Warm Springs Counseling Center
Operated and managed by the Children's Home Society of Idaho
740 Warm Springs Ave., Boise ID 83717

Patient Consent Form

COUNSELOR – PATIENT SERVICES AGREEMENT

Welcome to our clinic. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and 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 we provide you 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. The law requires that we obtain your signature acknowledging that we have provided you with this information.

Client Rights:

It is important that your needs be addressed and the best effort be made that they may be met. You are the consumer of services and as such have the rights of any consumer. These include, but are not limited to, the following:

You, the client, have the right to:

- Receive respectful treatment that will be helpful to you.
- Receive treatment or end treatment without obligation or harassment.
- A safe environment, free from sexual, physical, and emotional abuse.
- Ask questions about your therapy.
- Have written information about fees, methods of payment, insurance reimbursement, and cancellation policies before beginning therapy.
- Refuse to answer questions or disclose information you choose not to reveal.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
- Request the transfer of a copy of your clinical record (PHI) to any therapist or agency you choose. On my request, the Clinic will provide me with a list of other providers.
- Terminate treatment or receive a second opinion at any time about your therapy.
- Request that the therapist inform you of your progress.

The Idaho Board

The Idaho Board of Psychological Examiners, Social Work Examiners and Counselor Examiners have the general responsibility of regulating the practice of licensed psychologists, social workers and clinical professional counselors. The licensure of any individual under the licensing laws of Idaho does not imply or constitute an endorsement of that psychologist or counselor nor guarantee effectiveness of treatment. The Idaho Board of Psychological Examiners, Social Work Examiners and Counselor Examiners, through the Idaho Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702-5642, is responsible for licensure of psychologists, social workers and counselors within the state of Idaho.
Sexual intimacy between a counselor and patient is never appropriate, and should be reported to the Idaho Board of Psychological Examiners, Social Work Examiners or Counselor Examiners.

Psychologists, Social Workers and Counselors are required to adhere to the professional code of ethics adopted by the Idaho Board of Psychological Examiners, Social Work Examiners and Counselor Examiners.

Consent to Treatment:

It is important that your therapy be based on as full a disclosure of information as possible relative to your rights as a patient/client, treatment procedures used, any known potential risks and legal and/or ethical obligations of the therapist, which might affect your treatment.

- I acknowledge that I have received, have read (or have had read to me), and understand this document and/or other information about the therapy I am considering. I have had all my questions answered fully.
- I do hereby seek and consent to take part in the treatment by my therapist. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
- I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)
- I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I am at the risk of services being cancelled and of being referred to another agency.
- I am aware that an agent of my insurance company or other third-party payer may be given information from my clinical records including, but not limited to, the type(s), cost(s), date(s), and providers of any services or treatments I receive.
- I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

Potential Risks:

Research has demonstrated that psychological therapy is generally helpful and positive, but in small percentages of cases can have negative effects. Great care will be taken to insure that you benefit from your therapy experience in a positive way. Therapy may be painful and you may experience periods of unpleasant emotion; these are generally short-lived and will pass with resolution of your problems. Negative outcomes are generally related to an individual feeling alienated and uncared about as a result of the treatment. Please bring these emotions up if they emerge during your therapy; working through them can be a source of therapeutic progress. If the treatment is for a relationship problem (i.e. marital or family, etc.) the outcome may not always be what is most desired by one party or the other; the goal is to make relationships work, however, on occasion therapy leads to dissolution rather than resolution of difficulty.

Office Fees:

- Initial Intake (first appointment) $150.00 (50 minute session)
- Therapy, Individual/Family/Couple $110 (32-50 minute session)
- Therapy, Individual/Family/Couple $135 (50 minute session)
- Letter Writing $25.00 (per hour)
- Court Appearances (1/2 day) $1,250.00 non-refundable deposit
- Internship: Master's Level Counseling Student $20.00
- Scholarship/Subsidy available upon approval

Warm Springs Counseling Center requires a 24-hour cancellation notice.

- After the first missed session you will receive a letter explaining our cancellation policy.
- The second missed session will result in you being removed from on-going appointments, and you will be limited to scheduling appointments one at a time.
- The third missed appointment will result in cancellation of your services and you will be referred to another organization.

Crisis and Emergency:

If you find that during a crisis you need to contact your therapist, please call at the office and designate that it is a crisis. Your therapist will return your call as soon as possible but within 24 hours and usually during business hours.

Crisis is something different than emergency. If you find that you are in an emergency (imminently suicidal, psychotic, life threatening, etc.) you should contact the nearest emergency room or call 911. Specialists in the emergency services best handle emergencies.

Limits on Confidentiality:

At the base of an effective therapeutic relationship is your right to privacy and confidentiality with regards to what you disclose in therapy. Your communications with your therapist are considered privileged and legally protected. This protection is not absolute, however, as detailed below.

Your therapist can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Idaho law. However, in the following situations, no authorization is required:

- Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, your therapist will make every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. Your therapist will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that your therapist practices with other mental health professionals and employs administrative staff. In most cases, your therapist needs to share protected health 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.
- You may have multiple mental health professionals assigned to your "care team." Your mental health provider will need to share your protected health information for collaboration and treatment consultation purposes.
- Your therapist may also have contracts with a transcriptionist and collection agency. 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.

There are some situations where your therapist is permitted or required to disclose information without your Authorization:

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

- If a patient files a complaint or lawsuit against your therapist, the therapist may disclose relevant information regarding that patient in order to defend themselves.
- If a patient files a worker's compensation claim, your therapist may be required, upon appropriate request, to provide all clinical information relevant to or bearing upon the injury for which the claim was filed.

Legal and Ethical Responsibilities:

As health care providers, we are responsible to protect consumers and the public from harm. At times, the rights of an individual in treatment may come into conflict with our responsibilities, both legally and ethically, to society in general. In these fortunately rare cases, we are legally and ethically mandated to "break" confidentially to protect either the individual in treatment or third parties from harm. These include:

- Suspected or reported physical or sexual abuse to children, the elderly, or the handicapped require that the situation be communicated to the Idaho Department of Health and Welfare protective services within 24 hours.
- If a client/patient should become dangerous to an identifiable third party, it is required that both the individual in potential danger and local law enforcement officials are notified.
- If a client/patient threatens to hurt him or herself in a clear and planful manner, necessary steps will be taken to protect life. This might include insistence on voluntary inpatient hospitalization, the notification of local law enforcement and/or the initiation of involuntary commitment procedures.
- If you introduce the facts that you are or have been in treatment in any court action (e.g. divorce, criminal defense, lawsuit, etc.) you may have given up your right to confidentiality.

Professional Records:

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in a clinical record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that is received from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

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, we recommend that you initially review them in your therapist's presence or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of $0.25 per page (and for certain other expenses). If your therapist refuses your request for access to your Clinical Records, you have a right of review (except for information supplied to me confidentially by others), which your therapist will discuss with you upon request.

Patient Rights to Clinical Records:

HIPAA provides you with the right to request:

- That your therapist amend your record;
- Restrictions on what information from your Clinical Records is disclosed to others;
- An accounting of most disclosures of protected health information that you have neither consented to nor authorized;
- Determining the location to which protected information disclosures are sent;
- Having any complaints you make about my policies and procedures recorded in your records;

- The right to a paper copy of this Agreement and the Privacy Notice form.

Minors & Parents:

In Idaho, a child **over the age of 14** generally has the right to get and amend their records related to mental health treatment. Your therapist cannot, as a health care provider, disclose confidential statements made by the child to the child's parents or others without the written permission of the child. There are a number of exceptions to this rule. For example, we may disclose such information if it is necessary to obtain insurance coverage, to carry out the treatment plan or to prevent harm to the child or others.

Consent to Treat a Minor:

Both biological parents(s), or court appointed guardians, who have medical decision rights for the minor, are required to sign the consent for care and to authorize the release of protected health information.

Divorce:

In the case of divorce or separation, the party responsible for the account prior to the divorce (signer on paperwork) remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Billing and Payments:

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Most plans require a co-payment which we will collect on the day of your visit. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.
If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Children's Home Society of Idaho (dba: Warm Springs Counseling Center) have 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 me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Insurance Reimbursement:

Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. ***Once again, it is important to understand that you are responsible for full payment of your account (not your insurance company***). It is very important that you find out exactly what mental health services your insurance policy covers. Also, if your insurance requires a pre-authorization, you are responsible for obtaining it.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual

level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short- term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

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 are provided 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. This information will become part of the insurance company files and will probably 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. We will provide you with a copy of any report we submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above unless prohibited by contract.

Please complete and sign the "HIPAA Information and Consent Form" indicating that you give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or yourself; you understand that you are responsible for all charges, regardless of insurance coverage; you hereby assign medical benefits, including those from government- sponsored programs and other health plans, to be paid to Warm Springs Counseling Center; have read and understand the above Counselor - Patient Services Agreement and have been provided the opportunity to discuss any area addressed in the Agreement or other concerns related to your treatment (or treatment of your minor child); you have read the above and agree to its terms and also acknowledge that you have received or reviewed the HIPAA Privacy Notice Form described in the Agreement.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Children's Home Society of Idaho (dba: Warm Springs Counseling Center) (the Practice) to use and disclose my protected health information (PHI) to perform Treatment, Payment and Health Care Operations (TPO).
With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

****

By signing below you agree that you have read and understand this document

If this Consent and Authorization *applies to someone for whom you are a legal representative,* ***please print their name below****, if not, please indicate so by populating the blank with N/A.*

1)_____
(Print name of Responsible Party/Legal Representative of patient)

_____
Signature of Responsible Party/Legal Representative of patient Date

2)_____
(Print name of Responsible Party/Legal Representative of patient)

_____
Signature of Responsible Party/Legal Representative of patient Date

3)_____
(Print name of Patient)

_____
Signature of patient, if 14 Years of Age and Older Date

I, as the patient's assigned Clinician, have reviewed the intake paperwork, assessments, medical history, psychiatric history, and consent forms with the patient and/or the patient's parent/guardian. I have engaged in discussion with the patient/parent/guardian and have taken the time to answer questions and to provide clarity and understanding of the therapeutic process. I have also reviewed termination/discharge criteria with the patient and discussed that termination is inevitable and should never be done casually and can be the most important part of the therapeutic process. Either party may terminate therapy, if it is believed to be in the best interest of the patient. I have suggested that prior to termination the clinician and patient meet to discuss further treatment recommendations.

4)_____
(Print name of Clinician/Psychologist/Provider)

_____
Signature of Clinician Date