Palmetto Family Works, LLC

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Professional Disclosure Statement/ Consent for Treatment/ Confidentiality Policy

Note: The majority of this document is mandated by both South Carolina State Law and Public Law 104-191; it is provided for your protection. Palmetto Family Works, LLC has tried to anticipate any risks you may face as a result of participating in counseling. If you have any questions regarding this document, please feel free to discuss them with your counselor.

Services: Services provided may include assessment, individual therapy, group therapy, and family therapy. I understand and agree that as a part of the services provided, and in order to maximize the benefits of counseling, family members may be asked to participate in services. The goal of the counseling is to enrich and enhance a person's ability to be successful in their lives. Any or all of the following areas of functioning may be the focus of treatment for an individual receiving these services: emotional, social, behavioral, and academic/ vocational difficulties. I realize that sometimes treatment may result in a temporary increase in the referral problem, before things begin to improve. I also realize that any behavioral change in a person or family results in both positive and negative consequences. I expect my counselor to help me understand and plan for this as part of treatment.

Confidentiality:
I may place restrictions on the information that is released about counseling services through a separate signed release of information form. I understand that the information shared in counseling sessions is confidential and is considered to be protected health information (PHI) under the Health Information Portability and Accountability Act (HIPAA, 1996). This information may be disclosed under the following circumstances without your consent:

- Suspicion of child (or vulnerable adult) physical or sexual abuse, neglect.
- Threats of self-harm or suicidal thoughts/ plans.
- Threats of harm to others or homicidal thoughts/ plans.
- Court orders (signed only by a judge) for information release.

In addition, if an individual has been court ordered for services or is in the custody of Department of Social Services, they may request information about treatment, and which may or may not require that you sign a release of information. A court order may be substituted for a signed release of information.

You have the right to limit the information that you share with your counselor if you are concerned with potential risks to confidentiality. You may share information about your counseling sessions to anyone you choose. If you would like your information released to another individual, you will be asked to sign (or have a guardian sign) a release of information authorizing this disclosure.

Informed Consent:
You will be asked to sign the last page of this document. Your signature verifies that you have been given this document and the HIPAA document that follows, that you have read and understand these documents, and that you consent for treatment. Further you need to be aware of the following:

- Treatment is not always successful and may open unexpected emotionally sensitive areas.
- Individuals are responsible for any charges that are not paid by their insurance company.
- Cases are not taken for counseling services on a contingency basis (payment arrangements must be made in advance or fees paid at time of service).
- Counselors are not physicians and cannot prescribe medications.
- In the event that you want your counselor to consult with your physician, attorney, or other counselor, a release of information may obtained with your signature.
- Counselors in this office are not available 24 hours a day. Voicemail and email are provided to leave non-emergency messages throughout the day and evenings.
- Please allow at least 24 hours for return calls during the week, 48 hours over the weekend, and 96 hours during holidays. Email is monitored at least weekly.
- A licensed counselor will be available for emergency coverage during the event of extended illness, vacation, or other type of leave of absence.

Supervision of Counselors (if applicable):
If your counselor is being supervised for their graduate degree or licensure as a Professional Counsleor by Jennifer Elkins, EdD, LPCS, RPTS or other LPCS/ Supervisor, you will be asked to initial that on the signature page for this consent. ***Videotaping: You will be asked to consent to videotaping if applicable for the purposes of supervision if the counselor is under supervision***

Fee Schedule	**LPC/LISW-CP**
Initial Appointment/ Assessment	$200.00
60 Minute Individual/ Family Therapy Session	$150.00
45 Minute Individual/ Family Therapy Session	$125.00
30 Minute Individual/ Family Therapy Session	$ 75.00
Group Therapy Session	$ 50.00

Fee Schedule	**All specialties**
Reports/ Letters (Extensive/ Brief)	$ 175.00/ $ 100.00 *does not apply to evaluation reports*
Court Appearance- per hour (1 hour minimum)	$300.00 *with/ without testimony*
Add Mileage $0.55 per mile from office location	
Observations/ Consultations- per hour	$125.00
Phone Consultations- per 15 minutes	$ 45.00
Returned Check Fee	$ 30.00
Records	$ 0.50 per page

Fee Schedule	**PsyD**
Initial Appointment/ Assessment	$225.00
60 Minute Individual/ Family Therapy Session	$175.00
45 Minute Individual/ Family Therapy Session	$125.00
30 Minute Individual/ Family Therapy Session	$ 75.00
Group Therapy Session	$ 50.00

A 2% late fee will be assessed each month on the balance due after 60 days of nonpayment.
Note: If your account has not been paid for more than 60 days and no payment arrangements have been made, legal options may be used to secure the payment. This may involve hiring a collection agency, or going through small claims court. If such legal action is necessary, then costs for this may be included in the claim as well. In most collection situations, the only information that will be released regarding a patient's treatment is his/ her name, the nature of the services provided, and the amount due.

Returned Checks: A $30 fee will be billed on returned checks that are presented for payment. If a second check is returned, payments must be made in the form of cash, debit, credit or money order.

Insurance Reimbursement
If you have a health insurance policy or EAP that you would like to use for your services, then eligibility will be verified with your Insurance/ EAP provider. This helps to ensure that you have coverage for the services, and that Palmetto Family Works, LLC is an approved provider. Your insurance will be filed for you, when at all possible.

Many times insurance companies/ EAPs only authorize a few sessions for therapy services. You may feel that more time is needed to accomplish your treatment goals. If this occurs, we will work together to either have more sessions authorized, make a referral to an approved provider, or make a payment agreement.

Most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes additional clinical information, such as treatment plans or summaries are requested to determine benefits. Some insurance plans require your medical doctor to sign off on authorization paperwork. This information will become part of your insurance record. Though the insurance companies claim to keep this information confidential, Palmetto Family Works, LLC has no control over it after it is submitted. You may request a copy of any information that I send to your insurance company on your behalf.

For clients who have private insurance policies, we will begin collecting the full allowable charge for the first appointment/ initial assessment (CPT code 90791). These fees vary depending on the type of policy and coverage. Once this session has been filed to insurance, and the proper copay has been determined from the EOB, any difference from the first session will be applied to future copays. If the client has a zero liability, a refund will be issued to the client. Progress on deductible will be monitored monthly for those with liability due to deductible. This policy also applies to current clients who have an insurance change during the course of their treatment, or a fiscal/ calendar year deductible reset.

SOVA claims:
1. Primary insurance coverage will be checked at referral. Clients will be informed of their financial responsibility for each session.
1) Counselor may assist with initial SOVA applications and the mental health report.
2) After insurance is filed (if applicable), claim will be filed SOVA office.
3) Until approved by SOVA, and payments begin, insurance copays will be collected.
4) Clients are asked to bring in SOVA acceptance letter once received. Copays may be suspended at that time.

Secondary Insurance: Secondary insurance may be filed on behalf of the client. It is not guaranteed that it will cover any balance that the primary insurance did not cover. The client is still responsible for any fees for services that remain after insurances are filed.

Out of Network Benefits: For out of network insurance policies, the client will be asked to determine if they have out of network benefits and will be provided with the information that they need to file with those policies. Payment for services, at the rates listed on page two, will be expected at the time of service.

Cancellation Policy: In the case of a missed appointment without 24 hours' notice, recurring appointments will be cancelled, and clients will schedule their appointments 1 week at a time. Additional missed appointments without 24 hours' notice, may result in discharge.

Discharge Policy:
Clients will be terminated from services, and sent a discharge letter if one of the following applies:

- You have missed two appointments without adhering to the cancellation policy,
- You have not been seen in 30 days since your last appointment, without an agreed upon reason for pause in treatment with provider.
- You have an unpaid bill and have not attempted to make a payment plan within the past 60 days.
- You have decided to terminate services with us.

Telehealth Policy:

1. I understand that my healthcare provider wishes me to engage in a telehealth consultation.
2. My healthcare provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Palmetto Family Works, LLC uses **Telehealth by SimplePractice** as the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. TheTelehealthbySimplePracticeServicefacilitatesvideoconferencingandisnotresponsiblefo rthedeliveryofany healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me.

That I fully understand its contents including the risks and benefits of the procedure(s).

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

That I am authorizing my insurance carrier to assign payments to Palmetto Family Works, LLC for therapy services provided.

I understand that I am ultimately responsible when an insurance company does not pay for services.