COUNSELING CONSENT TO TREAT

INITIAL EACH_____ AS CONFIRMATION

CLIENT INFORMATION

First:	Middle:	Last:
Street Address/City/State/Zip:		
DOB: Age:	Social Security #:	
Contact Telephone #:	Contact Email:	
Responsible for Payment:		
Street Address/City/State/Zip (if different than above):		
Contact Telephone #:	Contact Email:	
Referral Source:		

*LifeWorks reserves the right to contact this person/agency to verify their agreement to be financially responsible.

IF A MINOR (MUST SIGN CUSTODY ADDENDUM)

Parent / Guardian Name:	
Street Address/City/State/Zip:	
Contact Telephone #:	Cell_____/ Home_____/ Work _____

AGREEMENT OF PARTNERSHIP

_____I agree to engage in receiving psychological counseling services with LifeWorks Counseling & Consulting, Inc. via in-person or LifeWorks HIPAA compliant Telehealth platform.

CONFIDENTIALITY

_____LifeWorks Counseling & Consulting Inc. will maintain the practice of holding all communication between the therapist/mediator and the client in strictest confidence and will not allow information to be released to anyone without written permission or according to law. Mental health records will be handled according to the following legal requirements: 1) Therapists are required to report circumstances wherein a client states an intention to harm self or others, in cases of recent or ongoing abuse, and with court related custodial concerns; 2) Indiana law requires reporting any activity wherein a child or adolescent describes participating in circumstances involving sexually oriented activities. It is LifeWorks Counseling & Consulting Inc's. legal responsibility as a care provider to report such to the respective Division of Family and Children's Services and/or the respective police department. Thus, such information cannot be considered confidential information within the counseling setting, and so it also cannot be maintained only between the client and therapist/care provider; 3) Court ordering of unlicensed therapists to do so; 4) Notice of Privacy Practices; 5) Upon request or compliance from mental health insurance carriers.

_____I understand LifeWorks utilizes an automatic email/text service for appointment reminders appearing as "LWCC."

_____I understand that information contained in my confidential files will not be released to any person(s) outside of LifeWorks without my written consent.

_____I understand professional counselors/therapists are prohibited by respective Code of Ethics to purposefully communicate or engage in contact on social media platforms.

HIPAA (HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT)

_____I have received, reviewed, and accept this policy as reflecting the new Health Information Portability and Accountability Act (HIPAA). LifeWorks Counseling & Consulting, Inc. will maintain this acknowledgement in my mental health record.

_____I understand HIPAA specifically outlines care for psychotherapy notes under the Right to Access.

COUNSELING CONSENT TO TREAT

_____I understand HIPAA specifically outlines detailed information that an individual does not have a right to access private health information (PHI) that is not part of a designated record set because the information is not used to make decisions about individuals. This may include certain quality assessment or improvement records, patient safety activity records, or business planning, development, and management records that are used for business decisions more generally rather than to make decisions about individuals.

_____In addition, two categories of information are expressly excluded from the right of access:

_____Psychotherapy notes, which are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, that are maintained separate from the rest of the patient's medical record. See 45 CFR 164.524(a)(1)(i) and 164.501.

_____Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. See 45 CFR 164.524(a)(1)(ii).

_____However, the underlying PHI from the individual's medical or payment records or other records used to generate the above types of excluded records or information remains part of the designated record set and subject to access by the individual.

CANCELLATIONS

_____LifeWorks utilizes TheraNest to send clients appointment reminders via email and text. Clients are still responsible for missed appointments if technology fails.LifeWorks reserves the right to exercise the option of discontinuing treatment after the second occurrence and assessinga full-fee charge for missed appointments.

_____Making an appointment is a contract between the therapist and the client that both will be present at the appointed clinical hour. However, we are aware that genuine emergencies do arise which preclude the keeping of the appointment.

_____Late cancellations, however, do not allow us to fill the hour with persons who are waiting for an appointment. Cancellations require 24-hour notice. There is a minimum $50.00 fee for late cancellations or missed appointments which will be charged to the credit card on file.

_____A late cancellation fee of $50.00 will be assessed should a client attempt to attend and in-person appointment sick or under the suspected influence of alcohol or drugs and will be charged to the credit card on file.

_____Missed appointments without a cancellation notice cannot be billed to insurance and will charged the full-fee rate if the appointment is not cancelled according to the 24-hour notice policy.

_____Therapists/Counselors also need to cancel appointments on occasion due to illness or therapeutic emergencies. LifeWorks will contact clients or parents to cancel and reschedule.

GOOD FAITH ESTIMATE

_____Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling health care items and services.

_____A Good Faith Estimate is an estimate and *not* a contract and does not create an obligation to receive services from a LifeWorks provider. The Good Faith Estimate is just that: an estimate, as actual services or charges may differ. The spirit of the law is to provide clients with transparency in pricing. Revising a Good Faith Estimate, when it needs to be more specific on the basis of newly gathered information, is keeping with that spirit. A Good Faith Estimate may be revised based on information gathered from the client at the initial meeting and have a better sense of symptoms, likely diagnoses, and severity. The provider may recommend additional services that are not reflected in this estimate and need to be schedule separately. Should LifeWorks fees change during the course of the year, an updated Good Faith Estimate will be provided. A Good Faith Estimate is only for the cost of a psychotherapy session and does not include other Non-Covered Services such as legal or court fees.

LAST:	FIRST:	MIDDLE:	DATE:	CLIENT #:

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FEES & RATES

_____I understand and agree that I am personally and fully responsible to pay for all services rendered. I am to pay in full at the time of appointment and I am responsible to file any claim for reimbursement with my insurance carrier, unless LifeWorks is contracted to do so. No client is permitted to carry a balance due by the client.

_____If I am covered by Medicaid or have insurance with a carrier which has a contract with LifeWorks, LifeWorks will file claims on my behalf. I agree to pay any deductible or copayments required by my insurance company. I also agree to pay for any services not covered by my insurance carrier's contract with LifeWorks. If any action at law or in equity is brought to enforce or interpret the provisions of this Agreement, LifeWorks shall be entitled to reasonable attorney's fees and related Court costs and expenses, in addition to any other relief to which it may be entitled.

_____LifeWorks utilizes a HIPAA compliant and security compliant platform to store credit card information. Sessions will be charged at the time of the appointment.

_____Clients who do not have access to a credit card may pay in cash or by a check payable to LifeWorks Counseling & Consulting or LifeWorks. Returned checks will be assessed a $50.00 fee. Should the fee from the bank be in excess of $50.00, the client will be charged the full penalized amount.

_____I understand utilizing Telehealth carries additional fees and I will be assessed an annual fee of $15.00 per calendar year (January – December).

_____Should LifeWorks rates need to raise, we are committed to give a six week notice for those clients actively in our professional care.

NON-COVERED SERVICES

_____A Non-Covered Service is a service utilized for the benefit of counseling and is not covered by an individual insurance benefit plan. Some of those services include but are not limited to: a service provided that is rejected by the insurance entity, psychological testing and interpretation, services provided regarding legal matters such as court preparation and appearances, depositions, expert and non-expert witness services, extended counseling sessions beyond the billable clinical hour, phone calls in excess of ten minutes, etc. Payment for a Non-Covered Service is the responsibility of the client or parent/legal guardian. A lapse in mental health coverage is also considered a Non-Covered Service and is the responsibility of the client or parent/legal guardian.

_____When possible, a LifeWorks clinician or an Administrative Professional will discuss the estimated fee associated with a Non-Covered Service. Fees are due at the time service is rendered.

_____Services provided regarding legal matters such as custody, court preparation, court appearances, depositions and travel time will be estimated by the clinician at which time 50% of the estimated fee is due one (1) week prior to this service being provided. To clarify, any and all forms of testimony required, including expert or non-expert, from anyone on LifeWorks Counseling & Consulting, Inc. team, will be charged applicable fees according to LifeWorks fee structure, a minimum of $250.00 per hour.

OTHER

_____I understand minors under the age of 15 years old may not be left at LifeWorks without a legal adult present.

_____A four-week notice is required to release copies of any record for medical, billing or legal purposes (see Notice of Privacy & Practices). LifeWorks reserves the right to bill for these services, as is customary with Indiana law. Payment is due before release of records.

_____I understand that I am responsible for reviewing and understanding my benefit coverage for mental health services. I understand that LifeWorks will verify these benefits with my insurance company. I will not hold LifeWorks responsible for any misquote by the insurance company and am responsible for any fees not covered by my benefits.

_____I have received the LifeWorks Intake Letter pertaining to my individual payment method.

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_____LifeWorks utilizes the area outside the building as an extension of counseling when appropriate. I consent permission to be outside the building for the myself or the client consented to be treated.

_____LifeWorks has pets who are on the premises at specific times but only for specific clients. I understand the pets are used for therapeutic purposes.

_____I choose to have any of the pets involved in therapy. I will not hold LifeWorks or any person associated with LifeWorks responsible for any transferable disease or for any accident that may occur.

_____I choose not to have pets involved in therapy.

INTERN CONSENT, IF APPLICABLE

_____I understand that information contained in my confidential files will not be released to any person(s) outside of LifeWorks without my written consent.

_____I understand that this facility is a training facility and if my successful treatment is beyond the scope of the intern's ability, I may be referred to another counselor that is better equipped in responding to the presenting problem.

_____I understand that the intern is trained and expected to execute LifeWorks policies and procedures, ethics, and governing laws of the profession.

_____I understand the intern's site supervisor may need to sit in on a session as required by his/her training.

_____I understand the intern may need to audio/video tape a session as required by his/her training. Audio/video tapes are the treated under HIPAA and are destroyed by the college/university after feedback is given. Audio/video tapes will only be done with consent prior to the session.

TELEHEALTH SPECIAL CONSIDERATIONS

_____Telehealth is a voluntary counseling therapy option. Telehealth offers its own unique considerations and although helpful, it is not in the best interest for every person. If at any time Telehealth does not sufficiently meet the needs of a client and an assessment determines that in-person counseling is more appropriate based on safety concerns, a referral will be made immediately if in-person counseling is not an option.

_____Telehealth is not covered by all insurance companies. Each client is responsible for obtaining their mental health benefits from their insurance provider(s) to determine reimbursable rates for mental health psychotherapy services.

_____If, telehealth is considered a Non-Covered Service with the client's insurance provider, I understand I am responsible for payment.

_____I understand LifeWorks utilizes an encrypted HIPAA compliant telehealth platform, however, in general telehealth platforms can pose risks with HIPAA compliancy and security. I will not hold LifeWorks Counseling & Consulting, Inc. or any of its employees, or agents, responsible for any damages.

_____I understand the level of encryption utilized by myself of minor under my care, may directly impact the privacy of the connection.

_____LifeWorks cannot guarantee confidentiality or security utilized by the client. I understand I am responsible to secure my own environment and will not hold LifeWorks Counseling & Consulting, Inc. or any of its employees, or agents responsible for any damages.

_____I understand that my upper body must be fully visible with adequate lighting, and I must be appropriately and fully dressed.

_____I understand Telehealth is regularly assessed for therapeutic efficacy. If my counselor/therapist determines it is not in my best interest to continue Telehealth, arrangements for in-person counseling or areferral will be made for continuity of care.

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_____I understand Telehealth is not appropriate if I am having thoughts of harming myself or someone else.

_____I understand Telehealth may not be appropriate if I am experiencing psychosis, I am in an abusive or violent relationship compromising safety of the Telehealth session, or if I am actively abusing substances. Each case will be thoroughly assessed by the counselor/therapist.

_____I have read, understand the above policies and procedures, and consent to be treated via in-person or telehealth.

Client Signature:_____Date: _____

Parent/Legal Guardian Signature:_____Date: _____

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FOR OFFICE USE ONLY

☐ This is the original Consent to Treat when I entered into counseling services.

☐ This is an update Consent to Treat effective on (date):_____

☐ The Good Faith Estimate was given at the onset of counseling or for existing clients according to the legal guidelines.

ADDITIONAL NOTES

LAST:	FIRST:	MIDDLE:	DATE:	CLIENT #: