Agile Mind Counseling
506 Maple Street
Athens, Tn. 37303
Phone 423-746-2441
Fax 423-746-2442
debra_grant@agilemindcounseling.com
rebecca_green@agilemindcounseling.com

A Wellness Approach
to Mental Health
www.agilemindcounseling.com

AGILE MIND COUNSELING

Client Agreement with Policies and Procedures

And Informed Consent for Care

Please sign and date on at areas requested

Welcome to Agile Mind Counseling!

The following documents are provided to assist you in understanding Agile Mind Counseling office policies and procedures. Agile Mind Counseling is conducted in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and Tennessee state laws. It is important to provide the highest quality of care possible. You will be provided with a Patient Notice of Privacy Rights and Practices document and asked to sign a receipt stating that you understand your confidentiality rights. Questions or concerns are always welcome for discussion.

Possible Consequences and Benefits of Therapy:

Congratulations in deciding this is the right time to engage in changing your thoughts, feelings, and behaviors. You may risk leaving yourself open to feeling uncomfortable in a variety of ways. New emotions and behaviors may change your relationship within your marriage or any of your other personal relationships. People you engage with in your life may become unhappy with the personal changes you choose to make. In other words, your personal growth process may make others uncomfortable or resentful. There is no absolute guarantee of the extent of your personal growth or the therapeutic outcome. It will be helpful for you to give and accept active feedback about these experiences with your therapist. You also have the right to terminate therapy at any time. Agile Mind Counseling reserves the right to terminate your therapy if you are not benefitting from the services of this office. If you or your therapist decides to terminate therapy you will be provided with referrals.

The therapy process and personal growth also have numerous benefits. You will have your therapists' undivided attention and support throughout the therapeutic process. Therapy is strictly confidential and respectful. You will be able to clarify who you are and who you are not. Therapy allows for authentic change by teaching you ways to gain and maintain your personal power. You will be able to face long standing emotional and physical health issues and learn new ways of coping and growing in your world.

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Appointments:

Your appointment is reserved exclusively for you and will not be filled by another client. Therefore, it is expected that you will notify this office at least **48 hours in advance** of any cancellation or need to change your appointment time. If your appointment is scheduled for a Monday you are expected to cancel or change your time by Thursday of the week before. This policy applies to any holidays as well. There is a ***$65.00*** **charge for late cancellations or missed appointments. Late cancellation or missed appointment fees cannot be charged to your insurance company. In other words the $65.00 charge is your sole responsibility.** This policy will be strictly enforced. The charge applies even if the appointment is re-scheduled. *This office will not charge you if we can fill your time slot with another client.* ***If for some reason a balance on your account remains unpaid your past due balance will be turned over to a medical collection agency.*** *In this case a 50% fee will be added to your outstanding balance to offset the expenses of using a collection agency. The collection agency may have additional fees. Be aware to determine liability for payment, to obtain reimbursement, and pursue collection on your account, there will be disclosure of the financial aspects of your account.*

I have read and understand the above statement and agree to pay Agile Mind Counseling a $65.00 cancelation fee for any appointments that are rescheduled in less than 48 hours and appointments that I fail to show for at my scheduled time. I understand that there are no exceptions to this agreement.

Please print your name(s):____

Client # 1 Signature & Date: ____

Client #2 Signature & Date: ____

Fees:

Payment is due at the time of service is rendered. You will be asked for your payment (check, cash, bankcard, health savings, or flex card) before your session begins.

- Initial Consultation Individual or couples therapy $110.00
- 45 minute sessions thereafter is $90.00
- Missed appointment or late cancelation fee: $65.00
- Letter writing, filling out reports for your place of work, and/or disability insurance paperwork, etc. will be billed at $35.00 for each half hour of needed documentation.

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- Legal Services: If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time. You will be billed $300.00 for each hour of time spent on your court related issues. In the event disclosure of your records or testimony is requested by you or required by law, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged by this office or service of any subpoena for our time involved. Our professional time includes time involved in traveling to and from the testimony location, reviewing records and preparing to testify, report writing, consultation with attorneys, waiting at the location, giving testimony, and any other court case related business. This policy applies even if we are called to testify by another party. If we are required to appear in court you will be billed based on how long we must plan to be away from our office. An anticipated deposit of $900.00 will be required prior to any legal services provided outside of this office.

Most insurance provides reimbursement for counseling. You may have a yearly deductible that needs to be met or you may have an out of pocket co-payment due. As a courtesy to our clients Agile Mind Counseling accepts assignment from most commercial insurance and Employee Assistance Programs (EAP). When we see you as a part of your health insurance benefit a portion of the fee is discounted. You accept sole responsibility for payment of fees regardless of insurance coverage and reimbursement. This office will file insurance with reimbursement assigned to your individual therapist. Each client will receive an Explanation of Benefits (EOB) from their insurance company explaining how an insurance claim from this office was paid on your behalf. Anything the primary plan does not cover (copays, deductible, denial of payment, etc.) will be paid by the client unless otherwise arranged.

Insurance copays are required at the time service is rendered. Your copay will be collected prior to each session. If your deductible has not been met, a payment for services will be due at the beginning of each visit until your deductible has been paid in full. At this point your insurance most likely will pay most of the fee and only the co-insurance amount is required at the time of service by this office.

I have read and understand the above fee structure and agree to pay Agile Mind Counseling in the manner stated above.

Please print your Name(s): ____

Client # 1 Signature & Date: ____

Client # 2 Signature & Date: ____

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Please sign the following if using your insurance plan or Employee Assistance Program:

"I authorize the release of any information (which may include notes, treatment summaries, and diagnosis) necessary to process insurance or Employee Assistance claims, to determine medical necessity of treatment, quality of care, or to request additional sessions."

Client #1 Signature & date: ____

Client #2 Signature & date: ____

Insurance Companies and Confidentiality Issues:

All insurance companies require information about you that includes a psychiatric diagnosis that becomes a permanent part of your medical record. Insurance companies quite often require details of information about your therapy. They may also require that you follow their prescribed treatment plan. If at any time in the future you apply for life insurance, disability insurance, or private health coverage, these companies will probably require you to sign a release so they can get a copy of your records. Once a company gets your information you may be denied coverage or to have to pay increased premiums. There is no way to control confidentiality of any information (including diagnosis) once it is disclosed to a third party. You will not know whether your employers have access to this information about you or if such information is distributed to national data banks. The security of data on the web is compromised at increasingly frequent intervals as hackers become more sophisticated in their methods. Health care companies make every attempt to protect your information but there is no real guarantee of confidentiality. **If you choose not to use your insurance you always have the option to pay privately.** Counseling packages are available with advanced self-pay.

Authorization for Reimbursement and Billing

I understand that it may be necessary to release medical or incidental information that may be necessary for my therapist to secure insurance reimbursement or to acquire authorization for continuing treatment sessions. I am giving my therapist authority to contact my insurance company regarding amounts due including those for claims filed. I acknowledge that my insurance company may request information about my treatment including diagnosis, background information, and various other details of my treatment. I authorize disclosure of the financial aspects of my personal health information in order to determine liability for payment, to obtain reimbursement, and to pursue collection.

I authorize payment of my mental health benefits to my therapist for counseling services rendered. This authorization will be in effect until such time that I revoke it in writing. *I acknowledge that I am responsible for any balance on my*

account that is not covered by my insurance. I agree to pay my therapist in full for any balance due on my account after receipt from insurance reimbursement.

I may revoke this authorization at any time in writing. This release is good from the date indicated until I give my therapist my written revocation. Any information that has been disclosed prior to my revocation shall not constitute a breach of my confidentiality.

Please Print Your Name(s):____

Client # 1 Signature & Date: ____

Client # 2 Signature & Date: ____

Methods of Payment Accepted:

Agile Mind Counseling accepts Master Card, Visa, health savings, flex cards, checks, and cash as payment for services rendered. There is a fifty dollar fee for all returned checks.

Contacting Me and Emergency Calls:

Please note that this office ***does not*** provide 24-hour crisis or emergency therapy services. You may call and leave a message for us 24 hours per day 7 days per week. As we work together you will notice that we do not take phone calls while with clients. Anytime you call the office you may reach voicemail. On the days when we are in the office we check our messages throughout the day. After hours and on days when we are not in the office we also check messages on a regular basis. We will return your call as soon as possible, almost always the same day. You will be billed $35.00 for any calls that exceed 15 minutes. *Once again, although every precaution is taken voicemail and e-mail are not an absolute guarantee of confidentiality.*

In the event of an emergency after business hours or when your therapist is unavailable call 911 or go to the nearest emergency room.

24 Hour Crisis Hotline: 800-704-2651

Starr Medical Center
24 Hour Emergency Room
1114 West Madison Ave.
Athens, Tn. 37303
423-745-1411

Woods Memorial Hospital
24 Hour Emergency Room
886 Highway 411 N
Etowah, Tn.
423-263-3600

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Consultation:

In order to serve you to the very best of our ability clinical staff at Agile Mind Counseling may on occasion consult with other clinicians as a treatment team when appropriate. Names and any identifying details will not be disclosed.

Office Confidentiality:

Agile Mind Counseling has an ethical and legal obligation to keep all patient information confidential. You control the release of information obtained from this office unless the therapist is required by law to take some action or to make disclosures. Examples of disclosures required by law are suspected child abuse or neglect, suspected sexual abuse of a child, suspected abuse of dependent adults, serious threat of harm to self or others (i.e. high suicide or homicide risk, national security threats, etc.), a legally executed court order, or judicial proceedings. Your insurance company or employee assistance program (EAP) may require utilization reviews and they reserve the right to come in the office and audit your chart. It is also possible that your insurance company or employee assistance program (EAP) may request utilization reviews by fax or e-mail. Once again, even though every effort to protect information is in place any information transferred through electronic means can become corrupted. Confidentiality cannot be guaranteed in any situation where consent is given for clinical information to be provided to a third party. Once your information is in the hands of a third party it is out of the control of this office. This information includes diagnostic or other information requested by your insurance company in order to file your claims. Feel free to discuss any of these issues with your therapist.

I understand the confidentiality issues discussed above and have been given a chance to ask questions about anything I did not understand:

Please print your name(s): ____

Client # 1 Signature & Date: ____

Client # 2 Signature & Date: ____

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This office uses every possible security measure to protect your information. Any e-mail correspondence between you and this office is subject to corruption and so is essentially not secure. Therefore when you communicate through e-mail confidentiality cannot be guaranteed. If you agree to send an e-mail to this office or receive e-mails from this office you are doing so at your own risk. All e-mail correspondence has the potential to be intercepted by a third party. Be aware that all are retained in the logs of Internet service providers. It is not likely that anyone will read these logs but in theory they are available to be read by the system administrator(s) of the Internet service provider. Since you can't see my facial expressions or hear our tone of voice, my responses to an e-mail from you will be kept brief. All e-mail correspondence becomes a part of your permanent medical record. This office does not use text messaging for the same reasons: *it may compromise your confidentiality.*

By signing below you are saying that you understand the limitations of confidentiality and agree that you are responsible for keeping your e-mail private to the extent that you desire for it to be private.

Please print your name(s):____

Client #1 Signature & Date: ____

Client # 2 Signature & Date: ____

Social Media Policy:

We do not accept "friend requests" or "contact requests" from current or former clients on social networking sites (Facebook, Linkedin, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our privacy. It may also blur the boundaries of our therapeutic relationship.

Please initial: Client # 1:____________ Client # 2: __________

Disclaimer: This office maintains a list of professionals that you have access to upon request. *WE are not responsible for care or advice received from any professional to whom we give you a referral.*

Please initial: Client # 1:____________ Client # 2: __________

Children are not to be left unattended in the waiting room during your session. Please initial that you understand and are aware of this policy. If you bring your children please bring another adult along with you to stay with them while you are in counseling. This office is not child proof and they will need to be closely watched while you are in session. Please initial: Client # 1: _________ Client # 2: _________

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<u>Your Informed Consent That You Agree With Agile Mind Counseling Policies and Procedures</u>

The purpose of this document has been to inform you about our policies and procedures. Confidentiality is an extremely important part of this agency and is taken very seriously. These policies are in effect until further notice. Agile Mind Counseling reserves the right to amend these policies. If they are changed during the course of our work together you will be informed of the changes and offered a copy of the revised policies. You have the right to ask questions at any time with regard to these policies and procedures. By signing below you are acknowledging your informed consent to treatment and acceptance of Agile Mind Counseling policies regarding fees, payment of services, and the billing of your insurance company or employee assistance program. You also acknowledge having been given a copy of the Patient Notice of Privacy and Practices document. You are also acknowledging that Agile Mind Counseling may exchange information between the professional staff in a consultative capacity.

Please print your name(s):____

Client #1 Signature & Date: ____

Client # 2 Signature & Date: ____