Foundations Family Counseling

Client Guidelines

Welcome to Foundations Family Counseling. We would like to take a moment to provide some information regarding our practice. Please review this document carefully as it provides you with our policies and procedures, we can discuss any questions you may have in your next appointment.

Services Provided

The treatment providers who work in this office are highly trained and legally qualified to provide a full range of psychological and/or counseling services to individuals, families, and couples. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems clients bring to treatment. There are many different methods used to manage problems that you hope to address. Psychotherapy is not like a medical doctor visit. It calls for a more active effort from clients. In order for the psychotherapy to be successful, it is important for clients to engage in appointments on a consistent basis and apply session work in your personal life.

Psychotherapy services are designed to help you find solutions to the problems that brought you to treatment. Therapy may be provided in individual, family, couples, or group settings depending on your specific needs. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness and helplessness. With proper engagement with your therapist, psychotherapy has the potential for life changing benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

The first few sessions will involve a thorough assessment of your needs. By the end of the assessment, we will provide impressions and recommendations of what our work will include, should you decide to continue with therapy. You should evaluate the initial feedback along with your own opinions and comfort working with your therapist. Therapy involves a large commitment of time, money and energy, so you should be conscientious about the therapist you select. If you have questions or concerns, please discuss them with your provider.

Appointments

An intake assessment is conducted prior to the initiation of treatment. This generally takes anywhere from one to three sessions. For therapy, sessions are generally scheduled once per week or biweekly for 60 minutes. Unlike physicians, psychologists only schedule one client in a given time slot. **If you must break an appointment, you must cancel at least 24 hours in advance, or a "late cancel/no show" fee of $100 will be charged to your account. Medical insurance companies will not pay for missed appointments; therefore in most cases you will be held responsible for this fee**. Psychologists must charge these fees, as we reserve an hour that cannot be reasonably refilled on short notice. We request that you responsibly schedule appointments and prioritize the time you schedule with our company.

Contacting your Therapist

In order to provide quality services to clients during sessions, your therapist will not be available by phone in many circumstances. If you need to communicate with your therapist at times other than your regularly scheduled appointment, you may call the office and leave a message. The receptionist will forward your message to the therapist who will determine an appropriate way to respond. The receptionist can work with you to make appointments or address questions you may have. When a receptionist is not available to accept your phone calls, you may leave a voice mail and the receptionist will review these messages and return your call as soon as they are able (usually within 24 business hours). If you are unable to reach agency staff and feel that you cannot wait for a return phone call, contact your family physician, or contact the nearest emergency room. If your therapist is not available for an extended period of time, any message that you might leave will be forwarded to the therapist who is providing “coverage” for them.

Fees

Fees charged for services vary based on the nature of the contact and the time involved. A list of fees is provided below:

First appointment (60 minutes)	$275
Psychotherapy (45 minutes)	$190
Psychotherapy (60 minutes)	$235
Family psychotherapy	$235
Group psychotherapy	$70

Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request. These services will be billed at a prorated rate of the regular hourly rate ($235). If you become involved in legal proceedings that require your therapist participation, you will be expected to pay for all of the professional's time, including preparation and transportation costs, even if called to testify by another party. You will be charged $400 per hour for these activities. Please note that insurance companies will not reimburse you for these services. If you request documents to be prepared for other entities, you will also be charged a prorated fee of $235 per hour for the completion of these documents.

Billing and Payment

You will be expected to pay in full for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires a different arrangement. In circumstances of unusual financial hardship, we will do our best to work with you to pay our fees in a scheduled manner.

You will receive a monthly statement itemizing all charges and payments if you owe a balance. If there is a balance due, it must be paid in full. Accounts overdue by more than 60 days may be sent to a collection agency and may result in termination of treatment. **Please note:** If paying by check and there are not sufficient funds in your account, you will be charged a **$35** fee that must be paid with cash or credit card.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. The office will 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. **You are responsible for knowing what your insurance policy covers**.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Our office will attempt to gather information regarding your coverage prior to the first appointment and will provide you with whatever information we receive. **Please note**: occasionally insurance companies provide us with inaccurate information.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Occasionally, clinicians are requested to provide additional clinical information ranging from treatment plans to copies of a client's entire record. We will inform you prior to sending any such information and will not send it without your consent. This information will become part of the insurance company files and likely be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

Misunderstandings about money sometimes arise. If there are billing or payment problems that have not been discussed, you and your counselor may become uncomfortable working together. Please discuss financial concerns with the office staff or your counselor if you have any questions or concerns.

Professional Records

The laws and ethics of mental health practice require us to maintain treatment records. You are entitled to receive a copy of your records unless there is clinical reason to restrict such access, in which case we will send your records to any mental health professional you choose. 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 provider in order to process the contents. Clients will be charged an appropriate fee for any time spent in preparing information requests.

Minors and Parents

Clients under 14 years of age who are not emancipated, be aware that the law allows parents to examine their treatment records unless the therapist decides that such access would injure the child. Children between the ages of 14 and 18 may independently consent to receive up to 6 sessions of psychotherapy (provided within a 30-day period) without information being disclosed to parents. While privacy in mental health treatment is often crucial to successful progress, particularly with teenagers, parental involvement is also frequently important for treatment.

For children age 14 and over, it is our policy to request an agreement between the client and his/her parents allowing us to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have. It is this agency's policy to attempt to engage both parental figures in their child's treatment unless parental rights have been terminated. Additionally, both parents may have access to view and/or request copies of the child's treatment record. If parental rights have been terminated, it is the responsibility of the parent who is seeking treatment for the child to provide documentation reflecting termination of parental rights.

Confidentiality

In general, the privacy of all communications between a client and a psychologist is protected by law, and information can only be released with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent the release of any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order the therapist's testimony if he/she determines that the issues demand it.

There are some situations in which all therapists are legally obligated to take action to protect others from harm, even if we have to reveal some information about a client's treatment. For example, if there is reason to suspect that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency.

If your therapist believes that a client is at imminent serious bodily harm to another, the therapist is required to take protective actions. These actions may include notifying the potential victim, contacting the police or seeking hospitalization for the client. If the client threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, every effort is made to fully discuss it with you before taking any action.

Generally, therapists find it helpful to consult other professionals about cases. During a consultation, every effort is made to avoid revealing your identity. The consultant is also legally bound to keep the information confidential. Generally, these consultations are not shared with the client unless doing so is important to the therapeutic work.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. Your therapist will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

Release of Liability

If you fail to show for an appointment, the office will attempt to contact you at the number you have provided. If we do not hear from you within one week for the missed appointment, you have released the agency of all liability for your psychological care. Also, if you cancel an appointment without rescheduling, you release the agency from all liability for your psychological care. You are welcome to reschedule at any time. Of course, there may be extenuating circumstances, such as an extended vacation, family emergency, unforeseen business trip, etc. in such cases, please contact the agency as soon as possible to keep us informed.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Further, you understand that the conditions of this policy apply equally in the case of treatment for a minor child, as the parent/legal guardian you are the only person who can consent to release information about the child's treatment.

Signature of Parent/Guardian Date

Print Name

Informed Consent

Your signature below indicates giving your informed consent for assessment and outpatient services for your child.

Signature of Parent/Guardian Date

Privacy Notice Acknowledgement

Your signature acknowledges that you have been given a copy of the Privacy Notice (rev. 2/1/17) and understand these rights and responsibilities. Further, that if you have any questions about these issues you understand that you can discuss them with your therapist or the agency's Privacy Officer.

Signature of Parent/Guardian Date

Billing Authorization

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on the account for any professional services rendered. If I do not pay this balance within 30 days of being billed, I understand that a 1.5% per month (18%/year) interest charge may be added to my account until the balance is paid in full. I certify the information I have provided is true and correct to the best of my knowledge, and I will notify you of any changes in my health insurance, employment, or contact information as soon possible.

Signature of Parent/Guardian Date

_____ I choose to self-pay for my child's therapy services.

_____ I choose to utilize my child's insurance benefits, and authorize you to release the needed information to insurance company to secure payment. Please sign below.

Health Insurance Claim Form Signature

Your signature is needed to bill your insurance company. Only sign if you plan on using your insurance benefits.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____ DATE_____	SIGNED _____

Cancellation Policy

I UNDERSTAND THAT IF I GIVE LESS THAN 24 HOURS NOTICE TO CANCEL AN APPOINTMENT, OR I DO NOT SHOW UP FOR A SCHEDULED APPOINTMENT, I AGREE TO PAY THE $100 CANCELLATION NOTICE, WHICH IS NOT BILLED TO INSURANCE.

Signature of Parent/Guardian Date

Psychosocial History
(Adolescent/Child Form)

Legal Name: _____ Date: _____

Name your child likes to be called: _____

Pronouns: _____ Date of Birth: _____ Age: _____

Parent/Legal Guardian Name(s): _____

Address: _____

_____

Family & Social Information

Names of biological parents: _____

Who raised your child? _____

What are the names and ages of brothers and sisters? _____

With whom does your child live? _____

_____

Who gives your child emotional support? _____

Who gives your child financial support? _____

Has your child ever been in trouble with the law? _____

Education & Occupational History

Where does your child go to school? _____

In what grade is your child? _____

Is your child in any special classes? (explain)_____

Does your child have a 504 plan or IEP? _____

Does your child have a history of developmental concerns or delays? _____

What kind of grades does your child receive? _____

Does your child participate in any extracurricular activities? Please list:

_____

What are your child's strengths? _____

What are your child's interests? _____

Does your child work? If so, where? _____

Abuse History

Has your child ever been physically abused? (describe)_____

Has your child ever been sexually abused? (describe)_____

Has your child ever been mentally abused? (describe)_____

Has your child ever witnessed domestic violence? (describe) _____

Medications

Medication	Dosage	Condition	Prescribing Physician

Does your child use drugs or alcohol? How often do they use? When did they last use? Please describe:

_____

_____

_____

_____

Mental Health History

Has your child ever seen a counselor before? (describe)_____

Has your child ever been hospitalized due to mental health concerns? Please provide dates of hospitalizations. _____

Has your child ever received treatment for a drug or alcohol problem? _____

Why are you seeking counseling for your child at the present time? _____

_____

_____

_____

_____

_____

_____

_____

Foundations Family Counseling

Email Consent Form

You can receive an appointment reminder to your email address, your cell phone (via text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.therapyappointment.com** to schedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Name of client _____ Date _____

I authorize Foundations Family Counseling, to leave detailed messages at the following email addresses:

Email address: _____

Warning Work email accounts are able to be accessed by employer;
email is not a secure HIPAA compliant transmission in most instances.

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Cell phone number: _____

I authorize the appointment reminders to be messaged in the following way (**Please check only ONE**):

- ☐ Via an email to the address listed above
- ☐ Via text message on cell phone (normal text message rates will apply)
- ☐ Via telephone call to my home phone
- ☐ I decline, do not leave any messages (missed session fees still apply)

I may revoke this authorization at any time in writing pending acknowledgement by the office.

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____

Signature of Parent/Guardian Date

Foundations
FAMILY COUNSELING

6641 N. High Street, Suite 205
Worthington, Ohio 43085
(614)504-4466 | (614)356-8960

Authorization to Release Information to Primary Care Physician

We believe coordinating your mental health care with your primary care physician is an important part of your treatment. As a reflection of this, our providers send a letter to your physician with your diagnosis, treatment goals, and a basic update of your progress following your initial session, and every three months thereafter. To give your provider permission to do this, please complete this form. If you do not wish to give your permission, you may leave this form blank. You may also discuss this with your provider before signing if you have questions.

Client Name: _____Date of Birth: _____

Name of Physician (PCP)/Practice: _____

PCP Address: _____

PCP Phone: _____

I hereby authorize Foundations Family Counseling and my primary care physician:

[ ] to exchange any information needed for diagnosis and treatment (including diagnoses, attendance in counseling, psychosocial history, alcohol/drug information, and treatment recommendations) with my physician

[ ] to exchange only diagnosis and medication information with my physician

[ ] not to exchange information with my physician

The purpose of this exchange of information is:

[ ] Coordination of care [ ] Formal evaluation

The information exchanged should reflect material collected:

[ ] Since first contact with the client [ ] in the last _____ year(s)

I may revoke my consent to release this information at any time except to the extent that action will have been taken or information released prior to the revocation of my consent. I understand that treatment is generally not a condition of my signing an authorization to release information. This authorization form is valid until six months after last contact. Generally, this information may not be re-released, but I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule. This information has been disclosed from records whose confidentiality is protected by Ohio Revised Code 5122.31.

Parent Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness: _____

Rev 01/2023

Informed Consent for Telehealth Services Definition of Telehealth

Telehealth involves the use of electronic communications to enable Foundations Family Counseling's mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. CFS utilizes secure, encrypted audio/video transmission software to deliver telehealth.

4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.

5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

8. I understand that my express consent is required to forward my personally identifiable information to a third party.

9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside

10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

11. I understand that different states have different regulations for the use of telehealth.

Payment for Telehealth Services
Foundations Family Counseling will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth or provide full coverage, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, payment will be due at the time of services. Payment may be made via credit card at the front office by calling: 614-504-4466. In the event payment cannot be made at the time of service, we will provide you with a statement to the address on file.

Patient Consent to the Use of Telehealth
I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____
Print Name

_____ _____
Client's Signature Date

_____ _____
Parent or Guardian Signature Date

Parental Rights Statement

Client Name:_____

It is this agency's policy to attempt to engage all parental figures in their child's treatment unless parental rights have been terminated. Additionally, parents may have access to view and/or request copies of the child's treatment record.

Please initial next to the most appropriate statement regarding the status of the child's parents.

____ The child lives with both biological parents in the same home.

____ The child's parents are divorced, separated, or were never married.
In this situation the parent who did not bring the child to treatment will be contacted to make him/her aware of the child's participation in treatment at this agency and to include him/her in the treatment process.

____ The child's parents are not together and the child's other parent has had his/her parental rights terminated. If parental rights have been terminated, it is the responsibility of the parent who is seeking treatment for the child to provide documentation reflecting termination of parental rights. Please attach a copy of the court document that terminates the parental rights of the other party.

____ The child lives with Adoptive Parent(s). Please attach a copy of supporting documentation of the adoption.

____ The child is in the custody of a non-parent (Foster Care, Kinship Care, etc.).
(Attach supporting documentation regarding custody i.e. court entry).

Please provide the following information for the parent who did not bring the child to treatment:

Name: _____

Address: _____

Telephone Number: _____

Or

_____ I do not know the name/location of the parent who did not initiate treatment for this child.

I agree that the information provided is accurate:

_____

Signature Date

_____

Print Name □ Letter sent to other parent

Foundations Family Counseling

Privacy Notice

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

This agency may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
    - *Treatment* is when staff of this agency provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when staff consult with another health care provider, such as your family physician or another mental health provider.
    - *Payment* is when this agency obtains reimbursement for your healthcare. Examples of payment are when staff disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within this agency such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of this agency, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If, in the staff's professional capacity, staff know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, staff are required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

- **Elder Abuse:** If we have reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, staff are required by law to immediately report such belief to the County Department of Job and Family Services.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release this information without written authorization from you or your persona or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If we believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we are required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).
- **Comply with the Law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it want to see that we are complying with federal privacy law.
- **Respond to Organ and Tissue Donation Requests:** We can share health information about you with organ procurement organizations.
- **Work with Medical Examiner or Funeral Director:** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Worker's Compensation:** If you file a worker's compensation claim, we may be required to give your mental health information to relevant parties and officials.

IV. Client's Rights and Provider's Duties

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in agency mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request process. It may take several days to arrange for the inspection of your records and/or to copy your records. A fee may be associated with the copying of your records.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from this agency upon request, even if you have agreed to receive the notice electronically.
- *Right to Choose Someone to Act for You* – If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has the authority and can act for you before we take any action.

Mental Health Provider's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise these policies and procedures, the new policies and procedures will be posted on the agency web site: www.foundationsfamily.com
- The agency will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you many change your mind at any time, notifying us in writing.

HIPAA Breaches:

In the event a breach, the agency will notify clients by written notice within 60 days of the date that the breach is discovered. Notices will be mailed to the last known address of the client.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact the client's rights officer listed in the "Client Guidelines" form. If you believe that your privacy rights have been violated and wish to file a complaint with this agency, you may send your written complaint to:

Privacy Officer
Foundations Family Counseling
6641 N. High Street, Suite 205
Worthington, Ohio 43085

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on February 1, 2017. This agency reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that is maintained. We will provide you with a revised notice by posting these changes to the agency web site.

Foundations Family Counseling

Child Therapy Contract

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the 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 independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I 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, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

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. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

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Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $300 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

_____ _____

Client Name Date of Birth

_____ _____

Parent/Guardian Signature Date

_____

Print Name

_____

Therapist Signature and Credentials

Abbreviated Contract Draft

- If you decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship.

- You are waiving your right to access to your child's treatment records**.**

- I will inform you if your child does not attend the treatment sessions.

- At the end of treatment, I will provide you with a summary that includes a general description of goals, progress made, and potential areas that may require intervention in the future.

- If necessary to protect the life of your child or another person, I have the option of disclosing information to you without your child's consent.

- You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).

- You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

- If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will not include recommendations concerning custody or custody arrangements.

- If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $300 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.