modern therapy

PATIENT REGISTRATION

*Please complete regardless of insurance coverage

Patient Information:

Name (Last, First): _____ Date: _____

Address: _____

Street City State Zip Code

Phone (Home): _____ (Work): _____ (Cell): _____

Patient Social Security Number: ___-___-___ Patient Birth Date: ___/___/___

Email: _____ Patient Employer: _____

If Student, please indicate current school/university: _____

How did you hear about us?: **Please be as specific as possible** _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Member ID #: _____ Member ID# _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Policy Holder (Primary) Name: _____ DOB: ___-___-___ SSN: ___-___-___

Policy Holder (Secondary) Name: _____ DOB: ___-___-___ SSN: ___-___-___

Patient Relationship to Policy Holder: _____

*Please complete regardless of insurance coverage

Emergency Contact:

Name: _____

Phone (Home): _____ (Cell): _____

Relationship to Patient: _____

Shana Kemp-Price, Counseling Associates LLC dba Modern Therapy LLC
78 Village Pointe Drive Powell, OH 43065; 3040 Riverside Drive, Ste. 120, Columbus, 43221,
Ph: (614) 329-8862 / admissions@moderntherapyohio.org / www.moderntherapyohio.com

Client Information and Acknowledgment of Informed Consent to Treatment

All clinicians at Modern Therapy are licensed in the state of Ohio. Clinicians who are in the process of obtaining independent licensure receive regular supervision from clinicians who are independently licensed with Supervision status in the state of Ohio.

Mental Health Services

The purpose of mental health and chemical dependency recovery services is to help you better understand your situation, change your behavior, or move toward resolving your difficulties. Using our knowledge of human development and behavior, we will make observations about situations and help you to develop new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur.

The services offered can have risks as well as benefits. Treatment often involves discussing unpleasant issues, and you might experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health and substance abuse care may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Supervision

Clinicians who are in the process of obtaining their independent licensure will receive direct and indirect supervision from Terry Southwick, LPCC-S, LICDC-CS, Tracy Short, LPCC-S, LICDC, Amy Smitke LISW-S, LICDC, or Shana Kemp-Price, LPCC-S, LICDC-CS. This includes reviewing diagnoses, treatment plans, goals, progress, and concerns. If you have any questions regarding this, please speak to us so we can provide clarification.

Appointments

Appointments are made by calling **(614) 329-8862**. **Please call to cancel or reschedule at least 24 hours in advance, or you will be charged $100.00 for the missed appointment unless we determine an emergency was involved.** Third party payers will not cover or reimburse for missed appointments. For clients who are exempt from late fee, will be discharged after 2 late cancellations/no shows. Appointments are 45-50 minutes in length, but session length may vary for clinical reasons. The number of appointments depends on many factors and we will discuss this as part of your treatment planning. Since there is no way a therapist can see another client when they have a late arrival, no reductions are provided when a client arrives late for an appointment. Some insurance companies will only pay for the actual time during which services are rendered. In that case you, the client, will be billed for the portion of the appointment time when no services could be rendered. In some cases, governmental insurance or employee assistance programs do not allow billing for missed or partially missed appointments and if that is the case you will be billed in accordance with those programs' rules. ***You, the client, are always financially responsible for services received from Modern Therapy.***

Relationship

Our relationships with clients are considered a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that we not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Please do not attempt to "friend" us individually on Facebook or on any other social media site. However, please feel free to follow our practice's Facebook, Twitter, or Instagram. You always have the right to terminate services with us at any time and for any reason.

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Goals, Purposes and Techniques

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment we recommend and to have input into setting the goals of your therapy. As therapy progresses these goals may change. You and your therapist will jointly determine how to effect the changes you are seeking to make for yourself. You always have the opportunity to seek either another opinion or a different therapist. We will let you know if we feel that we are not a good fit or if you might obtain better help elsewhere. We always retain the right to terminate therapy with you in the event that we feel you would be better served elsewhere, if we feel you are not complying with treatment requests, or if payments due remain unpaid. In the event that we terminate services with you we will offer you referrals.

Confidentiality

Laws protect the privacy of all communications between a client and a therapist. In most situations we can only release information about your treatment to others if you sign a written authorization. There are some situations where we are permitted or required to disclose information either with or without your consent or authorization. For example:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order us as your therapist to disclose information;
- If a government agency is requesting the information, we may be required to provide it;
- If you file a complaint or lawsuit against us, we may disclose relevant information about you in order to defend ourselves.
- If you file a worker's compensation claim, we may be required, upon appropriate request, to provide a copy of your records, or a report of your treatment.
- If using insurance, insurance require information about your treatment.

There are some situations in which we are legally obligated to take actions that we believe are necessary to attempt to protect others from harm, and in such cases we might have to reveal some information about your treatment. If such a situation arises, we will make every effort to fully discuss it with you before taking any action, if we deem that to be appropriate under the circumstances and will limit disclosure to what is necessary. For instance:

- If we have reason to believe that a child, a developmentally or physically disabled or elderly adult is being neglected or abused, the law may require us to report that information to the appropriate state or local agency;
- If we believe you present a clear and substantial danger of harm to yourself and/or others, we may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and/or notifying the police.

You agree that we may release information about your claim(s) to the Ohio Department of Insurance in connection with any insurance company's failure to properly pay a claim in a timely manner as well as to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.

You agree that from time to time we may have the need to consult with our practice attorney regarding legal issues involving your care (this is an infrequent occurrence, but does happen from time to time). Our practice attorney is bound by confidentiality rules also. In addition, we will reveal only the information that we need to reveal to receive appropriate legal advice in connection with those contacts.

You should be aware that we may practice with other health professionals and that we may employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as typing, scheduling, billing, and quality assurance and you agree that we may do that. If we do that we will only release the information necessary in order for us to provide help to you, the client. All of the health professions will be bound by the same rules of

confidentiality. All staff members understand the importance of protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Also, we may have a contract with a collection agency. We will have a formal business contract with this business, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed or is required by law.

In addition, we may have a contract with a billing service. We will have a formal HIPAA BAA business associate contract with this business/agency, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed or is required by law. Please understand outstanding fees that continue to be unpaid may be turned over to small claims court or a collection service and you agree to allow us to do that. If we do this, we will only report information that is needed to collect fees due to us.

This summary is designed to provide an overview of confidentiality and its limits. It is important that you read the Notice of Privacy Practices form that has been provided to you for more detailed explanations, and that you discuss with us any questions or concerns that you have.

Informed Consent for Telehealth Services

Definition of Telehealth: Telehealth involves the use of electronic communications to enable Modern Therapy's mental health professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent. I understand that I have the right to withhold or withdraw my consent to the use of telehealth during the course of my care at any time, without affecting my right to future care or treatment. I also understand that some clinicians only provide telehealth and I may need to be transferred to a clinician who offers in-person sessions, if I chose to withdraw my consent to telehealth.

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

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

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

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

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained.

I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:

(1) omit specific details of my medical history that are personally sensitive to me,

(2) ask non-clinical personnel to leave the telehealth room, and/or

(3) terminate the consultation at any time.

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

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

By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

I understand that different states have different regulations for the use of telehealth. Ohio requires services to be provided to clients who are physically in the state of Ohio during services.

Payment for Telehealth Services: Shana Kemp-Price, Counseling Associates, LLC dba Modern Therapy LLC will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual will be required to pay out-of-pocket for services. We will provide you with a statement of service to submit to your insurance company if you wish.

If your clinician is using a Google Voice number, please be aware these are not HIPPA compliant and should be used with discretion.

Legal Situations

If you or the client (if the client is a minor or a ward of a guardian) become involved in legal proceedings that require our participation you will be expected to pay for all of our professional time, even if we are called to testify by another party. We will ask that a retainer be paid of half of the expected fees at least one week prior to providing these services, and the second half of expected fees and any additional fees that may have been accrued be paid within one week after services are delivered. Any unused amounts will be refunded. Our professional time for legal proceedings may include preparation (document review or letter preparation), phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that we wait in court prior to or after we may be called to testify). Due to the time-consuming and often difficult nature of legal involvement, we charge $375.00 per hour for these services. You will also be responsible for any legal fees that may incur in connection with the legal proceeding, which may include responding to subpoenas.

Please be advised that as a treating clinician(s), your clinician cannot ethically provide any recommendation on guardianship, custody, visitation, parenting capacity or abilities or what is in the best interest of the child(ren) if you or your child(ren) are involved in custody/divorce/guardianship proceedings.

Professional Records

The laws and standards of our profession require that we keep Protected Health Information about you in your client file. Your client file may include information about your reasons for seeking therapy, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment

history, results of clinical tests (including raw test data), any past treatment records that we receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of all of your records that we have prepared in connection with your treatment if you request them in writing, unless we determine for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, and in that event under Ohio law we may exercise the option of turning the records over to another mental health therapist designated by you, unless otherwise required by federal law. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, we therefore recommend that you initially review them with us or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so we will let you know what the charge is at the time that a records request is made. If you desire to have the information sent to you electronically, if we maintain the information in an electronic format, we will provide the information in that format if you agree to accept the potential risks involved in sending the information that way.

As your therapist, we may also keep a set of psychotherapy notes which are for our own use and which are designed to assist us in providing you with the best treatment. These notes are kept separate from the rest of your records. In order for psychotherapy notes to be released to third parties, you must sign a separate authorization in addition to one for the rest of your records. We will discuss with you whether or not we are maintaining psychotherapy notes on you.

Recording sessions

For reasons of confidentiality, and in order to remain in compliance with HIPPA regulations, it is the policy of Modern Therapy that no session, telehealth or in person are to be recorded in any form including but not limited to; video and audio recordings. Furthermore, no session is to be broadcast to any audience outside of the clinician and client at any time for any reason.

Violation of this policy will be grounds for immediate discharge and will prohibit the client from receiving services of any kind from Modern Therapy or any of their affiliates.

Fees, Payments, and Billing

Payment for services is an important part of any professional relationship, but even more so in private practice. ***This is how clinicians are paid for their services already rendered to you. You are responsible for seeing that our services are paid for. Meeting this responsibility shows your commitment and maturity.***

Our current regular fees are as follows. You will be given advance notice if our fees should change. Regular therapy services are $150.00 for the first diagnostic session, with subsequent 60 minute sessions billed at $120.00 and 45 minute sessions billed at $100.00. You will be billed for your session the morning of your appointment (you will be billed on Friday for weekend appointments). ***Your card will be charged***, please ensure that your credit card information is valid, up-to-date, and have sufficient funds to cover session. ***EVERYONE IS REQUIRED TO HAVE A VALID CREDIT CARD ON FILE TO RECEIVE SERVICES.*** We accept most credit cards and also Health Savings Account payments.

Even if you have insurance, more and more clients are choosing to self pay—to forego insurance and pay us directly out of pocket. The reason most choose to do this is because they want to protect their privacy and confidentiality. If you pay us directly, without insurance, we do not need to give you a diagnosis. Your care and treatment will not be influenced or managed by an insurance company or other strangers. Instead, you and your therapist will solely determine the course of your treatment and outcome of treatment.

Telephone consultations: we believe that telephone consultations may be suitable or even needed at times in our therapy. If so, we will charge you the regular fee, prorated for the time needed. If we need to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about this, please be sure to discuss it with us in advance so we can set a policy that is comfortable for all parties

involved. Please bear in mind, most insurance companies will **not** cover costs associated with telephone services and you, the client, will be responsible for fees. Of course, there is no charge for calls about appointments or similar business issues.

Reports: we will not charge you for our time spent making routine reports to your insurance company. However, other reports will occur a fee, please see paperwork and documentation requests for fees.

If you think you may have trouble paying your bills on time, please discuss this with us. We will also raise the matter with you so we can arrive at a solution. If your unpaid balance reaches $100.00, we reserve the right to not schedule additional sessions with you. If it then remains unpaid, we may stop therapy with you if we cannot agree on a payment plan. If therapy services are delayed or discontinued, we are happy to provide referral resources to you, or you can call your insurance carrier to find out if they have providers available to treat you. Fees that continue unpaid after this may be turned over to small-claims court or a collection service and you agree to allow me to do that. If we choose to do that, we will report only enough information to collect fees due to us. We may also charge a late fee of $25.00 each month on balances that remain unpaid.

Because we are licensed mental health therapists, many health insurance plans will help you pay for therapy and other services we offer. Because health insurance is written by many different companies, **we cannot tell you what your plan covers. We can not tell you if we are a covered provider with your plan.** When checking insurance information, please be aware all insurance information is under Shana Kemp-Price, LPCC-S, LICDC-CS (owner/founder of Modern Therapy), not necessarily under the clinician you see for therapy. Please read your plan's booklet under coverage for "Outpatient Psychotherapy" or under "Treatment of Mental and Nervous Conditions." Or call your employer's benefits office to find out what you need to know.

If your health insurance will pay part of our fee, we will help you with your insurance claim forms. However, please keep two things in mind: 1. ***We have no role in deciding what your insurance covers***. Your employer or you (if you have individual coverage) decided which, if any, services will be covered and how much you have to pay. 2***. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments***, and so forth. Your insurance contract is between you and your insurance company***; it is not between us and the insurance company*** unless we have signed a separate agreement with that company. ***You are responsible for paying the fees and unpaid balances by insurances and agree we may charge your credit card***. In **rare** exceptions where we bill a separated spouse, a relative, or an insurance company and we do not receive payment on time, we will then expect this payment from you, and you agree to pay amounts due. In addition, the plan may have rules, limits, and procedures that we should discuss, and we may not be on one of their panels. In addition, insurance companies may use certain companies to manage behavioral health plans, sometimes called "carved outs", which we may not be paneled. Insurance plans may also change **Clients with copays and deductibles are charged the morning of the appointment or on the Friday before for weekend appointments.**

We will provide information about you to your insurance company with your consent, and by signing below you agree that we may do that. If we have a contract with your insurance company, then billing will be sent in accordance with the contract we have with that company. If we are not contracted with that insurance company, you will be responsible for costs of sessions. You may request an invoice for our services with the standard diagnostic and procedure codes for billing purposes, the times we met, our charges, and your payments. You can use this to apply for reimbursement.

If you choose to not have us send information to your insurance company, you must select this option before each session and then pay for the session in full. We will then not report any information to your insurance company about that session. Although insurance companies say that they maintain confidentiality, oftentimes they report information to a national data bank that may later affect your ability to obtain other types of insurance. ***Even if you have insurance, more and more clients are choosing to self pay—to forego insurance and pay us directly out of pocket. The reason most choose to do this is because they want to protect their privacy and confidentiality. If you pay us directly, without insurance, we do not need to give you a diagnosis. Your care and treatment will not be influenced or managed by an insurance company or other strangers. Instead, you and your therapist will solely determine the course of your treatment and outcome of treatment. We DO NOT accept secondary insurance.***

ADDITONALLY: We will automatically bill clients for full service fees if they fail to coordinate benefits in a timely manner.

Paperwork and Documentation Requests

We do NOT complete FMLA paperwork, disability paperwork, leave of absence paperwork, and do not write Emotional Support Animal letters.

Minors

If you are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order or if we feel that the release of your records to your parents might have an adverse effect on you, in which case under Ohio law they can name another mental health therapist that we will have to turn them over to, unless otherwise required by federal law. Before giving parents any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have. Except in unusual circumstances, we like to make both parents and/or guardian aware of and involved in the treatment. In addition, if one parent, or guardian brings in a child and the therapy only involves the child, under Ohio law since generally both parents have access to the child's records unless that access is blocked by a court order, anything that either parent says in the sessions is available to both parents. **Legal documents need to be provided in cases where custody, visitation, shared parenting, guardianship** or other matters which are covered by court documents are involved before we see a minor for treatment. Minors 14 years of age and older should be aware that they have an option to see us on a limited basis without their parents' knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of our intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option.

Minors with divorced parents: we need documentation of who can sign off medically for the minor (usually can be found in parenting agreement). We can not see minors without proper authorization from parents.

Emergencies and After-Hours Care

We are an outpatient counseling practice; we are not set up nor appropriate for emergencies. If you have an emergency you should go directly to a hospital emergency department, call 911, or Netcare Access at (614) 276-2273. The National Suicide Prevention Lifeline number is 988.

Our front desk hours of operation are normally 8am-4pm, with an hour break at 12pm. We may be reached at admission@moderntherapyohio.org or at (614) 329-8862 weekdays during these times. We will make every effort to return messages within 24 hours; however, we may not always be able to do that, especially on weekends.

In case of emergencies, your therapist may need to recommend a higher level of care for you.

Incapacity or Death of Therapist

In the event that your therapist is incapacitated or dies, it will be necessary for another therapist to take possession of your file and records. By signing this form, you consent to allow another licensed mental health professional whom we designate to take possession of your file and records, provide you with copies upon request, or to deliver them to a therapist of your choice.

Disclosing Information to Family Members, Relatives, or Close Friends

In the event you are incapacitated, in an emergency situation, or are not available, you agree to allow us to contact a family member, a relative, a close friend or any other person you identify, and disclose your personal health information that directly relates to that person's involvement in your healthcare. This information will be disclosed as necessary only if we determine that it is your best interest based on our professional judgment.

Email, Texting, and Electronic Communications

We do not like to use e-mail, texting, or electronic communications other than for appointments and scheduling. If you decide you want to utilize any form of electronic communication, you acknowledge that there are confidentiality risks inherent in such communications if they are unencrypted and you agree to accept those risks.

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Acknowledgment of Informed Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize you to provide such care, treatment or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company or third-party payer, to obtain reimbursement unless I direct otherwise.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through you at any time. I also understand that there are no guarantees that treatment will be successful.

I have read and understand the information provided above regarding policies, procedures, payments, insurances, telehealth, etc. and have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor is the client I am signing on behalf of the minor as the authorized parent/guardian. (Information on Minor rights will be shared with the minor).

**I also acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Client Name(s) (please print)

_____

Client Name(s) (please print)

_____ Date _____

_____ Date _____

Client(s) Signature or Parent(s) or Guardian Signature (for minor child or children or disabled adults)

Modern Therapy LLC
78 Village Pointe Drive Powell, OH 43065; 3040 Riverside Drive, Ste. 120, Columbus, 43221,
Ph: (614) 329-8862 / admissions@moderntherapyohio.org / www.moderntherapyohio.com

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

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

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes in most instances without your consent under HIPAA, but we will obtain consent in another form for disclosing PHI for other reasons, including disclosing PHI outside of our practice, except as otherwise outlined in this Policy. In all instances we will only disclose the minimum necessary information in order to accomplish the intended purpose. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist.

  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage, which would include an audit.

  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within our practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information, including uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Examples of disclosures requiring an authorization include disclosures to your partner, your spouse, your children, except in some limited instances where they are involved in your health care, in which case we will obtain your consent first. Any disclosure involving psychotherapy notes, if we maintain them, will require

your signed authorization, unless we are otherwise allowed or required by law to release them. You may revoke an authorization for future disclosures, but this will not be effective for past disclosures which you have authorized.

III. Uses and Disclosures Requiring Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization as allowed by law, including under the following circumstances:

- **Serious Threat to Health or Safety:** If we believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s). We will inform you about these notices and obtain your written consent, if we deem it appropriate under the circumstances.
- **Worker's Compensation:** If you file a worker's compensation claim, we may be required to give your mental health information to relevant parties and officials.
- **Felony Reporting:** We are allowed to report any felony that you report to us that has been or is being committed.
- **For Health Oversight Activities:** We may use and disclose PHI if a government agency is requesting the information for health oversight activities. Some examples could be audits, investigations, or licensure and disciplinary activities conducted by agencies required by law to take specified actions to monitor health care providers, or reporting information to control disease, injury or disability.
- **For Specific Governmental Functions*:*** We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, and for national security reasons, such as for protection of the President.
- **For Lawsuits and Other Legal Proceedings*:*** If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by law. We cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order, or at times an administrative subpoena, unless the information was prepared for a third party. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information. In most situations it is not in your best interest to have your therapist involved in any legal proceedings. If a patient files a complaint or lawsuit against us, we will disclose relevant information regarding that patient in order to defend ourselves.
- **Abuse, Neglect, and Domestic Violence*:*** If we know or have reason to suspect that a child under 18 years of age or a developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates a buse or neglect of the child or developmentally disabled individual under 21, the law requires that we file a report with the appropriate government agency, usually the County Children Services Agency. Once such a report is filed, we may be required to provide additional information. If we have reasonable cause to believe that a developmentally disabled adult, or an elderly adult in an independent living setting or in a nursing home is being abused, neglected, or exploited, the law requires that we report such belief to the appropriate governmental agency. Once such a report is filed, we may be required to provide additional information. If we know or have reasonable cause to believe that a patient or client has been the victim of domestic violence, we must note that knowledge or belief and the basis for it in the patient's or client's records.
- **To Coroners and Medical Examiners:** We may disclose PHI to coroners and medical examiners to assist in the identification of a deceased person and to determine a cause of death.
- **For Law Enforcement:** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Required by Law.** We will disclose health information about you when required to do so by federal, state or local law.

- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, non-accidental physical injuries, reactions to medications or problems with products.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Other uses and disclosures will require your signed authorization, unless the use or disclosure is allowed or required by law .

IV. Patient's Rights and Duties

Patient's Rights:

- ***Right to Request Restrictions and Disclosures***–You have the right to request restrictions on certain uses and disclosures of protected health information about you for treatment, payment or health care operations. However, we are not required to agree to a restriction you request, except under certain limited circumstances, and will notify you if that is the case. One right that we may not deny is your right to request that no information be sent to your health care plan if payment in full is made for the health care service. If you select this option, then you must request it ahead of time and payment must be received in full each time a service is going to be provided. We will then not send any information to the health care plan for that session unless we are required by law to release this information.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. If your request is reasonable, then we will honor it.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record, except under some limited circumstances. If we maintain the information in an electronic format you may obtain it in that format. This does not apply to information created for use in a civil, criminal or administrative action or proceeding. We may charge you reasonable amounts for copies, mailing or associated supplies under most circumstances. We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to your PHI, you may ask that our denial be reviewed. Under certain stances where we feel, for clearly stated treatment reasons, the disclosure of your record might have an adverse effect on you, we will provide your records to another mental health therapist of your choice.
- ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request but will note that you made the request. Upon your request, we will discuss with you the details of the amendment process.
- ***Right to an Accounting*** – With certain exceptions, you generally have the right to receive an accounting of disclosures of PHI, not including disclosures for treatment, payment or health care operations for paper records on file for the past six years and for an accounting of disclosures made involving electronic records, including disclosures for treatment, payment or health care operations, for a period of three years. On your request we will discuss with you the details of the accounting process.
- ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Our Duties:

- We are required by law to maintain the privacy of PHI, to provide you with this notice of my legal duties and privacy practices with respect to PHI, and to abide by the terms of this notice.
- We reserve the right to change the privacy policies and practices described in this notice and to make those changes effective for all of the PHI I maintain.
- If we revise our policies and procedures, which we reserve the right to do, we will make available a copy of the revised notice to you on our website, if we maintain one, and one will always be available at our offices. You can always request that a paper copy be sent to you by mail.
- In the event that we learn that there has been an impermissible use or disclosure of your unsecured PHI, unless there is a low risk that your unsecured PHI has been compromised, we will notify you of this breach.

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V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we make about access to your records, you may file a complaint with us and we will consider how best to resolve your complaint. Contact Shana Kemp-Price, the CEO and Privacy Officer, if you wish to file a complaint with us. In the event that you aren't satisfied with our response to your complaint, or don't want to first file a complaint with us, then you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., 200 Independence Avenue S.W., Washington, D.C. 20201, Ph: 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/compliants/.

VI. Effective Date:

This notice is effective as of September 1, 2019.

VII. Privacy and Security Officer:

My contact information is listed at the beginning of this form.

By signing, I acknowledge I read and understand policies and practices for protecting my health information.

_____ _____

Client Signature or Parent(s) or Guardian Signature Date

(for minor child or children or disabled adults)

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CONSENT FOR CONTACT INFORMATION

Where may we attempt to contact you?

Primary Phone number: _____

Is it ok to text? ☐ YES ☐ NO (please circle)

Email: _____

Is it ok to email? ☐ YES ☐ NO (please circle)

Many times, when calling, we will reach an answering machine/voicemail. Are we allowed to leave a detailed message with our name and request for information or information for you?

☐ YES ☐ NO (please circle)

If you are a minor, would it be okay to send your parent(s) reminders of appointments?

Parents' phone number: _____

Is it ok to text? ☐ YES ☐ NO (please circle)

Parent's Email: _____

Is it ok to email? ☐ YES ☐ NO (please circle)

Client Name: _____ Relationship: _____
(Please Print Name)

Client Signature: _____ Date: _____

Client Signature or Parent(s) or Guardian Signature (for minor child or children or disabled adults)

*Note: Information of a highly sensitive nature will continue to only be given directly to you.

** **All clients, parent or guardian please sign this page**

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AUTHORIZATION FOR CREDIT/DEBIT/HSA CARD

I, _____ authorize ***Shana Kemp-Price, Counseling Associates LLC dba Modern Therapy LLC,*** and/or it billing company to charge my credit/debit/HSA card for services rendered to myself and/or clients listed below. In providing us with your card information, you are giving ***Shana Kemp-Price, Counseling Associates dba Modern Therapy LLC,*** or designated billing company permission to automatically charge your card on file for the following fees and/or balance(s) for you and/or other clients listed on form at time of service.

Co-pay/Co-insurance/Deductible: The amount defined by the client's insurance company for behavioral health services that are due at time of service. Card will be charged at rate of benefits as quoted by client's insurance company. If an EOB (Explanation Of Benefits) shows a copay/co-insurance/deductible rate which differs from quoted/charged copay/co-insurance/deductible, company will appropriately and retroactively correct charge to client. **Additionally, if EOB shows client is not covered for benefits, card will be charged full session rate.**

Self-pay: The clinician's fee for service when insurance and/or employee assistance programs do not apply. Card will be charged at time of service unless otherwise noted.

Denial/Reversal of insurance: Card will automatically be charged for services rendered if claim is denied or reversed.

No Show and Late Cancellation Fees: The fee listed in the *Office Billing and Insurance Policy*.

Outstanding Balance: If the client's insurance provider has paid their portion of the bill and there is still an outstanding balance owed, **card will automatically be charged.**

I authorize ***Shana Kemp-Price, Counseling Associates LLC dba Modern Therapy LLC***, to charge the above fee(s) and outstanding balances to my credit/debit/HSA card:

Visa◯ **Mastercard**◯ **Discover**◯ **American Express**◯

Credit Card # _____

Expiration date: _____ Security Code: _____

Address associated with Card: _____

Card holder's name (please print): _____

Signature: _____ Date: _____

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SELF-ASSESSMENT

What is happening in your life which resulted in this appointment?

Have you ever been involved with counseling before? If so, with whom, when, and how long? What were some things you like/didn't like about your previous experiences with counseling?

Previous inpatient/hospitalizations:

Current medications (dose, frequency, and reason if known):

Allergies?

Tell us a little about your family. Any family history of mental health or substance abuse issues?

Do you use alcohol and/or drugs? If so, how much and how often?

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Legal history (arrests, incarcerations, etc.)

What is the highest level of education you've completed? Any developmental/learning issues?

Tell us a little about your support and significant relationships in your life:

What do you feel are your strengths?

What would you like to accomplish in therapy?

Please check all that apply to you:

- ☐ Depression
- ☐ Feeling that you are not real
- ☐ Low energy
- ☐ Feeling that things around you are not real
- ☐ Poor concentration
- ☐ Lose track of time
- ☐ Hopelessness
- ☐ Unpleasant thoughts won't go away
- ☐ Worthlessness
- ☐ Anger/frustration
- ☐ Guilt
- ☐ Easily agitated/annoyed

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- ☐ Sleep disturbance (more/less)
- ☐ Defies rules
- ☐ Appetite disturbance (more/less)
- ☐ Blames others
- ☐ Thoughts of hurting yourself
- ☐ Argues
- ☐ Isolation/withdrawal
- ☐ Excessive use of prescription medication
- ☐ Sadness/loss
- ☐ Excessive use of drugs and/or alcohol
- ☐ Stress
- ☐ Blackouts
- ☐ Anxiety/panic
- ☐ Physical abuse issues
- ☐ Heart pounding/racing
- ☐ Sexual abuse issues
- ☐ Chest pain
- ☐ Spousal abuse issues
- ☐ Trembling/shaking
- ☐ Excessive behaviors (spending, gambling)
- ☐ Sweating
- ☐ Fear of going crazy
- ☐ Chills/hot flashes
- ☐ Easily agitated
- ☐ Tingling/numbing
- ☐ Can't hold onto idea
- ☐ Phobias
- ☐ Fear of dying
- ☐ Nausea
- ☐ obsessions/compulsive behaviors
- ☐ Thoughts racing
- ☐ Not thinking clearly/confusion
- ☐ Other problems/symptoms:

_____

_____

Please email this paperwork ASAP to admissions@moderntherapyohio.org

If you are being seen for telehealth, at the Riverside location, or outside of regular business hours; we MUST receive your paperwork one day prior to your scheduled appointment. If we do not receive your paperwork within this time period, your appointment will be cancelled and need to be rescheduled.