Consent Form

PT Concepts, Client PLLC

DBA Waters Edge Counseling, Play Therapy & Training

The following information entails details about the policies and procedures of PT Concepts, PLLC counseling. Please read the material and sign to acknowledge that you have read and understand it.

The goal of PT Concepts is to foster growth and wellbeing of the clients that seek services with us. We believe that each client has specific rights and responsibilities in the counseling process. This center provides short-term individual, family and marital/couples counseling.

Confidentiality

With a few exceptions listed below, we are ethically and legally bound to strict guidelines for confidentiality. We will not reveal what has been discussed in a therapy session without prior written permission. We may legally speak to another healthcare provider, or in the case of a minor, the legal guardian or parent without prior consent. You may revoke your permission for us to share information at any time. There are some exceptions: 1) If you direct your therapist to give information to someone and/or give written consent to do that; 2) if it is determined that there is a threat to life by homicide or suicide; 3) if there is a strong suspicion of abuse of children, the handicapped or elderly; and 4) if there is a court order by a judge to disclose information.

If you elect to communicate with your therapist via email, be aware that email is not completely confidential. All emails are retained by your, or my, internet service providers; they can be accessed by the system administrator but under normal circumstances are not looked at. Our clinicians may choose to use tiger text, an encrypted form of sending and receiving text messages. If you are interested in using tiger text to discuss non-therapeutic topics, such as schedule changes please discuss with your clinician.

First Session

During the first session, there will be an introduction and a determination by both client and therapist of ability to work together. We will also begin the evaluation and assessment process. You will also be informed of your therapist's practice and view of therapy. This session will also begin the goal setting process. If there are any questions about payment, please discuss with our office manager and/or your clinician.

Payment Responsibility

The standard fee, for sessions 46-60 minutes, is $150.00. Fees for a marital and/or family session are $150.00 per 50-60-minute session. Any court appearances or consultations with attorneys require additional fees. Payment is expected at the beginning of the session. Checks can be made to PT Concepts, PLLC. We also accept cash, check, HSA cards, and all major credit and debit cards. If there are any concern regarding payment we can discuss those in the first session.

Your insurance will be filed, or if you are on an EAP those sessions will be filed with your EAP. The client is responsible for any co-pays and any outstanding balances not covered by your insurance company. A copy of a valid credit card is required to keep on file. You will be notified via email before any charges are made to your card.

Appointments and Cancellation Policy

Appointments are scheduled by each individual therapist on staff at PT Concepts PLLC or by the office manager. Appointment times are held for you or your family only; therefore, we must have a 24-hour cancellation notice. In cases of true emergencies, there are some exceptions. A $50 fee will be charged for late cancellations or "no show" appointments. All fees left unpaid will be turned over to a local collection agency. There will be a 35% up-charge for collections fee.

Please confirm your appointment when the email or text message reminder is sent, 24 hours before your appointment. Appointments not confirmed by 8am on the day of the appointment, may be given to clients that are on a waiting list for that week's appointment times.

Emergencies

In the case of emergencies, you can contact PT Concepts, PLLC during regular business hours. In the case when no one is available, please contact Springwoods Behavioral Health in Fayetteville, Arkansas, 888-521-6014, call 911 for emergency assistance, or go to the local hospital emergency room.

If you have any questions or are not sure that you are clear about any of these policies, please discuss these matters with your therapist. This below signature is to affirm that *you have read and understand the policy statement on this page as well as the previous page of the client consent form, and you have also had the opportunity to ask questions and receive any further explanation. This signature represents consent to treat.*

_____ _____

Clients printed name Date

_____

Signature of Client, if over 18 years of age, or Signature of parent or legal guardian, if client is a minor

_____ _____

Signature of Therapist Date

Client's Name:_____Date of Birth:_____

Physical Address:_____City:_____

State:_____Zip:_____Email:_____

Phone:_____ Alternate Phone:_____
Okay to leave voicemail at this number? Y or N Okay to leave voicemail at this number? Y or N

Employer:_____City/State:_____Phone_____

Relationship Status (circle one): Single Married Divorced Widow Significant Other

Circle One: Male Female Transgender

How important is spirituality to you? 0 1 2 3 4 5 6 7 8 9 10 (circle your response)
Least being 0 most being 10

Do you attend church? Y N Church Name _____

Spouse/Significant Other Name:_____Date of Birth:_____

Physical Address:_____ City:_____

State:_____ Zip:_____ Phone:_____

Employer:_____Employer's Address:_____

City/State/ZIP_____ Employer's Phone: _____

How important is spirituality to your spouse? 0 1 2 3 4 5 6 7 8 9 10 (circle your response) Least being 0 most being 10

Does your spouse attend church? Y N Church Name _____

Emergency Contact: Name:_____

City/St/Zip_____Phone:_____

(**must have release of information on file for emergency contact**)

For minors (under 18 yrs of age) **Must have court custody documents on file before treatment**

Parent/Guardian Name(s)_____

Circle primary custodial guardian: Father Mother Grandparent Other

Other(indicate relation to client)_____ Phone:_____

Address/City/State/Zip:_____

Insurance Information

Primary Insurance:_____

Policy #:_____Group #:_____

Name of Policy Holder (If different from the client) _____

Relation to client _____ Date of Birth Policy Holder:_____

Insurance Provider Phone Number: _____

EAP Information (company name, address, contact phone):_____

_____

EAP Authorization Number:_____

Person Responsible for the Payment:

Name: _____Address:_____

City/State/ZIP:_____

Phone:_____ Relation to client:_____

By signing below, I am acknowledging that I am responsible for any charges accrued for services. We will make every effort to file with insurance or EAP companies, but if there is a balance due after payment by the insurance/EAP or if insurance or EAP denies payment all remaining charges will be paid by the person stated above: There will be a 35% upcharge for any balances sent to collections.

Signature:_____Date:_____

When/If using medical insurance covering my mental health services provided by Waters Edge Counseling, Play Therapy and Training I am aware and agree to releasing records requested by my insurance provider. I understand that any records requested by my insurance provider, will be sent by the therapist providing services. Insurance may request records for medical necessity and if records are not sent, insurance may deny claims. It is understood that if you choose to decline signature for releasing records to insurance, you agree to be a self-pay client at the rate of $150.00 per session.

Signature:_____Date:_____

Have you or client (in case of minor) ever participated in counseling services? Yes or No

Circle all that apply: Individual Family/Marital Group

Would you say that the counseling experience was helpful? Yes or No

Note any medical condition, illnesses, operations or medications taken in the past or currently:

_____
_____
_____
_____
_____

List any known allergies: _____

Circle all that apply to client:

Feeling Worthless	Easily Angered	Day Dreaming
Insomnia	Physical Conflict	Difficulty Focusing
Irritability	Verbal Outbursts	Difficulty Concentrating
Low Energy	Pressured Speech	Fidgety
Loss of Interest	Decrease Need for Sleep	Impulsive Acts
Social Withdrawal	Hyper Social	Hyperactive
Crying Spells	Elevated Mood	Risk Taking Behavior
Restlessness	Rapid Thoughts/Ideas	Spiteful
Excessive Worry	Poor Judgement	Disorganized Speech
Muscle Tension	Ideas of Grandiosity	Hallucinations
Easily Fatigued	Motor Agitation	Blaming Others
Panic Attacks	Easily Distracted	Age Inappropriate Sex
Difficulty Sleeping	Increased Appetite	Fire Setting
Erratic Sleep Patterns	Decrease Appetite	Sexually Inappropriate
Sleeping Excessively	Anorexia	Bed Wetting
Difficulty Falling Asleep	Bulimia	

	SELF	Relative	Relationship to Client	Treatment Required
Depression				
Anxiety				
Schizophrenia				
Mania				
Paranoid Thinking				
Hallucinations				
Alcohol Use				
Drug Use				
Phobias				
Domestic Violence				
Suicidal Thoughts				
Suicide Attempts				
Abuse: Sexual, Physical, Emotional				
Neglect				
Other Trauma				
Caffeine Intake Daily				
Tobacco Use Daily				

Consent Form

PT Concepts, Client PLLC

DBA Waters Edge Counseling, Play Therapy & Training

Fees for Written Reports, Letters, Court Appearances and Depositions

Due to preparation time and the likelihood of canceling appointments for other clients, there will be an additional charge reports, letters, court appearances and depositions. I understand that these are typically not covered by insurance and I agree to pay for these services in advance.

Full payment is expected prior to receiving any letter, report of in the event of court appearances and depositions.

The minimum fee for court testimony and depositions is $1500 per day if your clinician is required to appear in court or testify at deposition, regardless of whether or not the clinician actually testifies or not. The fee will be paid in full prior to any court proceedings or depositions.

The minimum fee for written reports and letters is $150/hour.

Please discuss any questions regarding these fees with your clinician.

Client Signature_____ Date_____

_____Date_____

If client is a minor, Signature of Parent or Guardian

HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

"Protected health information" (PHI) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payment for the provision of health care.

Your Rights Regarding Your PHI

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with laws that may be in place now or in the future

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at info@watersedgecounselingnwa.com
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Sharing of psychotherapy notes

Our Uses and Disclosures

IF you give us permission, how would we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: Your physician and I may need to coordinate your care.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website, www.watersedgecounselingnwa.com.

Acknowledgement

I hereby acknowledge receiving a copy of this notice.

_____

Printed Name

_____ _____

Signature Date

Effective date of this notice is January 1, 2020