Therapeutic Counseling South Carolina, Inc.
Consent for Services

Patient Name: _____ Patient Date of Birth: _____

Therapist: _____

By initialing each below, I acknowledge that I have read and accept these terms. Place N/A where necessary.

_____ I understand that phone conversations in excess of 10 minutes will be billed as a brief session, and I agree to pay out of pocket according to the time (Example: 15 minutes = $25).

_____ If I am told by my therapist that the email volume approximates a session I will be advised and billed accordingly.

_____ I understand that payment is expected at the time of service.

_____ I understand that appointments are scheduled for 45-50 minutes unless otherwise explained to me by Therapist. If I am late, I understand that I will forfeit that time and agree to an abbreviated session.

_____ Likewise, when I have an appointment and am unable to attend, I will make every effort to notify the counselor as soon as I can. If I do not call/email/text 24 hours in advance and/or do not show, I will be charged a $50 fee.

_____ Unless other arrangements are made, the regular fee is $100.00 per 45-50 minute session and $120 for an initial 50 minute session.

_____ If my child is 10 years of age or older, I waive my HIPAA right to request therapy records, and agree not to receive a copy of the therapy notes in order to protect the therapeutic process.

_____ I understand that in the state of South Carolina both legal parents (regardless of custody) have full access to my child's medical record. My child's medical record includes the following: sessions with either parent, as well as sessions with the child alone.

_____ I understand the therapist does not specialize in custody and it is outside the scope of her practice. I will be discharged upon family court cases becoming active.

_____ I agree not to request my child's records for court purposes that pertain to issues of divorce and/or custody.

_____ I hereby acknowledge and agree that I will not audio or video record anything therapy related unless done so with expressed permission of the therapist, prior to recording. I also understand that doing so without consent interrupts the therapeutic alliance and may cause me to be dismissed from the practice.

_____ I have read and agree with statements on pages 3-6 of the Consent for Services Form.

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Permission is hereby given to Therapeutic Counseling South Carolina, Inc. to render treatment and/or service to:

Patient name: _____

Whose relationship to me is ___ Self ___Child ___ Other (Specify: _____)

My signature indicates that I have read and understand the information on pages 3-7 of this document, and that I agree to the terms of services. I agree and accept the fees for those services as lawful debt, and agree to pay costs of collections, attorney fees, and court costs, if necessary. I waive now and forever the right to claim exception under the Constitution and laws of the State of South Carolina or any other state. I also understand that failure to pay these fees may result in release of my name, phone number, address, and other info during the collection process.

Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Credit Card Information:

Cash and personal checks are welcomed, but many clients find it convenient and preferable to allow this office to hold on file a credit card to facilitate transactions.

____ Initial if you agree to pay the fee/copays with your card listed below.

Type: ___Visa ___Mastercard ___Discover __AMEX

Card Number: _____ Expiration Date: _____/_____

Name on Card: _____ Security Code: _____

Zip Code: _____

Reminder Service:

As a courtesy to clients, I can send you an email reminder to alert you to your appointment. You will still need to contact me directly via text, email, or phone should you need to make any changes to your appointment. **Please remember to provide at least 24 hours-notice when canceling any appointment to avoid charges.**

For appointment reminders, please Email

Emergency Info:

If you are having an emergency and the therapist cannot be reached by phone, you need to call 911 or go to the nearest emergency room. You may also contact the Tri-County Crisis Stabilization Center at (843) 958-3530, or the Mobile Crisis program at (843) 727-2086.

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Patient Rights and Business Policies:

This document contains important information about Therapeutic Counseling South Carolina professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that you are provided with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail.

PSYCHOTHERAPEUTIC SERVICES

During the initial consultation(s), you and your therapist will work together to establish the needs, concerns, and goals for your child, self, and/or family. In order for therapy to be most successful, it will be essential for your child, self, and/or family to work on various skills both during the sessions and at home between sessions. If you have any problems or concerns about the course of treatment, please discuss them with the therapist immediately. If your concerns continue, the therapist will be happy to help you set up a meeting with another mental health professional if you so desire. It is certainly your choice whether to continue services for your child, self, and/or family. The therapist will also not agree to work with your child, self, and/or family if he/she believes that there is a reasonable chance that work cannot be productive.

MEETING

Although the therapist will make every effort to avoid interruptions and delays, he/she may occasionally be unavailable for part or all of the regularly scheduled appointments (e.g., due to emergencies with other patients). These possible interferences are sometimes unavoidable. The therapist will try to provide you with a new appointment as soon as possible should this ever occur.

Appointments are contracted time. When you make an appointment, the therapist sets aside that time to spend with you. If you are unable to make a scheduled appointment, *please cancel 24 hours prior to the appointment time* so that the therapist can offer the time to another client. **If you do not cancel at least 24 hours prior to your appointment time, you will be responsible for the session fee.** If you are late for a session, you will most likely miss part of your therapy time.

Telehealth Expectations:

- Client commits to a safe, private location for sessions unlikely overheard or interrupted
- Responsible adult party is on the premises during sessions with therapist and minor clients
- Sessions cannot be recorded by either therapist or client without prior notification or permission
- Clients agree to follow technical failure procedures as previously discussed by therapist and client
- Clients agree to verify physical location at the start of each session (in case of emergency)

CONTACTING THE THERAPIST:

- The therapists' telephones and voicemails are completely confidential, but the therapist cannot always be immediately available, and will return calls within 24-48 hours during regularly scheduled office hours.
- You are welcome to leave voicemails, text messages or email to reach the therapist.
- Issues that you may need to email about will be discussed during the next appointment and not via email. Email should never be used in the case of an emergency!
- The therapist is available via phone for quick check-ins, scheduling, and other routine matters. However, there is a charge for calls lasting 10 minutes or longer ($25/15 minutes).
- If the therapist will be unavailable for an extended time, he/she will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL FEES

Legal consultations: Legal consultations (e.g. documents prepared for attorneys, telephone consultations with them, etc.) are charged at $500 per day and possibly at hourly rate of $100 per hour, depending on services being requested. These services must be paid by check (made out to Therapeutic Counseling South Carolina) or by cash. If you become involved in legal proceedings that require participation from the therapist, you will be expected to pay for all professional time, including preparation time, transportation costs, ancillary expenses, etc., even if the therapist is called to testify by another party. You will be expected to pay for time in or at court (e.g., while waiting to testify as instructed to arrive, but not called upon until later), even when the therapist is called to testify for another party. The therapist does not specialize in legal matters and you will most likely be referred to a professional who specializes in these matters.

Billing and Payments: You will be expected to pay for each service at the time it is provided, unless other prior arrangements are made. Unpaid balances should never accrue. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, Therapeutic Counseling South Carolina 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 the therapist to disclose otherwise confidential information.

You are responsible for full payment of psychotherapy service fees. P**ayment is always due at or before the time of service.**

PROFESSIONAL RECORDS

The laws and standards require that mental health professionals keep Protected Health Information (PHI) about you in your Clinical Record.

> *Clinical Record.* Your clinical record includes information about your reasons for seeking therapy for yourself, your child, and/or family, the ways in which these problems impact life for yourself, your child, and/or family, the diagnosis, the goals set for treatment, progress towards these goals, medical and social history, treatment history, any past treatment records received from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone.

Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to the therapist confidentially by others, or the record makes reference to another person (unless such other person is a health care provider) and the therapist believes that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them in the presence of the therapist, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, the therapist is allowed to charge a copying fee of $1 per page (and for certain other expenses). If the therapist refuses your request for access to your records, you have a right of review (expect for information supplied to the therapist confidentially by others), which the therapist will discuss with you upon request.

MINORS & PARENTS

If you are under 16 years old, please be aware that the law may provide your parents the right to examine your treatment records. Because privacy in psychotherapy is often crucial to successful progress particularly with teenagers, it is preferable to receive agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, the parents will be provided only with general information about the progress of your work together and attendance at scheduled sessions, unless the therapist suspects there is a high risk that you will seriously harm yourself or someone else. In this case, the therapist will notify parents with concerns. If requested in writing, the therapist will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, with exception of suspected risk of harm. Before giving parents any information, the therapist will discuss the matter with the child, and any objections he/she may have.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and mental health professionals. In most situations, the therapist can only release information about your child, self, and/or family's 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:

- **For case consultation with other professionals:** The therapist will make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. The therapist will note all consultations in your Clinical Record.

- **Administrative purposes:** Such as billing. All staff members are held to HIPAA standards about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Situations where disclosure is permitted or required without either your Consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services provided to you, such information is protected by

the counseling patient privilege law. The therapist cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order the therapist to disclose information.

- If a government agency is requesting the information for health oversight activities, the therapist is required to provide it to them.

- The therapist may disclose relevant information regarding a patient in order to defend or protect the professional license (for example, if the patient files a complaint or lawsuit against the therapist).

- Mandated Reporting: Mental Health Professionals are required to disclose information to the Department of Social Services if they receive information that gives them reason to suspect that a child or vulnerable adult's physical or mental health or welfare has been, or may be adversely affected by abuse or neglect, or by acts or omissions that would be abuse or neglect if committed by a parent or other caretaker. A report may also be made to the appropriate law enforcement agency. Once such a report is filed, the therapist may be required to provide additional information.

- If a patient threatens to harm himself/herself, the therapist may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

- If a patient reveals his or her intent to commit a crime, the therapist may be required to take preventative action, such as calling the police.

If such a situation arises, the therapist will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

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

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include the following:

- You can request that the therapist amend your record.
- You can request restrictions on what information from your Clinical Record is disclosed to others.
- You can request an accounting of most disclosures of PHI that you have neither consented to, nor authorized; determining the location to which PHI disclosures are sent.
- You can have any complaints you make about the policies and procedures recorded in your records.
- You have the right to a paper copy of this Agreement.

- You have a right to a paper copy of the notice form and the privacy policies and procedures.

PLEASE INITIAL AND SIGN WHERE INDICATED ON PAGES 1 AND 2 OF THIS DOCUMENT TO INDICATE THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE BEEN OFFERED A COPY OF THE SUMMARY OF PATIENT PRIVACY NOTICES FORM, WHICH IS POSTED IN THE OFFICE.