Consent for Treatment

I agree to take part in psychotherapy/counseling at Above It All Counseling Group. I understand that developing a treatment plan and regularly reviewing our work and goals is in my best interest. I agree to play an active role in the process.

I understand that psychotherapy/counseling has potential risks and benefits. I understand that no promises or guarantees have been made to me as to the results or success of treatment.

I also understand that I may withdrawal from treatment at any time. Withdrawal of consent can be in any form: verbal, active resistance, repeated noncompliance, or any other unwillingness to continue participating in treatment. If I withdraw consent, I will be responsible for paying for the services that I have already received.

My signature below shows that I understand and agree with all of the above statements. The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions. If the client is a minor or has a legal guardian appointed by the court, the client's parent(s) or legal guardian(s) appointed by the court, the client's parent(s) or legal guardian(s) must sign this consent and provide copies of Court/Custody Papers (if applicable).

Appointments not cancelled within 24 hours are subject to a **$60.00** administrative fee.

I UNDERSTAND THAT I AM RESPONSIBLE FOR FINDING A NEW THERAPIST IF I FAIL TO SHOW UP FOR TWO CONSECUTIVE APPOINTMENTS, WITHOUT PROVIDING A 24 HOUR NOTICE. WE WILL NOT CONTINUE TO PROVIDE SERVICE AFTER TWO NO-SHOWS. I HAVE READ AND AGREE TO THE ABOVE POLICY TERMS.

X (Client / Parent / Guardian Signature) Date

Notice of Privacy Practices Receipt and Acknowledgment of Notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of: **Above It All Counseling Group Notice of Privacy Practices**.

I understand that I may request a hardcopy of Above It All Counseling Group Notice of Privacy Practices or may access an electronic copy via Above It All Counseling Group's Website: **www.aboveitallcounseling.com**

I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Above It All Counseling Group, at **Above It All Counseling Group at 218 Brighton Park Blvd., Suite B, Summerville, SC 29483, 843-425-2116**

X (Client / Parent / Guardian Signature) Date

X (Signature of Personal Representative – **if applicable**) Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*_____

Above It All Counseling Group

Teletherapy Consent Form

This Informed Consent for Teletherapy contains important information for using the phone or the Internet for counseling services. Please read this carefully and let us know if you have any questions. When you sign this document, it will represent an agreement between with Above It All Counseling Group.

Benefits and Risks of Teletherapy

Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of teletherapy 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 if unable to continue to meet in person. Although there are benefits of teletherapy, there are some differences between in-person psychotherapy and teletherapy, as well as some risks.

- **Risks to confidentiality.** Teletherapy sessions take place outside of the clinician's private office, therefore there is potential for other people to overhear sessions if you are not in a private place during the session. All clinicians and student's will take reasonable steps to ensure your privacy and will use HIPAA compliant platforms. It is important for you to make sure you find a private place for session where you will not be interrupted. We ask that individuals participate in therapy only while in a room or space where other people are not present and cannot overhear the conversation. We ask all clients to not be driving at the time of their appointment.
- **Issues related to technology**. There are many ways that technology issues might impact teletherapy. 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. Above It All Counseling Group only uses platforms that are HIPAA compliant to minimize risks.
- **Crisis management and intervention.** If a crisis situation occurs during the session it may be required for clinicians to access a higher level of support and intervention. If an emergency occurs before engaging in teletherapy sessions again, an emergency response plan will be in place to address potential crisis situations that may arise during the future.
- **Efficacy**. Most research shows that teletherapy is about as effective as in-person psychotherapy. However, some clinicians and clients believe that something is lost by not being in the same room.

Electronic Communications

Above It All Counseling Group uses HIPAA compliant teletherapy services that should be fairly easy for anyone to use. Teletherapy services can be used from a computer or cellular phone. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in teletherapy. For communication between sessions, email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters and should be directed to the administrative team. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, clinical information will not be discussed by email or text and prefer that you do not either. 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. Clinicians will try to return calls 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.

Confidentiality

Above It All Counseling Group has a legal and ethical responsibility to make the best efforts to protect all communications that are a part of teletherapy services. However, the nature of electronic communications technologies is such that Above It All Counseling Group cannot guarantee communications will be kept confidential. Above It All Counseling Group 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. Above It All Counseling Group asks that clients take reasonable steps to ensure the security of communications (for example, only using secure networks for teletherapy sessions and having passwords to protect the device you use for teletherapy). The extent of confidentiality and the exceptions to confidentiality outlined in Informed Consent still apply in teletherapy. Please let us know if you have any questions about exceptions to confidentiality.

Appropriateness of Teletherapy
Above It All Counseling Group will let you know if teletherapy is no longer the most appropriate form of treatment for you. The clinician will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. To address some of these difficulties, Above It All Counseling Group has emergency plans in place if engaging in teletherapy services. Above It All Counseling Group will ask you to identify an emergency contact person who is near your location and who your clinician will contact in the event of a crisis or emergency to assist in addressing the situation. Above It All Counseling Group 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 your clinician 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 your clinician will wait two (2) minutes and then re-contact you via the teletherapy platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call your clinician or the main office on the phone numbers provided.

Fees
The same fee rates will apply for teletherapy 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 teletherapy sessions in order to determine whether these sessions will be covered.

Records
The teletherapy 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.

X (Client Signature) Date

X (Client's Parent / Guardian Signature) Date

Coordination with Primary Care Physician or Psychiatrist (if applicable)

It may be beneficial for our practice confer with your Primary Care Physician or Psychiatrist (if applicable) with regard to your mental health treatment. In addition, some Managed Care Plans require that we notify your physician/ psychiatrist by telephone or in writing concerning mental health services, unless you request that notification not be made. This information will not be released without your consent, except in an emergency.

Please check one of the following:

_____**I do** authorize Above It All Counseling Group to contact my Primary Care Physician or Psychiatrist whose name and address are shown below to discuss the diagnosis, treatment plan, and prognosis while under Above It All Counseling Group, LLC care. In addition, Above It All Counseling Group is authorized to obtain information from my Primary Care Physician or Psychiatrist concerning my medical diagnosis and treatment.

_____**I do not** authorize Above It All Counseling Group, to contact my Primary Care Physician or Psychiatrist whose name and address are shown below to discuss the diagnosis, treatment plan, and prognosis while under Above It All Counseling Group care. I am providing Above It All Counseling Group with the name and address of my Primary Care Physician or Psychiatrist for informational purposes only.

Name of Primary Care Physician:_____Phone #:_____

Name of Psychiatrist (if applicable):_____Phone #:_____

X (Client Signature) Date

X (Client / Parent / Guardian Signature) Date

Above It All Counseling Group

Consent for E-Mail and Electronic Means of Communication

As a covered entity under the HIPAA Privacy and Security Rules, we take your privacy and right for confidentiality seriously. Although it is convenient, email and other forms of electronic communication is not a secure medium because third parties can view and store confidential information. Therefore, email and other forms of electronic communication are *not* to be considered completely confidential forms of communication, and using email runs the risk of breaching your confidentiality.

RISKS OF USING E-MAIL & OTHER FORMS OF ELECTRONIC COMMUNICATION TO COMMUNICATE WITH ABOVE IT ALL COUNSELING GROUP Transmitting client information by e-mail has a number of risks that clients need to consider before using e-mail to communicate with your therapist. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by unintended recipients.
- E-mail senders can easily type in the wrong email address.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies or e-mail may exist even after sender or recipient has deleted his or her copy.
- Employers and on-line services have a right to archive & inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-Mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

TYPES OF PERMISSIBLE E-MAIL OR ELECTRONIC COMMUNICATION THAT CLIENT AGREES TO SEND AND/OR RECEIVE the types of information that can be communicated via e-mail with Above It All Counseling Group includes (please check which items you consent to): Appointment scheduling requests and appointment reminders Billing and insurance questions and patient education

☐ Use of e-mail for general client information only. **I agree not to use e-mail for clinical or psychiatric emergencies, other time sensitive matters, or for non-general clinical information**.

If you are an active client of Above It All Counseling Group and experiencing an urgent, clinical emergency and the office is closed, you may call emergency services at 911. Our office hours are 9am – 6 pm, Monday through Friday or please leave us a voice mail message if you have updated information.

If you feel that you have a **life-threatening emergency, call 911 or go to the nearest emergency room**. In addition, contact the **National Suicide Prevention Hotline # 1-800-273-8255 or 1-800-784 2433** to be connected to a skilled, trained counselor at a crisis center 24/7.

As part of our commitment in delivering the best care and service to you, we recently upgraded our electronic record system. We are pleased to now offer the option of receiving electronic text message, email, or telephone appointment reminders.

As a reminder, appointments not cancelled within 24 hours are subject to a $60.00 administrative fee.

Please complete the following sections to begin receiving automated appointment reminders:

Please Complete: [Print]

Client Name:_____

Email Address:_____

Phone #:_____

Please choose all that apply:

_____Electronic Text Message

_____Email Message

_____Telephone Message

_____None

Above It All Counseling Group

FINANCIAL POLICY

If you are not insured, payment in full is expected at time of service. Our services are charged as follows:

- **Comprehensive Clinical Assessment / Diagnostic Interview -$200.00**
- **Individual Therapy (60 minutes) - $150.00**
- **Family Therapy - $175.00 per hour**
- **Couples / Marital Therapy - $175.00 per hour**

First Appointment: Please arrive for your initial appointment 15 minutes early so that all paperwork may be completed before you see the clinician. Please bring your current insurance card with you EACH VISIT. On follow-up visits, you will be asked to verify demographic/insurance information so that our records remain up-to-date. Please be prepared to pay for the current visit as well as any past balances on your account. Payment for services will be required at the time of service. For your convenience, we accept CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS, AND DEBIT and keep your information on file.

Insurance Claims: For in-network insurance benefits, we will directly bill your insurance company on your behalf, using electronic claims submission. The full hourly rate for service will be billed to your insurance company. For insurance panels for which the Above It All Counseling Group providers are in-network, payment from insurance plus the applicable copays, deductibles, or coinsurance payments from patients may be less than the amount billed, however, Above It All Counseling Group has agreed to accept this as payment in full. For families using in-network benefits, you are responsible for paying Above It All Counseling Group the copay, deductible and/or coinsurance established by your insurance provider.

Collections: Accounts will be sent to collections after 90 days if not paid as agreed. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, our practice has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require our practice, as allowed by law, to disclose confidential information about you. You agree that if we must collect on your account that you will be responsible for the costs of collection, including attorneys' fees. In most collection situations, the only information our practice would release regarding a client's treatment is his/her name, the type of services provided, and the amount due [If such legal action is necessary, these costs will be included in the claim].

Missed Appointments and Late Cancellations: Please be mindful that your appointment time is reserved **exclusively** for you and be considerate of others – if you miss your appointment or cancel at the last minute, we will be unable to provide care for another client in your place and have no way of recovering lost revenue due to "no-shows" or last-minute cancellations.

Above It All Counseling Group charges a *$60 administrative fee for missed appointments or appointments cancelled / rescheduled with less than 24 hours advance notice (*Note: excludes the case of emergency situations). This fee is non-refundable and is **not** covered by your insurance or EAP. This fee will be charged to the card on file and at the time of the missed appointment unless other arrangements are made prior.

REVIEW OF PSYCHOLOGICAL / MEDICAL FORMS; DISABILITY CLAIMS, FORMS, REPORTS, & LETTER COMPLETION (COMPLETED OUTSIDE OF APPOINTMENT TIMES): $150 BASE FEE.
TELEPHONE CONSULT / AFTER-HOURS CONSULT WITH CLINICIAN - $60 (PER 15 MINUTES OR PORTION THEREOF) E-MAIL CONSULT WITH CLINICIAN - $60 PER ISSUE E-MAIL
COURT APPEARANCE / COURT TESTIMONY - $1,000 / Hour

I understand that I am financially responsible for all payments and missed appointments, or appointments cancelled without 24-hour notice. I confirm that information I provided is accurate and complete, to the best of my knowledge.

I understand that I am responsible for payment before services are rendered; I will be financially responsible for payment in full. I am also responsible for informing Above It All Counseling Group of any changes in my address, phone number, and emergency contact information.

All cash paying clients will receive a discount of $25 for individual or family sessions.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT
I have had the opportunity to discuss the above and acknowledge that I have read and fully understand and agree with the terms, policies, and conditions outlined in Above It All Counseling Group consent forms. I hereby acknowledge that any questions I may have had were answered.

X (Client / Parent / Guardian Name – **PLEASE PRINT** Date

X (Client / Parent / Guardian Signature) Date

Above It All Counseling Group

Above It All Counseling Group

Standard Authorization Mental Health Treatment

I,_____[Name of Patient/Client], whose Date of Birth is_____,
Authorize Above It All Counseling Group to disclose to and/or obtain from: _____

_____
the following protected health information (as that term is used in HIPAA) [Insert Name of Primary Care Physician, Psychiatrist, Practice, or Organization]:

Description of Information to be Disclosed (Client should check each item to be disclosed)

_____**Description of Care / Services Provided, Fees, & Charges Owed, & Other Information as is necessary to submit a claim to my insurer(s) and be paid**
_____**Client initials to indicate agreement for All information checked**

	Assessment		Verbal Communication		Progress in Treatment		Discharge Summary
	Diagnosis		Medication Management Info		Treatment Plan or Summary		Other
	Current Treatment Update		Participation in Treatment		Demographic Information		Other

Purpose The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. IT IS NOT THE PURPOSE OF THIS AUTHORIZATION TO AUTHORIZE THE RELEASE OF PSYCHOTHERAPY NOTES, AS DEFINED BY HIPAA. IF I WISH OR HAVE A NEED TO AUTHORIZE THE RELEASE OF PSYCHOTHERAPY NOTES, I WILL EXECUTE A SEPARATE AUTHORIZATION AUTHORIZING THE SAME. If the purpose is other than marketing, sale of information, research or as specified above, please specify:

Research: If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Above It All Counseling. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires on (i) 180 days following last treatment, or (ii) as otherwise indicated the following date:

Conditions: I further understand that Above It All Counseling Group will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: [Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections. I will be given a copy of this authorization for my records and acknowledge receiving a copy.

_____

X (Client / Parent / Guardian Signature) Date

_____

X (Signature of Personal Representative – **if applicable**) Date

**If you are a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*_____

_____

X (Signature of Staff Witness) Date