GOLDEN SKY
COUNSELING
Rikki Goldenberg, LMHC

OFFICE POLICY & CLIENT SERVICES AGREEMENT

Please read this Policy Statement carefully and sign the Statement of Understanding at the end.

Welcome to Golden Sky Counseling! This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information.

Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have already taken action in reliance on the agreement between us.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and their therapist or doctor. In most situations, your therapist or doctor can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- As your therapist, I may occasionally find it helpful to consult other health and mental health professionals about your treatment. During a consultation, I will make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. If you *don't* object, I will not tell you about these consultations unless I feel that it is important for our work together. I will note all consultations in our Clinical Record (which is called "PHI" herein).
- There are some situations where, as your therapist, I am permitted or required to disclose information without either your Consent or Authorization. These situations include:
    - If a client is involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.
    - If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.

- If a client files a complaint or lawsuit against their therapist, he/she may disclose relevant information regarding the client in order to defend him/herself.
- If a client files a worker's compensation claim, and your therapist is providing necessary treatment related to the claim, he/she must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, the insurance carrier or an authorized qualified rehabilitation provider.

There are some situations in which, as your therapist, I am legally obligated to take action, and may find it necessary to reveal some information about your treatment. These situations are extremely uncommon but include:

- If I know, or have reason to suspect that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited, the law requires that I file a report with the central abuse hotline. Once such a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or seek hospitalization of the patient. If such a situation arises, I may choose to discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PATIENT RIGHTS

HIPPA provides you with expanded rights with regard to your PHI and disclosures of protected health information. These rights include requesting that your therapist amend your PHI due to factual inaccuracies, requesting restrictions on what information from your PHI is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my practice policies and procedures recorded in your records; and the right to a paper copy of the Notice form. Your therapist is not obligated to amend clinical interpretations or diagnostic impressions.

Requests for edited versions of evaluation and testing reports, letters, treatment summaries, requests for accommodations, etc. will be provided only at the sole discretion of your therapist and will incur an additional fee. Your therapist reserves the right to decline such requests.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's PHI. Children between 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. I encourage parents/guardians to inform me of important occurrences and concerns in your child's life.

This agreement provides that during treatment, I will provide parents only with general information about the patient's attendance at scheduled sessions, his/her level of participation and the progress of the treatment. Because privacy in psychotherapy is often crucial to successful progress (particularly with teenagers) and parent's involvement is also essential, it is usually our policy to discuss with minors (over 13 years) and their parents about access to information. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections that they may have. Any other communications will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of his/her concerns.

TELEPHONE ACCESSIBILITY

If you need to contact me between sessions, please leave a message on my voice mail or send me a secure message through the Client Portal. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that face-to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept a friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

FEES AND PAYMENTS

Payment in full is expected at the time of each visit. Fees for therapy and consultations are based on a 50-minute session.

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours.

The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

Cancellations and the re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

PAYMENT POLICY

Although I do not participate with most insurance companies, the services provided are often reimbursable through your insurance plan through out-of-network benefits. On a monthly basis, you will be provided with a receipt, called a Superbill, that contains all the necessary information that is required by insurance companies. You can submit this bill to the insurance company to be compensated through your out-of-network benefits.

If you are interested in learning about what your plan covers, call the number on the back of your insurance card and ask what is covered for an out-of-network provider who is providing the services in which you are engaging (individual therapy, family therapy, or group therapy).

Here are a few suggested questions to ask of your insurance company:

- Do I have mental health benefits?
- How much does my plan cover for an out-of-network mental health provider?
- How do I obtain reimbursement for therapy with an out-of-network provider?
- What is the coverage amount per therapy session?

All services are billed directly to the client and full payment is expected at the time of service.
Payment for services can be made by any of the following means:

- Cash
- Personal check (made out to Rikki Goldenberg)
- Zelle bank transfer (use rikki@goldenskycounseling.org to find the account)
- Credit card through the secure Client Portal

There will be a $25.00 charge for any returned check.

CREDIT CARD GUARANTEE AND PERMISSION TO BILL

Golden Sky Counseling asks that you provide a credit card guarantee in the event that you fail to pay for services or due to a missed or late canceled appointment fee. Please make sure you read the practice policies. A full session fee is charged if 24 hours notice is not given to cancel/reschedule. No-show and late cancellation charges will be billed to your credit card within 24 hours to 30 days of the appointment.

By signing this document, you are authorizing Golden Sky Counseling to bill your credit card for any outstanding balances or late cancel/ no show fees within one week unless a formal written contract/payment plan is documented and agreed up.

By signing this document, you are also confirming your understanding that if for any reason, your credit information is incorrect or payments do not process, Golden Sky Counseling will submit overdue fees to

a collection agency after 30 days of no repayment plan formally documented/agreed upon. Golden Sky Counseling will make a good faith effort to try and resolve overdue fees before submitted to collections, based upon the contact information you provide.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after an appropriate discussion with you if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

POLICY ACKNOWLEDGEMENT

I acknowledge that I have read, understood and agree to all of the items contained in this document. I also acknowledge and accept full and complete responsibility for prompt payment for all services rendered by Golden Sky Counseling, as well as for late cancellations and no shows prior to the next scheduled appointment.

_____

Client Name

_____ _____

Client (or Guardian if client is a minor) Signature Date

_____ _____

Therapist Signature Date