Creating Connections Counseling Services, LLC

Consent to Treatment/Release of Information/ Payment Policy/ Authorization to Pay/ Late Cancellation/No Show Policy

CONSENT TO TREATMENT

I, ______________________________, voluntarily consent to therapy by the counselor at
(PLEASE PRINT FIRST AND LAST NAME)
Creating Connections Counseling Services as deemed necessary in his/her judgment. I am aware that counseling is not an exact science and that no guarantees have been made to me regarding possible outcomes of said counseling.

______________________________ ______ / ______ / ______
(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY) (DATE)

RELEASE OF INFORMATION

ATTENTION PATIENTS WHO REQUIRE SECURITY CLEARANCE, SUCH AS THOSE WHO WORK FOR THE GOVERNMENT

If you work for the government or plan to work for the government in the future, be advised that a diagnosis submitted to your insurance company for the purpose of processing a claim in your name could have an adverse effect on your security clearance. In these instances, we recommend that you not use your insurance to pay for your sessions.

I hereby authorize Creating Connections Counseling Services to release only that information that is relevant about me to my primary care or referring physician (if applicable), to consultants (if needed) and to insurance carriers to process insurance claims. I authorize any physician or healthcare facility to provide, upon request, Protected Health Information about me to Creating Connections Counseling Services for the purpose of facilitating my care or obtaining payment for services rendered to me.

Creating Connections Counseling Services contracts out the billing to a Capital Recovery Resources, I hereby authorize for Creating Connections Counseling Services to release only that information that is needed to submit insurance claims to Capital Recovery Resources.

______________________________ ______ / ______ / ______
(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY) (DATE)

PAYMENT POLICY

If I have insurance coverage for therapy sessions, and if I choose to use said insurance for the payment of claims for therapy sessions, I agree to furnish Creating Connections Counseling Services current, up-to-date information about said insurance coverage, including a copy of my insurance card. I further agree to keep Creating Connections Counseling Services updated as to any changes in said insurance coverage. I further agree to pay the co-pay amount, if any, at the time services are rendered.

I hereby agree to pay for my therapy sessions, by cash or personal check, if any of the following situations apply to me:

- I do not have insurance coverage.
- I choose not to use my insurance coverage for therapy sessions.

(PLEASE CONTINUE ON NEXT PAGE)

PAYMENT POLICY (continued)

- I am covered by a commercial insurance plan in which the counselor at Creating Connections Counseling Services is not a provider.
- My insurance carrier denies my claims.
- My insurance coverage includes an annual deductible that has not been satisfied.

The amount of said payment shall be calculated according to the following sliding fee scale:

Combined Annual Household Income	Price per 50-Minute Session
Less than $25,000	$35
$25,000 - $40,000	$50
$40,000 - $55,000	$65
$55,000 - $70,000	$80
More than $70,000	$90

_______________________________________ _______ / _______ / _______
(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY) (DATE)

AUTHORIZATION TO PAY

I hereby authorize payment of claims directly to Creating Connections Counseling Services.

_______________________________________ _______ / _______ / _______
(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY) (DATE)

LATE CANCELLATION/NO-SHOW POLICY

I understand that the counselor at Creating Connections Counseling Services sees many patients and sometimes has a list of potential patients waiting to schedule appointments. I further understand that it is the goal of Creating Connections Counseling Services to see patients in a timely manner. When I schedule an appointment, that block of time is reserved just for me and I am expected to keep the appointment. If I cannot keep the appointment, it is my responsibility to give at least 12-hour notice by calling Creating Connections Counseling Services at 575-915-4866 (and leaving an appropriate message if I reach voicemail).

I agree to pay a fee of $15 at my next appointment time if I miss a scheduled appointment without notifying Creating Connections Counseling Services at least 12 hours in advance of my appointment time. I am aware that it is legal to charge for missed appointments and that fees for same are not considered “covered expenses” by most insurance companies.

_______________________________________ _______ / _______ / _______
(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY) (DATE)

Creating Connections Counseling Services, LLC
Counseling Contract

What is Counseling?

Counseling is a change, growth and healing process in which you will be helped to learn to relate to and work through your feelings in healthy ways and learn to create strong and healthy intimate relationships.

Client Rights

Your counselor can be expected to respect you as an individual and to convey this respect by keeping appointments or contacting you if a change is necessary, by giving you complete attention during sessions and by providing the most effective counseling he or she can.

All information related to your attendance and participation in counseling will be maintained strictly confidential, with the following exceptions as required by law:

- If you disclose intentions or a plan to harm another person, disclose or imply a plan to harm yourself or commit suicide, or share information that suggests that a child or vulnerable adult is being abused, we are required to notify the appropriate authorities so that arrangements can be made to secure the safety of the individual involved.

- In the event of your death, your spouse or parents have a right to access their spouse's or child's records.

- Parents or legal guardians of minor clients have a right to access the records of their children.

- As deemed necessary, all information related to your attendance and participation may be shared with a licensed clinical consultant.

- For premarital counseling, information shared in the course of premarital counseling that, in the opinion of the counselor providing these services, is deemed a significant threat to the potential success of your relationship, will be shared openly with both parties involved as well as the pastor who will be performing the marriage ceremony.

- We encourage spouses to inform their marriage partner of their involvement in counseling. If contacted by the non-attending spouse, this counselor will acknowledge only that you are engaged in counseling.

- I/we give the counselor permission to notify our referral source of our attendance at our initial session:
  ☐ Yes ☐ No

- May we contact your primary care physician to coordinate care, if appropriate? ☐ Yes ☐ No

The Benefits and Risks of Counseling

As you grow and change, this can be challenging and can bring out feelings of fear and anxiety. This process can also be disruptive to close relationships—some may challenge you to stay the same as you strive to grow. The counselor-client relationship can bring out positive and negative emotions and discussing these feelings with your counselor is an important part of the change process. Most clients who decide to accept the risks of counseling find that it is helpful and that the feelings generated by the counseling process are necessary to discover healthier ways to deal with concerns. It can be easy to quit when the emotions intensify and you are challenged to be different, but we encourage you to continue with the counseling process even though it may be difficult.

Client Responsibilities

To ensure that you receive the most effective counseling possible:

- Be open and honest about your thoughts, feelings and behaviors.
- Come prepared to focus on a specific problem or issue.
- Give priority to your appointment by turning off all communications devices.
- Stay actively engaged both during and between sessions, reflecting on sessions and completing homework.

(PLEASE TURN PAGE OVER AND COMPLETE THE OTHER SIDE)

Once your appointment has been scheduled, it is your responsibility to keep the appointment. If for any reason you are unable to keep your appointment, we request that you call the counseling service, preferably 24 hours prior to your appointment time. You may be charged a $15 late cancellation fee if you fail to provide at least 12 hour's notice prior to your appointment. If you are not able to keep your appointment and do not call to cancel, your appointment time will become available to another client. If you miss a regularly scheduled appointment, we request that you contact the counseling service within two working days if you wish to schedule another appointment with this counselor.

Counselor Responsibilities

You can expect your counselor to:

- Give priority to your appointment by blocking outside interruptions.
- Treat you with care, respect and dignity.
- Be open and honest about counseling techniques, goals and procedures.
- Seek consultation with other experts in the area of specialty being focused on.
- Refer or terminate a client when necessary and appropriate, only after discussing the reasons with the client.
- Be concerned for your progress. This includes considering how often you meet, how long you meet, what you want to accomplish, and the progress being made.
- Provide appropriate after-hours services, including emergencies, when prior arrangements have been made. (In general, the counselor is not available for crises after hours. In the event of a crisis after hours, you are encouraged to call the appropriate crisis number. Cards with crisis numbers are available in our lobby.)
- Provide services beyond the session, such as consulting with other providers about you, filing reports and other paperwork, etc. (There could be an additional charge for these services, depending on the amount of time involved.)

Your counselor will help you sort out, understand and work towards resolving your issues and struggles, but will not directly solve your problems for you. Counseling is most effective when the counselor and client are equally invested in the change process.

Sometimes families and couples hold secrets, which can interfere with healing and maintaining healthy relationships. Secrets are not conducive to feelings of security and love. The counselor will be sensitive to feelings of shame and fear of losing a partner and will do his/her best to be supportive and maintain a sense of emotional safety in the session. If the counselor becomes aware of a situation that he/she feels is blatantly harmful, unfair or unethical, you may be asked to, or you may be asked your permission to, divulge the information before therapy continues. Maintaining the trust of all parties involved in counseling is crucial to the overall success of counseling. If the other parties involved in counseling later find out a secret was known and kept from them, they will likely feel betrayed and lose trust in the counselor, potentially disrupting or ending the counseling process.

You have the right to be informed about the training, licensure and education of your counselor:

Counseling sessions generally run 50 minutes; some sessions will run 90 minutes for premarital counseling. If for any reason you arrive at your session late, the session will end at the scheduled time.

After you end counseling, you may receive a brief evaluation questionnaire. This will help us evaluate our services in a constant effort to maintain quality, address any concerns you might have and provide feedback.

I have read and understood and/or had explained to me the terms of this client contract, have been offered a copy of the Federal Privacy Act (HIPAA) as it relates to counseling here at Calvary Counseling Service and I consent to treatment as indicated by my signature below:

______________________________	______________
CLIENT SIGNATURE	DATE
______________________________	______________
COUNSELOR SIGNATURE	DATE

Creating Connections Counseling Services, LLC

Summary Notice of Privacy Practices

Effective Date: Sept 24th, 2018

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU OBTAINED IN THE PROCESS OF COUNSELING MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Summary

One of our most important concerns as a counseling practice is maintaining confidentiality of patient records. This is to ensure that your health information remains private and is disclosed only to those authorized to receive it. These concerns translate into a formal law called the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). Calvary Counseling Service has to show compliance with this law.

For you, the patient, this means that we must display the actual Notice of Privacy Practices in our offices, provide you with a copy of the Notice if you request one, and ask you to sign this form saying that we have done so. The Notice covers the following areas, which require using the information we have on you, also known as INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI): counseling, payment for services, payments via the Internet, appointment reminders, treatment options, release of information to family/friends, email correspondence and disclosures required by law. We might also need to use your IIHI in certain special circumstances such as public health risks, lawsuits and similar proceedings, law enforcement and Workers Compensation.

The above does not state every single category for which we may use your IIHI. For a more complete list and to read the full text of the Notice, please request a copy of our Notice of Privacy Practices.

Your Rights

You have certain rights with respect to your personal counseling information: the right to inspect and copy, right to amend, right to request restrictions, right to receive confidential communications and right to a paper copy of this notice. You also have the right to file a complaint with us or with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated.

Changes to this Notice

We reserve the right to change this notice and to make the changed notice effective for all of the counseling information that we maintain about you, whether previously received or information we may receive in the future.

______________________________	______________________________
Patient Name (please print)	Patient Signature
______________________________	______________________________
Parent/Legal Guardian Name (please print)	Parent/Legal Guardian Signature