

Welcome to Green Counseling Services. We are honored you chose our practice for services for yourself or your child. We look forward to working with you. This document contains important information regarding our professional services and business policies. As we welcome you to our offices, we’d like to tell you a bit more about this process so you know what to expect in terms of the counseling relationship, appointment scheduling, confidentiality, records, and payment information. While this document is lengthy, it is very important that you review this information carefully prior to our first session. We will discuss any questions you may have regarding my policies and procedures at that time. At the end of this document, we will ask for your signature to verify you have reviewed the information below and that you consent to the terms of this agreement.

Psychotherapy is a process in which we will work together to examine thoughts, behaviors, and emotions related to the problems in your life. The goal of our work is to increase your understanding of the problems in your life and to help you develop and implement new approaches to more successfully deal with the problems. We will use many different methods to accomplish this goal. You will be asked to actively examine your thoughts, behaviors, and emotions via a series of in-session exercises and homework activities. In order for therapy to be most successful, you will be asked to be actively involved in all aspects of your treatment.

Psychotherapy can have risks and benefits. Therapy requires you to discuss difficult aspects of your life and you may experience uncomfortable emotions. On the other hand, you may also experience significant benefits from therapy, including reductions in bothersome symptoms, reductions in feelings of distress, a higher opinion of yourself, and better relationships with others. However, there are no guarantees of what you will experience. We will monitor your symptoms regularly and will make changes to our approach as necessary. This may include collaboration with a larger treatment team (physicians, nutritionists, etc.) if it appears you need a more comprehensive treatment approach or a referral to a different provider if our work together is not adequately meeting your needs.

Your first appointment is a diagnostic interview. Our goal during this appointment is to gather information about your current concerns. During this appointment, we will ask you a series of questions regarding your thoughts, behaviors, and emotions. We will also ask you about your psychological history. Many questions asked during your first appointment will be sensitive in nature, including questions about whether you’ve experienced physical or sexual abuse, whether you’ve had thoughts of suicide, etc. These questions can be uncomfortable to answer; however, this information is essential as we develop goals for your treatment.

To get a better sense of your concerns, we may also ask you to complete a series of questionnaires to evaluate your thoughts, behaviors, and emotions related to the issues that are concerning you. We may ask you to complete some of these online prior to your second session. During the second session, we will review your results and we will develop a preliminary plan for treatment. This plan may be that we continue to see you for individual therapy sessions. Alternatively, we may determine you need a higher level of care (example: inpatient or residential outpatient services). We may refer you to another provider so you can receive that level of care. We may also determine that a different therapist may be a better fit for your treatment. In that case, we will make a referral to a different therapist.

Therapy sessions typically occur one time per week, though this may be adjusted based on the intensity of your concerns. If concerns feel more severe, we may meet multiple times in a single week. If concerns feel less severe, we may meet less than once a week (example: every other week). We will discuss with you during each therapy session your progress and we will monitor the length of your therapy based on that progress. Please note that the total length of therapy can vary widely from person to person.

Therapy/medication management services:

* Initial Client Interview: $185
* 60 Minute Client or Client/Family Session: $155
* 45 Minute Client or Client/Family Session: $105
* Psychological Testing and Evaluation: $208
* 30 Minute Client or Client/Family Session: $80
* 60 Minute Group Therapy Session: $28
* ● 15 Minute Psychiatric Intake: $91
* ● 30 Minute Psychiatric Intake: $139
* ● 45 Minute Psychiatric Intake: $208
* ● 60 Minute Psychiatric Intake: $278
* ● 5 Minute Psychiatric Session: $28
* ● 10 Minute Psychiatric Session: $68
* ● 15 Minute Psychiatric Session: $109
* ● 25 Minute Psychiatric Session: $156
* ● 40 Minute Psychiatric Session: $218

Late (less than 24 hour) notice to cancel or no show: reserve the right to charge a $75 missed appointment fee (please note insurance will not pay this fee)

**Billing and Payments**

Please contact your insurance company to verify whether preauthorization is needed for mental health visits. Many insurance companies require authorization for mental health services even if authorization is not required for other medical services. Payment from your insurance company could be reduced or denied if authorization is not obtained. We will make every effort to obtain insurance reimbursement for your treatment but reimbursement is never guaranteed and you are solely responsible for the full cost of treatment.

For your convenience, we will submit the claim for each of your visits to your insurance company. We request that you pay your portion of the charges (your copay) at the time of service. Please remember the insurance contract is between you and your insurance provider. Questions about their payment and/or coverage should be directed to your insurance company. We cannot guarantee insurance coverage for services provided.

In the event of a delay or a denial of your claim, you are responsible for full payment in a timely manner. If payment cannot be made when due, please contact our offices to set up an extended payment plan. After 90 days, if no payments have been received or arrangements made, necessary collection proceedings will begin. You are responsible for all costs, including court costs and attorney fees, incurred in the collection of these charges.

**Cancellations/No Shows**

Your appointment time is reserved especially for you. If you are unable to keep your appointment, we ask that you notify us at least 24 hours in advance of your scheduled appointment time. If you miss your appointment and do not call to cancel at least 24 hours prior, you will be charged for the appointment. This fee is not reimbursable through insurance or third party payment. ***If less than 24 hours’ notice is given for a missed appointment, you may be billed $75.00.***

**Contacting Us**

If you are trying to reach Green Counseling Services via phone, call 319-800-5564 anytime from 10 a.m. to 6 p.m. We do not typically do not return calls on nights or weekends. If you are calling or e-mailing after hours to cancel an appointment or to schedule/reschedule, please leave a message and we will do our best to contact you on the next business day.

We do not provide comprehensive 24-hour services. If there is a life-threatening emergency or if you are concerned about an immediate safety issue, please call 911, go to the emergency room of your local hospital, call your physician (if that person offers 24-hour services), or contact The Crisis Center at 319-351-0140.

**Confidentiality**

The law protects the privacy of communications between a client and a therapist. In most circumstances, we can only release information regarding your treatment to others if you sign a written authorization form that meets legal requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA) and/or Iowa law. However, no authorization is required in the following situations:

* We may sometimes find it helpful to consult with other professionals regarding your case. During a consultation, we will not reveal your identity but will describe your symptoms and your history for the purpose of developing a better assessment or treatment plan. The other professionals with whom we consult are also legally bound to keep the information confidential. We will note all consultations in your Clinical Record.
* If you communicate an imminent threat of serious physical harm to yourself, we may be obligated to disclose information to ensure your safety. This information may be disclosed to law enforcement, local hospital staff, your family, or others involved in securing your safety. If this situation should arise, we will make every effort to discuss it with you prior to taking any action and will limit my disclosure to what is necessary.
* If you are involved in a court proceeding and a request is made for information concerning the professional services you have received, we will not disclose this information without your written authorization, a court subpoena, or a court order.
* If a government agency is requesting this information for health oversight activities, we may be required to provide it.
* If you file a complaint or lawsuit against me, we may disclose relevant information about your and our work together in order to defend myself.
* If you file a worker’s compensation claim, we must, upon appropriate request, provide information relevant to the claim.

There are some situations in which we are legally obligated to take actions which we believe are necessary to protect you or others from harm. In these circumstances (see below), we may have to reveal information regarding your identity and your treatment. The situations are rare in clinical practice, but can arise. If such a situation arises, we will make every effort to discuss it with you before taking any action and will limit my disclosure to necessary information.

* If I have reasonable cause to believe a child we have provided professional services to has been abused, or if we suspect a dependent adult has been abused, we are required by law to file a report with the relevant government agency (typically the Department of Human Services). Once the report is filed, we may be required by the agency to provide additional information.
* If you (the client) communicate an imminent threat of serious physical harm to an identifiable victim, we may be required to disclose information regarding your identity and your treatment in order to take protective actions. Protective actions may include hospitalization, notifying the potential victim(s), or contacting local law enforcement.
* Again, if you communicate an imminent threat of serious physical harm to yourself, we may be required to disclose information in order to take protective action. Protective actions may include initiating hospitalization, calling local law enforcement, or contacting family members or others who can assist in providing protection.

**Emailing/Faxing/Texting**

E-mailing, faxing, or texting information to us is not secure or confidential and your information could be read by others. Your signature on this document indicates you are aware of this risk and accept it as a limitation to confidentiality if you decide to communicate with me via these types of modalities.

**Professional Records**

As required by HIPAA, we keep Protected Health Information (PHI) about you in my professional records. The Clinical Record includes information about why you are seeking therapy, your progress, your medical history, your social background, your treatment history, your billing records, reports sent by others, and professional consultations that we have made regarding your case. Except in cases in which you 1) are a danger to yourself, 2) are a danger to others or 3) in cases that make reference to another person and releasing that information is reasonably likely to cause substantial harm to that other person, then you may examine and/or receive a copy of your Clinical Record if you request it in writing. These records sometimes contain information that may be upsetting or misinterpreted for an untrained reader. For this reason, we recommend that you initially review this record with me during a scheduled appointment or have them forwarded to another health professional to discuss the contents. If we refuse your request for access to your Clinical Records, you have a right of review (except for information supplied confidentially by others), which we will discuss upon your request.

**Patient Rights**

HIPAA provides you with a set of rights regarding your clinical records and disclosures of your protected health information. You have the right to request that we amend your record. You have the right to request restrictions on what information from your Clinical Health record is disclosed to others. You have the right to request an accounting of most disclosures of protected health information that you have neither consented to nor authorized. You have the right to determine the location in which your protected health disclosures are sent. You have the right to make complaints regarding our policies or procedures recorded in your records. You have the right to a paper copy of this form, the attached notice form, and our privacy policies and procedures.

**Termination Agreement**

Our relationship is mutually agreed upon and is at each of our discretions. You have the right to terminate our relationship at any time and to seek mental health treatment from any provider with whom you feel comfortable. If you have concerns regarding the quality or nature of our relationship or the services provided, please let me know. This will help me to address those concerns, attempt to strengthen our relationship, or help you to find a provider who is a better fit for you.

We reserve the right to terminate therapy services in the following situations:

* If it appears a different therapist or another therapeutic approach would work more effectively for your treatment.
* If you, your friends, or family behave inappropriately toward us or anyone in our offices.
* If we are court-ordered to testify regarding you.
* If you consistently fail to attend scheduled appointments.
* If you are unable to effectively use treatment services.
* If there is a failure to pay for services
* If it becomes clear that we will be teaching you as a professor in a class or will engage in another professional relationship with you (as an academic advisor for example – this is known as a dual role relationship and is prohibited by our ethical code)
* If either parent does not consent for psychological services (in the case of a minor child).

**Safety Within The Practice**

The possession or use of dangerous weapons within our practice office spaces is prohibited. Dangerous weapons include firearms, explosives, knives, or any other weapon or implement that might be considered dangerous or that could cause harm.

**Minors and Parents**

If you are below 18 years of age (and are not emancipated), then the law allows your parents to examine your treatment records. Because privacy is often crucial to treatment progress, it is our policy to request an agreement from your parents that they give up their access to your records. If your parents agree, we will provide them only with general information regarding the progress of your treatment and if you have attended the scheduled sessions. A summary of your treatment will also be provided once treatment is complete. We will notify your parents if I feel you are in danger or if you are a danger to someone else. Before giving your parents any other information, we will discuss the matter with you, if possible, and will do my best to handle any objections you may have. Please note that while we do my best to protect the privacy of my minor clients with a voluntary agreement from your parents, the law does dictate that your parents have access to your records. Parents may choose to access these records even when we advise against this.

**Voluntary Consent**

Your signature below indicates that you have read the information in this document, are voluntarily consenting to evaluation and/or treatment, and agree to abide by this document during our professional relationship. Your signature below also serves as an acknowledgement that you have received a copy of Green Counseling Services’ HIPAA Notice of Privacy Practices form (which should be given to you with this document). That notice is yours to keep.

Signature of Client/Guardian/Representative Date Signed

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The remainder of this document pertains to parents who are unmarried, separated, or divorced. If these conditions do not apply to you, you are finished with this document.

**Information for Separated, Divorced, or Never Married Parents**

Consent for Treatment

Parents with joint legal custody have equal rights when consenting to treatment for behavioral health services for their minor child, unless otherwise specified in a custody agreement or a divorce decree. It is necessary that both parents consent to treatment in this situation and we will be unable to work with your minor child unless this occurs.

Custody and Visitation Issues

We, as your child’s clinicians, cannot make recommendations regarding custody or visitation issues. If you would like to address these issues, we will refer you to another psychologist or therapist who specializes in custody evaluation. This is not our area of expertise.

I understand and agree to the terms of this document.

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Parent Signature and Date Parent Signature and Date