PROFESSIONAL COUNSELING SERVICES OF OHIO, LLC

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CLIENT INFORMATION AND ACKNOWLEDGEMENT OF INFORMED CONSENT TO TREATMENT

Emotional Health Services: The purpose of receiving emotional/mental/substance abuse services is to help you better understand your situation, change your behavior, or move toward resolving difficulties in your life. Your therapist, using his/her knowledge of human development and behavior will make observations and enter into dialogue with you regarding possible solutions. It will be important for you to examine your feelings/emotions, thoughts, and behavior, and consider trying new approaches. Psychotherapy calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things you talk about during your sessions and outside of sessions.

These sessions have risks and benefits. Since treatment often involves discussing unpleasant elements of your life, you may experience challenging feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental/emotional/substance abuse services have demonstrated through clinical studies to benefit clients of said services. Psychotherapy often supports relational life, contributes to solutions of specific problems, and reduces feelings of distress.

Appointments/Emergencies: Appointments are made by calling (937) 750-9590 and leaving a message. Due to our work schedules, we are often not immediately available to answer the telephone but will return your call as soon as possible. Please call to cancel or reschedule an appointment at least 24 hours in advance. You can email carlaurbanas@gmail.com regarding appointments but please note that this is not a secure email so please don't leave clinical information on this. We reserve the right to charge the full fee of $100 for a missed appointment or a late cancellation. Insurance third party payers will not cover or reimburse for missed appointments. Appointments are 45-50 minutes long but may vary for clinical reasons.

If you are late for a scheduled appointment, our policy is that the therapist will wait 15 minutes. If you are not in attendance by then, your therapist may not be able to see you and you will need to reschedule. You will be billed for the session fee.

If you have an emergency, please call (937) 750-9590. Some emergency circumstances may occur when your therapist is unavailable and therefore unable to respond. On these occasions, please utilize the local hospital emergency rooms, call 911, or call Crisis Care at (937) 224-4646 for an immediate response.

Confidentiality: The law protects the privacy of all communication between clients and their therapist. In most situations, your therapist can only release information about your treatment to another party if the client signs a written authorization form. There are some situations where we are permitted or required to disclose information with or without client authorization:

- If you are involved in court proceedings the court may order information be released.
- A government agency may require information be released.
- If you file for workers' compensation, records may be released.
- If a child or vulnerable adult is being neglected/abused, information may be released as required by law.
- If your clinician believes you are in danger of harming yourself or others, protective action may be taken, and may include contacting family members, seeking hospitalization, notifying the potential victims, and/or contacting the police.
- If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.

We may occasionally find it helpful to consult other health and mental health professionals about a case. We will make every effort to avoid revealing the identity of the client. Administrative staff may also come in contact with protected information during scheduling, billing, or quality assurance. All of the mental health professionals are bound by the same rules of confidentiality and all staff members have been trained about protecting your privacy. In certain cases, attorney and/or collection specialists may be contacted for an outstanding balance but information given to them would be solely for the purpose of collection. You should also be aware that your health insurance company may require that we provide them with information relevant to the services that are provided to you. By signing this agreement, you give your consent that Professional Counseling Services of Ohio can provide the requested information to your insurance company as needed.

Confidentiality of Online and Cell Phone Communication:

Therapeutic email is delivered via Hushmail. You agree to work with me online using Hushmail and the email address carlaurbanas@hushmail.com. Additionally,

- Text messaging via mobile phone is acceptable for appointments and housekeeping issues only.
- I do not store your name in my phone.
- If you call me, please be aware that unless we are both on land line phones, the conversation is not confidential.
- Any computer files referencing our communication are maintained using secure and encrypted measures.
- I will not respond to personal and clinical concerns via regular email.
- If you wish to use email as a way to "journal" information between sessions, you understand that I may not have the opportunity to review your journal emails until our next scheduled session.
- You understand that emails between sessions that contain confidential information will be sent via encryption.

I make every effort to keep all information confidential. Likewise, if we are working online together, I ask that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors and friends and whether or not confidentiality from your work or personal computer may be compromised due to such programs as a keylogger. I encourage you to only communicate through a computer that you know is safe i.e. wherein confidentiality can be ensured. Be sure to fully exit all online counseling sessions and emails. If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice

as a check-in location on various sites such as Foursquare. 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 my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone. It is not a regular part of my practice to search for client information online through search engines such as Google or social media sites such as Facebook. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) 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 I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Professional Records: The laws and standards of our profession require that protected health information about you be kept in your clinical record. Your clinical record includes information about your reasons for seeking therapy, a description of the way in which your problems affect your life, your diagnosis, the goals of treatment, your progress toward these goals, your medical and social history, your treatment history, results of any clinical tests, past records from other providers, professional consultations, payment records, and a copy of any reports to other professionals. You may examine your clinical records and request a copy if you make your request in writing. Records will be released except for rare occasions where, we believe, such a release could bring harm to yourself or someone else. Our copy fee is $0.25 per page. There will also be a $10 fee for records search plus postage.

In addition, our practice may have private psychotherapy notes which are designed to assist in providing quality care. These notes are kept separate from your clinical record. They are not routinely released to others with your clinical records except in rare legal circumstances or with a signed authorization from the client.

Minors: Persons under 18 years of age, please be aware that the law provides for your parents to examine your therapy records. However, our experience suggests that in order for many child/adolescent clients to feel comfortable in therapy, it is beneficial to offer them the opportunity to talk with the therapist and to know that what they tell the therapist will not get back to their parents except in cases of imminent danger to the client or others, or where the therapist considers the information to be so serious that the parents' ultimate responsibility for the client's welfare dictates that the parents be kept informed.

By signing this agreement, you are agreeing to this informal waiver of your right to full disclosure of the minor's records. If you choose not to informally waive this right, please talk with the therapist about your concerns prior to signing this form.

Professional Fees/Insurance Reimbursement: The fee for the initial assessment is $150. The charge for a 45 minute session is $100 and the charge for a 60 minute session is $125. Services for which clients are billed at this usual rate include psychotherapy, report writing, letters, consultations, travel time for out of office services, telephone counseling, and lengthy phone calls. The client fee for those who are cash pay is $100 per session.

Correspondence, report writing, and travel fees must be paid in advance of the service. For clients who have copayments, the copayment is expected to be paid at the time of service. You may be assessed a $5 re-billing fee for each session you fail to pay your copayment or co-insurance amount. If your account is in arrears, interest at a rate of 4% per month will be added to your balance. There will be a $25 charge for returned checks plus any additional charges that may occur from the financial institution. You may pay your bill with cash, a personal check, or credit card. A 3.5% charge will be added if you use a credit card.

If your therapist is required to participate in a legal proceeding, you will be expected to pay for all of his/her time including preparation and transportation time and costs, even if the therapist is called to testify by another party. There is a minimum of 3 hours at the rate of $150 per hour for court appearances. This fee must be paid in advance of the scheduled court appearance.

Please remember that it is your responsibility to investigate your insurance coverage before entering into a treatment contract with us. You are responsible for all charges incurred regardless of the amount paid by your insurance company unless arrangements have been made between our company and your insurance company.

If you fail to make payment of an outstanding balance, we reserve the right to obtain services of a collection agency or attorney. This may require us to disclose otherwise confidential information relevant to the collection of the balance due. You are responsible for all collection expenses and attorney fees required as a result of nonpayment of your account balance. We reserve the right to discharge clients for prolonged failure to pay for services.

Consent to Treatment: I, voluntarily, agree to receive emotional/mental health/substance use assessment, care, treatment, or services from Professional Counseling Services of Ohio. I authorize Professional Counseling Services of Ohio, LLC to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services that I receive from Professional Counseling Services of Ohio at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Client Information and Acknowledgement of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained within this consent.

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Client Name (Printed)

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Client Signature/Parent/Legal Guardian **Date**