Johnson Counseling

700 16th St. NE, Ste 205
Cedar Rapids, IA 52402
Phone: 319.382.4721

AGREEMENT FOR SERVICES AND INFORMED CONSENT

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Johnson Counseling Services, LLC is a Limited Liability Corporation owned and operated by Licensed Independent Social Worker, Katie Johnson.

Standard Fees and Billing

Intake (1 to 3 sessions)..... $175.00	60 minute therapy session..... $155.00
45 minute therapy session.....$135.00	30 minute therapy session.....$100.00

Payment: If you have health insurance coverage for psychotherapy, you are required to pay your entire copayment at each session. If you do not have health insurance coverage, you are expected to pay for each session in full, at the time of service, unless other arrangements have been made. Johnson Counseling Services, LLC will gladly arrange for submission of an insurance claim to your health insurance carrier (HIC) provided that we have the necessary information to do so. It is always wise to contact your HIC to ensure the following: if psychotherapy is a covered benefit, if your therapist is an approved provider, the amount of your copayment, whether psychotherapy is subject to a deductible, and if you require a pre-authorization for psychotherapy. If your HIC does not pay as you anticipated, *you are responsible for the amount that your HIC does not cover*. If financial difficulties arise for you, please let your therapist know immediately so you can discuss an alternative payment schedule or make other arrangements. Signing this document indicates that you understand and agree to these terms.

After hours calls/Emergencies: Johnson Counseling Services, LLC does not provide services during non-office hours (i.e., evenings, weekends, holidays, etc). You are encouraged to leave a message with your therapist during non-office hours. If you are in crisis and/or need immediate attention, please call the Foundation2 Crisis Center at 319.362.2174 or the Johnson County Crisis Center at 319.351.0140 and request assistance. You might also contact your preferred health care provider or go to the nearest hospital emergency room.

Late cancellations and missed appointments: A 24-hour advanced notice is required if you are unable to attend a scheduled appointment. This notice permits us to offer that time to someone else. If you have given 24 hour's notice, you will not be charged for the appointment. *However, if you break your appointment and do not notify the office within 24 hours, you may be charged $75 for the session*. We understand that there may be occasional emergencies when you will not be able to keep your appointment and also will not be able to notify us within 24 hours. We will take these circumstances into account. Charges for broken appointments and appointments canceled without 24-hours' notice cannot be billed to your third-party payer. *You will be personally responsible for the full amount due*. Missing multiple appointments and missing appointments regularly will negatively interfere with your treatment and impede progress, and for this reason your therapist may need to discuss the continuation of care.

PRIVACY PROTECTION AND PATIENT RIGHTS

Limits of Confidentiality

The law protects privacy of all communications between patient and a therapist. In most situations, your therapist can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA and/or Iowa law. However, in the following situations, no authorization is required:

- **Therapist Consultation:** Your therapist may occasionally find it helpful to consult with another practicing therapist about your care. During consultation, no identifying information will be shared. All therapists are required by law to keep confidentiality and receive training about rules and regulations about confidentiality.

- **Harm to Self or Others:** If you communicate an imminent threat of serious physical harm to yourself or to an identifiable victim, the therapist may be required to disclose confidential information in order to take protective actions. These actions may include initiating hospitalization, contacting a family physician or psychiatrist, contacting the police for a safety check, notifying the potential victim, or contacting family members or others who can assist in providing protection.

- **Billing:** Insurance and patient billing is done within our office by an independent contractor. Our independent contractor has received training about the rules, regulations, and ethics of confidentiality and completely understands the importance of protecting your privacy. The independent contractor never has access to your clinical record and is only provided with enough information to bill your HIC and/or the responsible party using the address you provided.

- **Abuse or Neglect:** If your therapist has reasonable cause to believe that a child, to whom she has provided professional services, has been abused OR if she suspects that a dependent adult, to whom she has provided professional services, has been abused, the law requires that she file a report with the appropriate government agency, usually the Department of Human Services. Once such a report is filed, she may be required to provide additional information.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, and a request is made for information concerning the professional services that have been provided by your therapist, such information is protected by the "therapist-patient privilege" law. Your therapist can not provide any information without your written authorization or a court order. Please note your records can be subpoenaed, which is a court order that requires your therapist provide the requested information. If you are involved in, or contemplating litigation, you should consult with your attorney to carefully consider whether or not it is in your best interest to ask your therapist to disclose your mental health information to any entity, including your own lawyer, involved in the litigation.

- **Third Party Contract:** If your therapist needs to contract with another business, such as an accountant for the purpose of a full audit, we are required by HIPAA to have a formal "Business Associate Contract" in place with that business. In this contract, the other business promises to maintain the confidentiality of any data provided by your therapist, except as specifically allowed in the contract or otherwise required by law.

- **Worker's Comp:** If a patient files a worker's compensation claim your therapist must, upon appropriate request, provide any information concerning the employee's physical or mental condition relative to the claim.

- **Deceased Patients:** In the event of your death, your right to confidentiality continues. The administrator or executor of your estate assumes your right to sign on your behalf for release or disclosure of your records.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that any questions or concerns are discussed. The laws governing confidentiality can be quite complex, and in situations where specific advice is required, a formal legal consultation may be necessary.

AUTHORIZATION FOR SERVICES

Therapy is a series of conversations between the two of us that is designed to help you make changes in your life. If you choose to proceed in therapy, a positive outcome becomes our mutual responsibility. This begins with your trust in a commitment to the treatment process and my commitment to address your questions and concerns as they arise in treatment. What we work on and how we work in therapy will be driven by your needs, concerns and goals, as well as my therapeutic recommendations.

Potential benefits and risks of therapy: The benefits you experience in therapy are highly contingent upon your attitude and the work you put in between our conversations to make changes in your life. However, regardless of both our efforts there is no guarantee that therapy will be successful. Potential benefits are, but not limited to: improved relationships, changes in harmful thinking habits, arrival at solutions to specific problems, reduction in feelings of depression or anxiety, improved adjustment to a major life change, and overcoming the effects of a past traumatic event. The risks associated with therapy are usually minimal, but are often an important part of the growth process. Potential risks are, but not limited to: some disruption in your daily life, unexpected changes within your relationships, feeling uncomfortable emotions, the potential that symptoms may be initially intensified, recalling unpleasant life events and questioning the beliefs and values of yourself and others.

Ending therapy: Ideally, therapy ends when you have made sufficient progress toward your goals. However, either of us may decide to end therapy for a variety of reasons. I respect your right to seek treatment elsewhere if you do not feel your needs are being met or if we do not seem to be a good "match" in style or personality. If I do not believe I have sufficient training to address your specific concerns, I will try to provide referrals that might be better able to meet your needs. If your life and/or health is at risk, or if the life of someone else is at risk, and you choose not to accept and implement my recommendations to ensure the safety of yourself or another, I retain the right to end therapy. If you consistently avoid working in therapy by missing appointments, forgetting appointments, cancelling appointments, and/or not making any effort to work toward the change you desire, I may choose to end

therapy. I will address my concerns with you and try to negotiate a solution before I decide to end therapy. Non-payment of services is also a reason for ending therapy. For each of these circumstances, I will provide you with referrals to other therapists and/or agencies in the area that might be better able to meet your needs.

_____ I acknowledge that I was given the opportunity to receive and read the "Agreement for Services and Informed Consent" document. I am aware that I can download a copy from www.johnsoncounselingllc.com. I will be provided a paper copy upon request.

_____ I acknowledge that I was given the opportunity to receive and read the "Notice of Privacy Practices" document. I am aware that I can download a copy from www.johnsoncounselingllc.com. I will be provided a paper copy upon request.

Scheduling Reminders
You can receive an appointment reminder to your email address or mobile phone via text message the day before your scheduled appointment. Appointment information is considered "Protected Health Information" under HIPAA. Given the risks associated with electronic transmission, your therapist can not guarantee your communication will remain confidential (e.g., others who have access to your email or mobile phone).

Please initial the option below that best fits your needs.

_____ I would like to receive appointment reminders as described above and waive my right to keep this information completely private.

_____ I do not wish to receive appointment reminders and will remember appointments on my own.

General Consent for Billing Insurance
Please review and initial next to the option below that best fits your needs.

_____ I authorize my therapist to release protected health information from my clinical record to any of the following entities as applicable for the purposes of certification of psychotherapy services and/or billing for payment of those services: 1) EAP program, 2) a county funding organization, 3) my health insurance company and/or it's 4) designated managed care company. I understand this authorization continues indefinitely unless I revoke it in writing. However, if I revoke this authorization, I understand that any of the above entities retains the right to information in my clinical record prior to the revocation date.

_____ I do not wish to have an insurance company or other third party pay for the psychological services provided to me. I agree to be responsible for payment of all services provided.

Fee for Service (if applicable)

Agreed upon fee: $_____ (60 minutes) $_____ (45 minutes)

_____ I agree to pay the above fee for service as stated above.

Late cancellation/missed appointment fee
By initialing below, I am indicating I have read and understand the policy regarding late cancellation and missed appointments, including the potential of a $75 no show/late cancellation fee. I have had the opportunity to ask questions regarding this policy and they have been answered to my satisfaction.

_____ I understand and agree to the late cancellation/ missed appointment policy.

Authorization for Electronic Receipt
Johnson Counseling Services offers a variety of payment methods for your convenience. One such option is via credit or debit card transaction where a receipt may be provided. Given the risks associated with electronic transmission, your therapist can not guarantee your communication will remain confidential (e.g., others who have access to your email or mobile phone). Please review and initial below to approve sending of payment receipts.

_____ I give permission to Johnson Counseling Services to send me electronic receipts from the therapist and a third party services such as Converge.

_____ I have been informed that third party receipts such as Converge and from the therapist via email is not HIPAA compliant.

Consent for Treatment

I have read, initialed and understand the above policies and procedures and informed consent information of Johnson Counseling Services. I understand that I may terminate treatment at any time and that if I have any complain or grievance regarding my treatment, I will be provided assistance. I agree to the stated terms of treatment and hereby give my consent for treatment.

_____ _____
Patient/Parent/Legal guardian signature Date

_____ _____
Patient/Parent/Legal guardian signature Date