

This document contains information required by federal and state law.

Client Information and Consent to Treatment/Evaluation

Welcome to Psychology & Counseling Associates, PC (PCA). This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have 1) taken action in reliance on it; 2) if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or 3) you have not satisfied any financial obligations you have incurred.

BEHAVIORAL HEALTH SERVICES

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

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

If you accept a referral for psychiatric services, treatment recommendations may include prescription medication. The psychiatrist will discuss risks and benefits of any medication prescribed.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what your treatment will include and an initial treatment plan, if you decide to continue with therapy. In some cases, particularly with children, the initial evaluation will take several sessions. You should consider this information along with your own assessment about whether your therapist is a person with whom you feel comfortable working. Therapy involves a large commitment of time, money and energy. If you have questions about your treatment, diagnosis, or sessions, you should discuss them with your therapist whenever they arise. If you are unable to discuss your concerns with your therapist, you may call and ask to speak with the Director.

APPOINTMENTS

Each therapy session will be approximately 45 minutes in length. Please be aware that your therapist will make every effort to be available to you at your appointment time. Because this time could have been available to another person, we will expect you to keep any appointment you make unless an emergency occurs or you give 24 hours notice. **Please refer to the Financial Policy agreement for our financial policies.**

CONTACTING US

We maintain a voice mail system that is available to take your messages 24 hours a day. In most cases, non-urgent messages can be left on voice mail and will be picked up and returned within a few hours during daytime office hours. Some of our therapists use email or texts for routine communication about appointments and other matters. If you communicate with your therapist via email or text, please be aware that privacy and security are a complex issue and cannot be guaranteed at the same level as telephone or written messages.

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EMERGENCIES

Your therapist, or someone else in our practice, will be on call for emergency assistance during regular office hours (9 am to 5 pm). From 5 pm to 9 am, weekends, and major holidays, emergency assistance will be handled by Belmont Behavioral Health (part of the Einstein Healthcare Network). When you call our voicemail system, follow the prompts for emergencies and you will be connected to an office person (during office hours) or to a representative at Belmont Behavioral Health (during non-office hours). Please identify yourself as a patient of Psychology and Counseling Associates when speaking to Belmont. You can reach Belmont Behavioral Health directly at 1-800-220-4357 or 215-581-3980.

If you are having any difficulty getting through to the appropriate person, or are unable to wait for a return call by a therapist (during office hours), or are in need of immediate attention, please go the nearest emergency room or call 911.

If you block anonymous calls, please turn off such blocking while you wait for a return call as we often return calls from confidential telephone numbers. Do not use email or texts for emergency communications.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a licensed mental health professional. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of any patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record.
- You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share your protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member. Even within PCA, only necessary information is shared. If more than one member of a family is in treatment here, therapists involved will share information only with your permission.
- We also have contracts with an answering service, an electronic billing company, computer services providers and other vendors. As required by HIPAA, we have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract. Again, only necessary information is shared.
- Disclosures required by health insurers are discussed elsewhere in this agreement.

The HIPAA Notice spells out situations where we are required to release information even without your consent. There are some situations in addition to those included in the Notice where we are permitted or required to disclose information without either your consent or Authorization:

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If we believe you are a danger to yourself or others, we will do whatever we need to do to protect you and others, including contacting your family, emergency services, or the police.
- If we have reason to suspect, on the basis of our professional judgment, that a child is or has been abused, we are required to report our suspicions to the authority or government agency vested to conduct child abuse investigations. (Please see the HIPAA Notice for more details.)

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Based on Act 147, passed by the Pennsylvania state legislature in 2005, it is PCA's policy that minors aged 14 – 17 control consents to release information, except that parents/legal guardians can consent to release of records to a primary care physician or current mental health provider if we believe it is in the minor's best interest. Parents/legal guardians have the right to: information necessary for providing consent, including symptoms, conditions to be treated, medications, other treatments, risks, benefits, and expected results.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you read the HIPAA notice and we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our professions require that we keep treatment records. You are entitled to receive a copy of the records unless we believe that seeing them would be emotionally damaging, in which case we 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. We recommend that you review them in the presence of your therapist so the contents can be discussed. Patients will be charged an appropriate fee for any time spent in preparing information requests, and for the records themselves.

If more than one person is seen in a session, both must consent to any release of the record.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will submit claims to insurance companies and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; **however, you (not your insurance company) are responsible for full payment of our fees.** It is very important that you find out exactly what mental health services your insurance policy covers. Often, YOU must make an initial contact with your insurance company and tell them you are beginning treatment with us to obtain prior authorization. You should carefully read the section in your insurance coverage booklet that describes behavioral health services, including the maximum number of sessions per year. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. Your health insurance company is required by state and federal law to maintain the privacy and security of any information we share with them. If you have questions about what your health insurance company does with the information that is disclosed to them, you may contact them to request a copy of their Notice of Privacy Practices. Increasingly, billing is electronic, rather than dependent on paper claim forms. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

Additional Consent to Treat a Minor:

Therapy is most effective when a trusting relationship exists between therapist and patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of

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independence and autonomy. By signing this agreement, you will acknowledge that we will provide your child with age-appropriate privacy and confidentiality.

It is our policy to provide you with general information about treatment status. We will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, we will share that information with you. We will not share with you what your child has disclosed without your child's consent. We will tell you if your child does not attend sessions. We will share general information such as issues discussed, progress made, and what other areas are likely to require intervention in the future. The details will vary with the age of your child and the specific situation—your therapist will clarify these issues in the initial session(s). If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Some of these behaviors may be minor problems, but at other times they may require parental intervention. Feel free to discuss with your therapist any concerns you have about how these issues will be addressed. If we ever believe that your child is at serious risk of harming him/herself or another, we will inform you.

The following is specific to potential custody or other legal disputes:

I am aware that requesting the release of treatment plans, notes or reports in custody disputes, or subpoenaing testimony about any of the content of my child's treatment, interferes with the therapy relationship and jeopardizes any gains made in psychotherapy. Therapists must be able to be neutral in family legal conflicts to be helpful. I agree that the role of Psychology and Counseling Associates (PCA) is limited to providing treatment and that I will not involve PCA in legal disputes, especially a dispute concerning custody, custody arrangements, visitation, etc. Therefore, I knowingly and freely waive my right to request the release of information to myself or my attorney or any other Officer of the Court for such disputes. I agree to instruct my attorneys not to subpoena PCA or its staff, or to refer in any court filings to what PCA staff has said or done. Except for records of attendance and billing, I understand that release of clinically significant information shall be by Court Order, signed by a duly appointed Judge. If I share legal custody of my child and both parents consent to treatment and I decide to withdraw my consent against the other parent's wishes, I agree to 4 termination sessions if PCA staff believes it is in my child's best interest.

PCA will continue to release records to your child's physician for treatment purposes with the consent of one parent.

If there is a court appointed evaluator in a custody dispute, and if appropriate releases are signed by both parents and a court order is provided, PCA will provide general information about the child which will not include recommendations concerning custody or custody arrangements. If for any reason, PCA staff are required to appear as a witness or speak to a custody evaluator or judge, time spent preparing reports, traveling, reviewing files, or other case-related costs will be charged at a non-insurance based rate to the party responsible.

SIGNATURE FOR CONSENT TO TREAT MINORS:

Child's name	Parent or guardian name	Signature	Date
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FOR ALL CLIENTS:

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

Print name (Relationship) (for minors, age)	Signature	Date
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