary Care Physician** is important to ensure that you receive comprehensive and quality health care. This form will allow your therapist to notify if needed, share protected health information (PHI) with your Primary Physician. **This information will not be released without your signed authorization.** This PHI may include diagnosis, treatment plan, progress, and medication if necessary (and provided).

Patient Name _____ Patient # _____ Date of Birth _____

PCP Name (Your Family Doctor): _____ Phone: _____

Fax: _____

Address: _____

(Street) (City) (State) (Zip)

ATTENTION PRIMARY CARE PHYSICIAN:

Please be advised, I provided services for the above named mutual patient on _____ (Date) at Associates in Behavior Counseling for: Mental Health concerns or counseling related to _____ (Diagnosis given). If you have any questions or would like to discuss this patient's care in greater detail, please call me at (765) 288-1110. Updated treatment plans or progress reports will be provided if it is pertinent to this patient's care. Thank you for sharing in the care of our patient.

(Provider):_____

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting Associates in Behavioral Counseling.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You are not required to sign this form as a condition of treatment, payment, enrollment, or eligibility of benefits.
- Information that is disclosed as a result of this authorization form may be re-disclosed by the recipient.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use or disclose information, yourself.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that information has previously been released/exchanged. I further understand this consent shall expire in seven (7) years from the date of signature, unless another date is specified. I have read and understood the above information and:

PATIENT PLEASE CHECK ONE (1)

_____ I **GIVE MY CONSENT** TO NOTIFY MY PRIMARY DOCTOR OF MY CARE AT ASSOCIATES IN BEHAVIORAL COUNSELING, AND, IF NECESSARY, RELEASE ANY APPLICABLE MENTAL HEALTH OR SUBSTANCE ABUSE INFORMATION.

_____ I **DO NOT GIVE MY CONSENT** TO NOTIFY MY PRIMARY DOCTOR OR RELEASE ANY MENTAL HEALTH OR SUBSTANCE ABUSE INFORMATION.

Patient Signature (or legal guardian of minor) _____ Date _____ ABC Witness _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records, the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

****NOTICE TO THE PCP RECEIVING THIS INFORMATION:**
THIS IS NOT A REQUEST FOR YOUR PATIENT RECORDS.**

This authorization is ONLY a consent to inform the Primary Care Provider of mental health/psychological treatment for the purpose of coordinating care of our mutual patient. Please DO NOT send any records at this time. Thank you.

ASSOCIATES IN BEHAVIORAL COUNSELING
Medical Information Sheet

Patient Name _____ Patient # _____ Date of Birth _____

ALLERGIES: YES ____ NO ____ IF YES PLEASE LIST	REACTION:
MEDICAL DIAGNOSES:	DATE OF ONSET:
OPERATIONS/PROCEDURES:	DATE:

CURRENT MEDICATION (Includes prescription, over-the counter, herbals, vitamin/mineral/dietary (nutritional) supplements) (Use back of sheet if needed) **OR NONE TAKEN** _____	DOSAGE EX: MG	FREQUENCY -# Times a day & HOW- Ex: Oral, Shot, etc	PRESCRIBING PHYSICIAN
USE BACK OF SHEET IF ADDITIONAL SPACE IS NEEDED			