Collaborative Counseling, LLC
Clinic Information and Client Consent Policies

Overview of Therapy
Therapy varies depending on the therapist, the client, and the client's particular situations and goals. Your therapist may use many different methods to deal with your particular situations and goals. In order for therapy to have the best outcome, you will likely have to invest energy in the process and work actively on things we talk about both during and between our sessions.

Therapy can have benefits and risks. The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety, or frustration when discussing aspects of your life or relationships. Research shows psychotherapy to have benefits that can include better relationships, solutions to specific problems, increased life satisfaction, improved physical health, and significant reductions in feelings of distress. However, it is impossible to predict or guarantee what you will experience.

Your first few sessions will involve an evaluation of your situation and needs, we will also discuss your goals. During this time, you and your therapist together will decide if your therapist is the best person to provide you with therapeutic services. Therapy can involve a significant investment of time, energy, and money so it is important you select a therapist you are comfortable working with. If at any time you have questions about any aspect of your work with your therapist, please discuss with your therapist or feel free to contact the Owner, Naomi Doriott Larson at 763.210.9966 or via email at naomi@collaborativemn.com. If you decide you do not want to continue in therapy, please inform your therapist. We do recommend a final session for closure. If you want help finding another therapist or other appropriate resources, we will happily assist you in doing so.

Confidentiality and Data Privacy Policy (HIPAA)
This notice describes how your health information may be used and disclosed and how you can access this information. Please review this and all other policies carefully. We are committed to protecting our clients' privacy and confidentiality. A state and federal law, the Health Insurance Portability and Accountability Act (HIPAA) went into effect on April 14, 2003 and requires us to inform you of this policy. HIPAA requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information to obtain payment of the services you receive (e.g. we can send information as requested by your health insurance plan). We may use or disclose your health information for our normal healthcare operations (e.g. staff who complete scheduling, training of staff who have signed confidentiality agreements, etc). We may share your medical information with our business associates, such as a billing service, administrative staff, etc… To protect your privacy and confidentiality we have a written contract with each business associate requiring them to protect your privacy. We may consult with other licensed professionals in counseling as necessary, protecting your confidential information, to gain guidance for your treatment. We may use your information to contact you (e.g. mailings). We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine, or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. Finally, we may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner(s). Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may

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request in writing we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use the address or telephone number you have on file with us. You have the right to transfer copies of your health information to another practice. You may have the right to see or receive a copy of your health information, unless there is a reason by law or contract why your therapist would not disclose the information. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add the new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact the Owner of Collaborative Counseling, Naomi Doriott Larson, via phone at 763.210.9985 or via email at naomi@collaborativemn.com.

The State of Minnesota and Wisconsin laws impose some limitations to your rights to confidentiality. The following is a list of situations in which you may lose your right to confidentiality:

- If use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- If your therapist suspects you have physically or sexually abused or neglected a child or vulnerable adult, your therapist must make a report to the proper authorities. This includes some cases of domestic abuse when a child is exposed to weaponry or is physically threatened and/or used as a weapon.
  If you are pregnant and using a controlled substance such as heroin, cocaine, phencyclidine, methamphetamine, or their derivatives
  When there is a court order to release your records to the legal authorities.
- If an investigation or disciplinary proceeding is mandated by the licensing board and your information is involved in those proceedings.
- A subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal so long as reasonable efforts are made to give you notice that your PHI has been requested or reasonable efforts are made to secure a qualified protective order, by the person requesting the PHI.
- To defend Collaborative Counseling or our therapist(s) in a legal action or other proceeding brought by you against our clinic or service providers.
- When required by the Secretary of the Department of Health and Human Services in an investigation to determine my compliance with the privacy rules.
- To Business Associates under a written agreement requiring Business Associates to protect the information. Business Associates are entities that assist with or conduct activities on our behalf including individuals or organizations that provide legal, accounting, administrative, and similar functions.

If you are a minor, you have a limited right to privacy in that your parents may have access to your records. However, if the therapist believes sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law.

Group Therapy: The right to confidentiality is addressed in the group setting. However, Collaborative Counseling and group therapists are not responsible for any breaches of confidentiality by group members.

There are instances in which individuals associated with Collaborative Counseling have duties that require access to the information you may share for claim processing, scheduling, reports, consultations, etc…

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Release of Records
The laws and standards of this profession require that we keep treatment records. You are entitled to examine and/or receive a copy of your records if you request it in writing. In order to see your records, you and your therapist will need to discuss the contents together. Because these are professional records, they can be misinterpreted and/or be upsetting to people who are not mental health professionals.

All information regarding patients is considered strictly confidential and will not be given out to other entities or individuals without your written consent, unless otherwise allowed by law. In the event of a request for transfer of records, the records will be forwarded upon completion of a consent form and a payment fee based on the current legal maximums allowed by the Department of Health. Copies of records are available for a $17.21 processing fee, plus $1.30 per page for copying.

Crisis Response and Contacting Your Therapist
Your therapist is often not immediately available by phone because we do not answer the phone when in session with clients. Feel free to leave a voicemail and your therapist will get back to you within 5 business days (Monday through Friday). We will make every effort to return your call as soon as possible (usually within a few hours and almost always within 24 hours Monday through Friday). If you are difficult to reach, please leave times you will be available. If you want discretion used when calling you or leaving a message for you, please let us know in advance. At times when your therapist will be unavailable for an extended time, you will be provided with a backup therapist to contact if necessary.

Outpatient mental health services are consultative in nature; we are not equipped to handle emergencies. Please call the National Suicide Prevention Hotline at 1-800-273-TALK (8255), 911 or go to the nearest hospital emergency room if you are in crisis. Phone consultations with clients, or parents of clients, during or after business hours, are not a part of the services we are able to offer at Collaborative Counseling. Please document any concerns you might have between appointments, and bring them to your next session so that we might discuss them. Phone consultations with prescribing physicians, school districts, and other collaborative services are always available free of charge for our clients, with your signed authorization for release of confidential information.

Telemedicine/Telehealth Services
Telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of protected health information, and education using synchronous or asynchronous audio, video, or data communications.

- ***Identity Verification***: You may be expected to provide a copy of your driver's license and other identity verifying documentation requested by the healthcare practitioner before any health services are provided.
- ***Privacy and Security of Communications***: All electronic communications between you and the healthcare practitioner will be transmitted using reasonable measures to ensure confidentiality. You will be responsible to secure and protect the functionality, integrity, and privacy of your hardware, files, and communication. Password protection for accessing your hardware and files is recommended. If others will be accessing the same computer, be aware that programs exist that copy every keystroke you make. It is recommended that you schedule your sessions with the undersigned healthcare practitioner when and where you can ensure the greatest level of privacy for all communications. Be sure to fully exit all programs and hardware at the end of each session. You explicitly waive confidentiality if there is another individual at your distant site you are using telemedicine at.
- ***Risks Associated With Distance Therapy*****:** There are privacy and security risks and consequences associated with telemedicine despite the policies and procedures in place to guard against them. The risks and consequences include, but are not limited to, interrupted or distorted transmission of data or information due to technical failures and access or interception of your protected health information by unauthorized persons.
- By signing this information and consent form below, you acknowledge the limitations inherent in ensuring client confidentiality of information transmitted in telemedicine and agree to waive your privilege of confidentiality with respect to any confidential information that may be accessed by an unauthorized third party despite the reasonable efforts of the Collaborative to arrange a secure line of communication.

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- Telemedicine services and care may not be as effective as face-to-face services. The Collaborative will continually assess the appropriateness of telemedicine for you. If the Collaborative determines that you would be better served by receiving different services, such as face-to-face services, recommendations for treatment and treatment providers or facilities will be provided to you.
- ***Communication Interruptions*****:** If you are unable to connect with the telemedicine platform or are disconnected during a session due to a technological breakdown, please try to reconnect within 5 minutes. If reconnection is not possible the Collaborative can be reached at the following phone number: 763-210-9966.
- ***Audio and Video Recordings*****:** You acknowledge and, by signing this information and consent form below, agree that neither you nor the undersigned healthcare practitioner will record any part of your sessions unless you and the Collaborative mutually agree in writing that the health session may be recorded. You further acknowledge that the Collaborative objects to you recording any portion of your sessions without the Collaborative's written consent. You expressly agree that audio and video recordings used for security or legal and documentation purposes are not part of your health records, and are therefore not protected by confidentiality or any other provisions under this agreement.
- ***Consent to Treatment Using Telemedicine and Distance Health Services*****:** I, voluntarily, agree to receive synchronous (or asynchronous) assessment, care, treatment, and services through the use of email and texts and authorize the Collaborative to provide such care, treatment, or services as are considered necessary and advisable. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Emailing or Text Messaging Your Therapist

Electronic communication (email and texting) is a commonly used way of exchanging information, however, there is no guarantee that this form of communication is secure. Collaborative Counseling cannot ensure the security or privacy of the information exchanged. Email is not an appropriate means for communicating about your therapy or about a mental health emergency. If you want to email your therapist please confirm their policy and preference since each clinician's preference may vary.

Although they add convenience and expedite communication, it is very important to be aware that email and cell phone communication can be accessed relatively easily by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Therapist emails and data on computers may not be encrypted, it is always possible that faxes can be sent erroneously to the wrong address, and computers, including laptops, may be stolen. Our computers are equipped with a firewall, virus protection and passwords, and we also password-protect and back up all confidential information from computers (stored off-site) on a regular basis.

You should also know that any email or text messages your therapist receives from you and any response sent back to you may become a part of your legal record and may be revealed if your records are summoned by a legal entity.

Please notify your therapist if you decide to avoid or limit, in any way, the use of emails, cell phones SMS (text), faxes, or storage of confidential information on computers. If you communicate confidential or private information via SMS (text) or email, we will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and your therapist and our clinic will honor your desire to communicate on such matters via email or text messaging.

Please do not use email or faxes for emergencies. Due to computer or network problems, emails may not be deliverable, and your therapist may not check my emails or faxes daily. We prefer to use email to arrange or modify appointments only. If you email your therapist content related to your therapy sessions, please note that email is not completely secure or confidential. If email communication outside of therapy requires more than 5 minutes to read and respond to, we may charge for my professional services rendered in 15-minute increments. Please indicate if you intend to pay these charges, or we will save it for review during your appointment time.

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How to Acknowledge in Public Settings
If one of our staff or therapists happens to see you outside of our counseling office setting in the public, we will only acknowledge you if you greet or acknowledge us. This is to respect your confidentiality.

Social Media Policy
Please note that Collaborative Counseling is on various social media websites as a way to market the services we offer. To protect your confidentiality Collaborative Counseling encourages you to consider the public nature of social media before liking, fanning or following our social media postings. Messaging on Social Networking sites such as Twitter, Facebook, Google+, or LinkedIn is not secure. It could compromise your confidentiality to use wall postings, @replies, or other means of engaging with Collaborative Counseling or your therapist online if we have an already established client/therapist relationship. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you have questions, please contact your therapist or our clinic administrator who can help clarify questions you may have.

Financial Responsibility
Most health insurance plans include behavioral health coverage, however, the exact coverage varies widely with the different health insurance plans. Clients are responsible for services received not covered by insurance; therefore, we strongly recommend you call your insurance company to verify your coverage. When you call your insurance company, ask to verify your coverage for outpatient mental health. It is also your responsibility to keep us up-to-date with any changes in your benefit plan and/or insurance coverage. We understand that insurance is tricky, but we are not responsible for verification of your insurance benefits and we cannot be held responsible for insurance coverage denials.

Cancellation Policy
Please give a 24 business hour notice if you will not be able to keep an appointment. If you do not give a 24-hour notice, you will be charged $100. This is not billable to most insurance companies. Kindly phone us with cancellations as soon as possible to avoid late cancellation fees, and out of respect to others who may need an appointment time. Here are clarifications about our policy:

- Cancellations must be at least 24 business hours prior to the appointment. For Monday appointments, cancellations must be made by Friday at 4pm.
- Late cancellations and no-shows will be charged $100. The credit card on file will be run at the time of the missed appointment, unless arrangements are made otherwise.
- The only exception to the cancellation policy is in the event of an impairing illness or emergency. Work conflicts do not constitute an emergency. In the event of transportation barriers, we can conduct the appointment via telehealth.
- Frequent cancellations and no shows/missed appointments (3 or more in 6 months or 2 consecutive) may result in the termination of treatment.
- If you are more than 15 minutes late for your appointment, the appointment will be considered missed and the cancellation/missed appointment fee of $100 will be charged.

Cases Involving the Legal System
Our services are not to be utilized for testimony, custody disputes, disability or any other form of court evaluations. We are happy to refer you to other providers in the area who provide these services should you require any court evaluation or testimony. Should we be subpoenaed or mandated by the courts to testify, you will be required to pay all fees, in advance, associated with the writing of case summaries and/or other reports, consultation with attorneys, consultation with mental health professionals, review of other records, and any other preparation. The client will also need to pay for other fees incurred including travel time, meals, parking and all other costs associated with the court time. Therapist testimony will require that the client be billed directly, as insurance will not cover these charges. All fees must be paid prior to the date of testimony. Court appearances are significantly more expensive due to the complexity and difficulty of being involved in such matters. Our current hourly rate for any legal related matters is $350 per hour. Please note: these fees apply to any court-related or legal-related work regardless of whether testimony ends up being required. Any legal fees are outside of insurance and outside of what is considered a mental health care services.

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Treatment of Minors
Treatment of children and adolescents is best done with the involvement of their caregivers and parents. Children with unmarried or divorced parents typically benefit from regular contact with both parents, unless it can be shown that this contact threatens the child's safety or mental health. Therapy is confidential, but not secret. Parents are entitled to understand the nature of their child's problem as well as the method and course of treatment. Both parents have right of access to medical or mental health treatment, regardless of custody unless the custodial parent provides us with a court order limiting access or communication.

Parents may have access to their child's medical records, however, often with mental health records it is often determined to not be in the best interest of the child or adolescent. Minnesota and Wisconsin State Law entitles parents with legal custody to information regarding their child's treatment and generally entitles parents to copies of their child's health records. Minnesota and Wisconsin State Law allows for an exception to the release of copies of health records in the case of mental health. Mental health records are kept confidential to protect the child's ability to speak freely about their relationships and concerns regarding each parent. It is rarely in the child's best interest to have therapy records read by parents. Parents are encouraged to meet regularly with their child's therapist and to stay informed of what is occurring in therapy. Arrangements can be made to observe appointments, review records in the office, and freely share information regarding the child's health and treatment.

In cases where there is joint (split) legal custody between parents or guardians who are not married or cohabitating, we require both parents' authorization and signature for treatment of their minor child/children. We believe it is best to identify and resolve potential parental conflicts or disagreements before treatment begins. We will not proceed with treatment if one parent is unavailable or unwilling to consent and we do not have a note from the child's medical doctor determining that it is appropriate to proceed with the consent of only one parent.

Counseling with children is done with the goal of providing an emotionally neutral setting to process current concerns and emotions. The usefulness of such therapy is extremely limited when the therapy itself becomes simply a matter of dispute between the parents or between parents and children. With this in mind, and in order to best help children in therapy we follow the following agreements in our therapy with minors:

- Counseling and therapy will not yield considerations about custody. We recommend that parties who are disputing custody consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than settle a custody dispute in court.
- The therapist of your child has the primary responsibility, as your child's therapist, to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g. pediatrician, teachers). In some cases, this may include a recommendation that you consult with a physician should matters of your child's physical health be relevant to this therapy.
- We ask that all caregivers remain in frequent communication regarding your child's welfare and emotional well-being. Open communication about his or her emotional state is critical. In this regard, we invite each of you to initiate frequent and open exchanges with your child's therapist.
- We ask that all parties recognize and as necessary, reaffirm to the child, that the therapist is the child's helper and not allied with any disputing party or familial side.
- Please be advised regarding the limits of confidentiality as it applies to psychotherapy with a child including but not limited to these considerations:
  - We keep records of all contacts relevant to your child's well being. These records are subject to court subpoena and may, under some circumstances, be solicited by parties (including attorneys) in divorce or other legal proceedings.
  - Any matter brought to your therapist's attention by either parent regarding the child, may be revealed to the other parent. Matters brought to our attention that are irrelevant to the child's welfare may be kept in confidence.
- We are not responsible for routine communication with parents who do not attend appointments and we cannot routinely contact the non-custodial parent after each appointment. We are unable to send a

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summary letter, note, or e-mail after each appointment, unless payment arrangements have been made for this service. Expectation is that parents will communicate with each other openly regarding treatment and that each parent will cultivate a healthy relationship and open communication with their co-parent and their child.

Ending Treatment

You have the right to end your treatment at any time without my permission or agreement. However, if you do decide to exercise this option, we encourage you to talk with your therapist about the reason for your decision in one or more termination sessions so that we can bring sufficient closure to our work together. We can also discuss any referrals you may need at that time.

As a therapy service, we also reserve the right to terminate therapy at our discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, or patient needs that are outside of my scope of competence or practice. If we are to end treatment we will provide you with referrals to another provider or service we believe to be appropriate.

If during psychotherapy either of us assesses that the therapist assigned to you is not effective in helping you reach your therapeutic goals, we are obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I we will provide a number of referrals that may be of help to you.

Client Bill of Rights

As a consumer of mental health services, you have the right to:

1) expect that the provider has met the minimal qualifications of training and experience required by state law;
2) examine public records maintained by the Board of Behavioral Health and Therapy that contain the credentials of the provider;
3) obtain a copy of the Rules of Conduct from Minnesota's Bookstore, Department of Administration, 660 Olive Street, St. Paul, MN 55155, or its current location;(if in Wisconsin, you can find these rules at: https://www.dhs.wisconsin.gov/clientrights/intro.htm)
4) report complaints to the Board of Behavioral Health and Therapy;
5) be informed of the cost of professional services before receiving the services;
6) privacy as defined and limited by rule and law;
7) be free from being the object of unlawful discrimination while receiving counseling services;
   have access to your records [For MN as provided in part 2150.7520, subpart 1, and Minnesota Statutes, section 144.292, except as otherwise provided by law; For WI as provided in Wis. Stat. § 51.30];
8) be free from exploitation for the benefit or advantage of the provider;
9) terminate services at any time, except as otherwise provided by law or court order.

Rates

Billing Code	*Service*	*Length of Visit*	*Fee for Service*
90791	Intake	45-50 minutes	$275
90832	Psychotherapy 30 minutes	16-37 minutes	$100
90834	Psychotherapy 45 minutes	38-52 minutes	$175
90837	Psychotherapy 60 minutes	53 minutes plus	$225
90847/90846	Family/Couple Therapy	45-50 minutes	$175
90785	Interactive Complexity (add-on)	n/a	$100
99354/99355	Prolonged Services with Psychotherapy	16-30 minutes per unit	$150
90839/90840	Psychotherapy for Crisis	Add 60/30 minutes	$200/$100
90853/90849	Group Therapy	60-90 minutes	$100/$250
96150-96154	Health/Behavior Assessment	15 minute units	$50/unit
H2019	DBT Group Therapy	15 minute units	$50/unit
96130-96139	Psychological and Neuropsychological Testing	60 minutes	$225
96116	Neurobehavioral Status Examination	60 minutes	$200
90887	Feedback Review of Assessment	60 minutes	$200
97532	Cognitive Rehabilitation	15 minute units	$50/unit
Billed to client	Phone Calls, Letters, Emails or Reports	15 minute units	$50/unit
Billed to client	Court Appearances or any legal request	Varies	$350 per hour
Billed to client	Late Cancel or No Show	n/a	$100

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Client Information

Client's name: ______________________________ Date of birth: ____________________

Address: ____
Street City State Zip Code

Home phone: ______________ Work Phone: ________________ Cell Phone: ______________

Emergency Contact: ________________ Relationship: ____________ Phone:______________

Email address: ____
Do you consent for the use of your email by Collaborative Counseling? Please circle: YES or NO

Employer (Note: if intake is for child, write employment for both parents.)

Name of Employer: ____________________ Address: ____________________________

Primary Insurance Information

Carrier	***Provider Phone Number***	***Policy ID***
Group Number	***Policy Holder Name (if not client)***	***Policy Holder Date of Birth***

(If Applicable) Secondary Insurance Information

Carrier	***Provider Phone Number***	***Policy ID***
Group Number	***Policy Holder Name (if not client)***	***Policy Holder Date of Birth***

Collaborative Counseling, LLC, reserves the right to change the policies, practices, and procedures described in this document. We will notify you in writing of any significant changes. My signature below indicates I am consenting to treatment at Collaborative Counseling, LLC, and have received and understand the contents of the clinic's counseling policies, including the Notice of Privacy Practices (HIPAA). My signature below certifies my consent to the billing and payment policy. All of my questions have been answered and the policy regarding billing is fully agreed to. I also, by signing below, consent to taking full responsibility for any outstanding bill for services rendered. I also agree that my signature authorizes Collaborative Counseling, LLC to pursue any outstanding balance due to them should I not follow the clinic policy. I am of sound mind and am fully competent to give informed and willing consent for therapy, either for myself and/or a minor child. If I have questions, the information has been explained and/or summarized for me.

____ ____________________
Signature (Client or Legal Guardian if client is under 18) Date

____ ____________________
Signature (Client or Legal Guardian if client is under 18) Date

Relationship to Patient (if patient is a minor). Check below to indicate custody status if patient is a minor:

- ☐ Parents are married to each other and both are legal parents of the child/minor.
- ☐ I am a single parent, with legal and physical custody of the child/minor.
- ☐ The child's other parent and I share legal custody. Consent must be obtained from other parent to continue services beyond the initial appointment.
- ☐ The child is in custody of the State of Minnesota or Wisconsin. County:____________________

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Billing Information and Policy

Our billing policy for services, which are the client's responsibility, is as follows:
Please initial each item:

_______ All co-pay, co-insurance, sliding fee scale, payment plan, and deductible amounts are due on the date of service. If client payments are not made on the date of service, or if arrangements for an alternate payment plan have not been made, charges will be submitted to the client credit or debit card on file in our office.

_______ Clients will not receive a statement for services that are the responsibility of their insurance company. Nor will clients receive a statement if their balance has been paid in full on each date of service, and their account is current.

_______ Any counseling services that are not eligible for coverage through a client's insurance plan become the responsibility of the client. If not paid on the date of service, these charges will be submitted to the credit card on file either on the date of service, or on the date we receive notice that services have been denied. Receipts for all credit or debit card transactions will be mailed to clients along with their statement. Payments due that are not paid are subject to fees within the limitations of the law.

_______ A late cancel fee will be submitted to the credit or debit card on file for clients with private insurance coverage, a payment plan, or a sliding fee scale, which includes cash clients. This charge is submitted on the date of service only if clients misses an appointment without giving a 24-hour notice to cancel or do not show up to a scheduled appointment without notice.

_______ By signing you agree that: I understand that if I default on any payment obligations as called for in this agreement Collaborative Counseling, LLC will have the right to forward my information to collections, and in the event that it becomes necessary to utilize a collection agency to resolve a past due account, up to an additional 30% will be assessed to my account to cover the costs of this action. I agree to pay all costs of collection, including but not limited to collection agency fees, court costs, and attorney fees. I understand and give my consent for Collaborative Counseling, LLC, to forward my information to collections, should I default on this agreement and fail to pay my Balance Due.

Credit Card Information

We require all clients to keep a credit card on file in accordance to the above billing policy. I agree that the card I provide to my therapist to keep on file can be used to process payments that are my responsibility.

Name on Credit/Debit Card: ____ Billing Zip Code for Card: ________

Credit Card Type: Visa: ______ MasterCard: _______ Discover: _______ American Express:______

Card #:____ Exp Date: ________ 3 Digit # on Back of Card: __________

I acknowledge I have been informed and agree to the above billing policy. I understand that payments are due on the date of service. I agree that Collaborative Counseling, LLC may bill the credit card on file for any payments which are my responsibility, that have not been paid on the date of service. I hereby consent for Collaborative Counseling, LLC to utilize my credit card information for any outstanding balance.

____ ________________

Signature of Credit Card Holder, Authorizing Payment Date Signed

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Consent for Returning to In-Person Therapy Services

This Consent for Returning to In-Person Therapy Services is a supplement to the general informed consent that we agreed to at the outset of our clinical work together. Please read this document carefully, and let me know if you have any questions.

The threat of COVID-19 is ongoing throughout the United States. As a way to mitigate the risk of exposure to COVID-19, our practice has transitioned to providing many services via telecommunications technology. Use of Telehealth technology reduces the need for persons to come into close contact with each other or to be in areas where exposure to COVID-19 may occur. However, in some situations, Telehealth services may not be adequate, and in-person services may be more appropriate.

The decision about whether to engage in in-person services is based on current conditions and guidelines, which may change at any time. It is possible that a return to remote services will be necessary at some point based on consideration of health and safety issues. Such a decision will be made in consultation with you, but we will make the final determination based on a careful weighing of the risks and applicable CDC recommendations and/or local guidelines.

In order for us to provide you with in-person services, the following protocols must be followed by patients/clients and providers:

- Social distancing requirements must be met, meaning that you must maintain a six-foot distance from others while in offices, waiting rooms, and other areas.
- Patients/clients and providers will be required to wear face coverings or masks while in the shared common areas of our office space.
- Therapist and client can determine use of masks in provider's office for sessions based upon risk factors, therapist/client comfort levels, vaccination of provider and client, and any other factors the client and/or therapist determine. Your provider will document your decision making around this in your clinical file.
- At this time you are allowed to wait in our waiting areas unless you are not able to do so while maintaining social distancing. This policy may be adjusted per location in the event that specific location's waiting rooms are unable to allow for social distancing.
- You agree not to present for in-person services if you have a fever, shortness of breath, coughing, or any other symptoms associated with COVID-19 or if you have been exposed to another person who is showing signs of infection or has confirmed COVID-19 within the past two weeks. In the event of this situation, we could offer you a Telehealth session or make sure to give 24 hour notice to avoid a $100 late cancellation fee per our main clinic policies.
- If you are bringing a child or other dependent in for services, you agree to ensure that both you and your child/dependent follow all of these protocols.

Client/Guardian Initials ____________

We remain committed to following state and federal guidelines and adhering to prevailing professional healthcare standards to limit the transmission of COVID-19 in our offices. Despite our careful attention to sanitization, social distancing, and other protocols, there is still a chance that you could be exposed to COVID-19 in our office. If, at any point, you prefer to stop in-person services or to consider transitioning to Telehealth services, please let your therapist know.

By signing below, you acknowledge that you understand that there is still a potential risk of exposure to COVID-19 and that you agree to follow the safety protocols outlined above in order to engage in in-person services. In the event you choose to make a visit in person, instead of using the telehealth services available, you assume all of the risk from potential COVID-19 exposure and you agree to release Collaborative Counseling LLC and its Contractors and agents from any and all legal liability or responsibility.

_______________________________________ _____________________

Patient/Client/Guardian Date

Authorization to Share Information Between Providers

In order to better provide integrated and collaborative services at Collaborative Counseling, our providers may share protected health information with each other. You can agree or not agree to this authorization.

Pick only one:

I Agree: ______________ (initial)

I do not Agree: ____________ (initial)

You acknowledge that you have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned therapist that you have received and reviewed.

You acknowledge that you have been advised by the undersigned therapist of the potential of the redisclosure of your protected health information by the authorized recipients and that it may not be protected from unauthorized disclosures as required by the federal Privacy Rule.

You further acknowledge that the treatment provided to you by the undersigned therapist was not conditioned on you providing this authorization.

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Signature of client (or parent/guardian if under age 18)

Client/Guardian Initials ____________