Associates in Behavioral Counseling
Registration Packet - **Minor**

TODAY'S DATE: _____

How did you hear about us? ( ) Internet Search ( ) Insurance ( ) Friend ( ) Family ( ) Professional

_____ ( ) Other _____
Name of Person Specify

PATIENT NAME: _____
FIRST MIDDLE LAST

PREFERRED NAME: _____ AGE: _____ **DATE OF BIRTH**: _____/_____/_____

SEX/GENDER: Male ___ Trans-Male ___ Female ___ Trans-Female ___ Non-Binary ___ Other _____

MARITAL STATUS: S___ M ___ D ___ W ___ Living Together ___ **SS #:** _____-_____-_____

ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE: _____ **CELL PHONE**: _____

WORK PHONE: _____ **EMAIL:** _____

EMPLOYED: _____ RETIRED: _____ STUDENT: _____ FT OR PT

PLACE OF EMPLOYMENT: _____

POSITION: _____

PRIMARY CARE PHYSICIAN: _____**PHONE**: _____

FAX: _____

Other Treating Providers:

Name: _____ Address/Phone: _____

Name: _____ Address/Phone: _____

EMERGENCY CONTACT

Name: _____ Cell #: _____

Relationship: _____ Work #: _____

Associates in Behavioral Counseling
Outpatient Services Contract

Name: _____ 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 has 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). 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.]

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 for telehealth will be collected by a credit/debit card on file. Payment schedules for other professional services will be agreed to when they are requested.

Name: _____ Date of Birth: _____

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 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.
You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

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].

Associates in Behavioral Counseling
Outpatient Services Contract

Name: _____ Date of Birth: _____

CONTACTING ME

I am often not immediately available by telephone. While I am usually in the office during business hours, I will not be available when I am with a patient. When I am unavailable, the telephone is answered by office staff or voicemail who know how to reach me. I will make every effort to return your call as soon as possible, 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 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.

Name: _____ Date of Birth: _____

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.

TERMINATION

Termination of services typically occurs by mutual agreement when treatment goals have been met, or when maximum benefit has been reached. We will periodically discuss termination as we track your progress. However, you have the right to terminate at any point. If possible, it is best to discuss therapy termination prior to ending contact. Please feel free to discuss with me any concerns or questions you might have about the benefit of your therapy or if, when, or how it should end. If I think that you no longer need my services or might be better served by other resources, including a more intensive level of care, I might initiate termination. I will consider therapy terminated by your actions if you do not reschedule as recommended or planned, have missed three appointments without notice, fail to make timely payments as per our agreement, or otherwise compromise the safety and integrity of our relationship and work together.

POSSIBLE REASONS FOR TERMINATION

- BY MUTUAL AGREEMENT WHEN:
  - Treatment goals have been met
  - Contract limits such as the number of allowed sessions is reached
  - Transfer to another provider or service is appropriate
  - Other environmental circumstances make it necessary
- BY CLIENT DISCRETION VIA ANY OF THE FOLLOWING ACTIONS:
  - Failure to initiate rescheduling within 90 days of a session, a no-show, or a cancellation
  - No-show (no notice) of more than three scheduled appointments
  - Cancellation of three consecutive appointments
- BY THERAPIST DISCRETION WHEN:
  - Circumstances compromise the feasibility or quality of service
  - Services are not benefiting or may be harming the client
  - Client conduct is inconsistent with the safety and integrity of the work (noncompliant with expectations for fee payment or clinical participation; any form of threatening or fraudulent behavior)

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
Outpatient Services Contract

Name: _____ Date of Birth: _____

Please see the rates and fees below:

Common Service	Fee Ph.D.	Fee LMHC/LSW	Fee M.A.	Common Service	Fees
Initial Diagnostic Evaluation, 60 min	200.00	170.00	140.00	Testing	200.00/hr.
Individual Psychotherapy, 16-37 min	100.00	100.00	65.00	**Court Testimony w/travel or Deposition	250.00/hr.
Individual Psychotherapy, 38-52 min	150.00	130.00	115.00	**Written Reports	200.00/hr.
Individual Psychotherapy, 53-60 min	175.00	155.00	125.00	**Same Day Late Cancellation	Full Session Fee
Play Therapy, 16-37 min	110.00	100.00	90.00	**Missed Appointment- No Notice Given	Full Session Fee
Play Therapy, 38-52 min	175.00	165.00	155.00	**Monthly Fee for Mailed Statements on Services in Arrears	5.00
Play Therapy, 53-60 min	200.00	190.00	180.00		
Family/Couples Therapy	160.00	150.00	140.00		
Crisis Session: 30 – 74 minutes	195.00	195.00	195.00		
Crisis Session: 75+ minutes	Additional 97.50	Additional 87.50	Additional 87.50		

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
Patient Rights and Responsibilities

Name: _____ Date of Birth: _____

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, 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 _____

MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately**. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.**

If you are separated or divorced from the child's other parent, please be aware **that it is my policy to notify the other parent*** that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. 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, parents decide whether therapy will continue. **If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances.** However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

By signing below, I attest that I am the custodial parent and have legal authority to do all things necessary with regard to seeking therapy/counseling for my child.

Printed Name: _____

Signed Name: _____

Date: _____

*If there is a **joint custody agreement**, the name and contact information of the other custodial parent/guardian is required.

Printed Name: _____

Phone Number: _____

Name: _____ Date of Birth: _____

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.

If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am [may be] required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will

need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

> ***Example***: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If you child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

> ***Example***: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of [this State] may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.
Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $XXX per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Associates in Behavioral Counseling
Outpatient Services Contract

Name: _____ Date of Birth: _____

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature** _____ Date_____

Custodial Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. _____ _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.

_____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above. _____ _____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

** For very young children, the child's signature is not necessary

Insurance Information

*****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
Notice of Privacy Practices

Name: _____ 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 the 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.

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.

Name: _____ Date of Birth: _____

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.

Associates in Behavioral Counseling
Notice of Privacy Practices

Name: _____ Date of Birth: _____

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
Attn: Dr. Michele Boberg, 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

_____
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

Name: _____ Date of Birth: _____

Introduction

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. If you have any questions about this policy, please feel free to discuss this with me.

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 nor do I respond to text message from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter, Facebook, Instagram, or TikTok. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate in various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

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 any questions about it, we should discuss this during your therapy sessions.

Name: _____ Date of Birth: _____

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews about me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your treatment. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has significant potential to damage our ability to work together.

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

Name: _____ Date of Birth: _____

ASSOCIATES IN BEHAVIORAL COUNSELING
Authorization to release confidential information to other persons and/or leave messages

It is the policy of Associates in Behavioral Counseling (ABC) to not release confidential patient information about you unless it is for patient care and treatment, payment, or operations. If you wish for our clinician and/or office staff to leave messages for you on your home telephone answering machine, work telephone, voicemail, cell phone or to any other person, then you must complete the following.

I authorize ABC to release confidential patient information about me by the following methods and agree it is my responsibility for notifying my clinician or office staff whenever I want this to change.

We can call your home	yes _____ no _____
We can leave a message on your home answering machine/voicemail	yes _____ no _____
We can call your cell phone	yes _____ no _____
We can leave a message on your cell phone	yes _____ no _____
We can call you at work	yes _____ no _____
We can leave a message on your work voicemail	yes _____ no _____
We can fax copies of information to other medical facilities who:	
Referred you to us	yes _____ no _____
You are referred to	yes _____ no _____

Please list in order the numbers you wish us to call:

1) _____ 2) _____
Home/Cell/Work Home/Cell/Work

Please list the names of any people and their relationship to you, if you wish us to release confidential patient information to (this includes the ability to make or cancel appts. for you):

Name: _____ Relationship: _____

_____ _____

_____ _____

_____ _____
Patient Signature/Legal Representative Witness Signature

_____ _____
Date Date

Associates in Behavioral Counseling

Name: _____ Date of Birth: _____

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 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_____ at Associates in Behavioral
(Date)
Counseling for: Mental Health concerns or counseling related to _____. If you have any
(Diagnosis given)
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. **

Associates in Behavioral Counseling

Name: _____ Date of Birth: _____

ALLERGIES: YES _____ NO _____ IF YES PLEASE LIST	REACTION:
MEDICAL DIAGNOSIS:	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

Name: _____ Date of Birth: _____

INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for

the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to “check-in” with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.
If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you 765-288-1110.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered. Payment for telehealth will be collected at the time of service by a credit/debit card on file.

Name: _____ Date of Birth: _____

Records
The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent
This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____ _____
Client Date

_____ _____
Therapist Date