

## **AFGC OUTPATIENT COUNSELING AGREEMENT**

*Welcome to AFGC Outpatient Program. Participating in therapy can result in a number of benefits to you and/or your child, including reducing emotional distress and resolving specific emotional and behavioral concerns, as well as increasing relationship satisfaction and one's ability to attain personal goals. Over the first few sessions, your therapist will work with you on a specific treatment plan outlining goals, techniques, and benefits and risks to treatment options. You are encouraged to give feedback and input throughout the course of your therapy. Outlined below are the policies under which our program is operated. Please read carefully, sign, and return the agreement to your therapist on your first session. Please feel free to ask your therapist any questions.*

### **Confidentiality**

Confidentiality is an important and necessary part of good therapy. This means that your name and any information about you will not be discussed with anyone without your and/or your guardian's permission. For most people, knowing that what they say will be kept private or confidential helps them feel more comfortable in sharing their concerns, and to develop trust in their therapist. There are three important exceptions to confidentiality that are important for you to understand before you share information with your therapist in session. (1) By law, all suspected abuse and/or neglect of a child or dependent adult must be reported; (2) Action must be taken if it is assessed that the client is a danger to themselves or others; (3) It is possible that client information/records will be released if court ordered.

Lastly, in order to provide the best overall treatment, AFGC Outpatient collaborates with other professionals or treatment agencies with which you may be involved. In such cases, please inform your therapist if you are receiving other related services. Please do not have any outside professional (e.g., psychiatrist, teacher, physician) contact your therapist without first signing a Release of Information Form provided by your therapist.

### **Policy of Minors in Treatment**

All clients under eighteen years of age are considered minors, and parent(s)/legal guardian(s) will sign an informed consent for the treatment of all minors. As minors, the law may give parents and legal guardians the right to examine treatment records. AFGC Outpatient encourages and values open communication and a collaborative approach to working with minors. However, confidentiality is vital in helping minors feel safe to explore feelings they may not be comfortable sharing with other adults. With the minor's involvement, the therapist will provide parents/legal guardians with general information about sessions, treatment goals, and progress. Further, the therapist will work with minors on developing a plan for sharing confidential information with parent(s)/legal guardian when appropriate, and beneficial for treatment progress. If at any time the therapist assess that there is a high risk that the minor may seriously harm him/herself or another person, then the AFGC clinician will notify parents/legal guardians immediately of the concern.

### **Electronic communication/social media**

In order to best protect your confidentiality, it is preferable to communicate either in person or by telephone. While therapists do have email addresses, your confidentiality cannot be completely protected in email messages. Therefore, therapists will not discuss clinical issues with you over email messages. If you send an email message to your therapist containing clinical concerns and questions, your therapist will either call

you to discuss these over the telephone, or wait until your next appointment to discuss these in person. Email could be an appropriate way to communicate information about scheduling and cancelling appointments.

On the same note, please be advised that while our therapists may have telephone numbers that are capable of receiving text messages, this is not a preferable way to communicate about clinical concerns and/or questions. If you send a text message to your therapist containing clinical concerns and questions, your therapist will either call you to discuss these over the telephone, or wait until your next appointment to discuss these in person.

Please also be advised that our therapists are not available after business hours or during weekends. If you send a voicemail message, email message and/or text message after hours or during weekends, our therapists will not be able to respond to you until the next business day.

Dual relationships are considered unethical according to the Code of Ethics. A dual relationship is defined as a relationship, other than the therapist-client one, that could impair professional objectivity or increase the risk of exploitation. Because of this, our therapists do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). Doing so may compromise your confidentiality and could blur the boundaries of our therapeutic relationship.

#### **Cost of Services**

The cost of services is as follows: \$150 for an initial assessment; \$120 for a 45-50 minute individual session (\$60 for each additional half hour); \$165.00 for initial assessment for couple/family; \$135.00 for couple/family session (\$75 for each additional half hour); and \$135 for parent session (\$75 for each additional half hour). Payment is expected at the end of each session, by cash or check only. There will be a 10% fee on unpaid balances at the first of each month or for returned checks. Phone consultation will be billed as a session if the call exceeds 15 minutes, prorated by the hourly session fee. The fee for written reports requested by clients is \$100.00 per hour.

- I am eligible for a sliding scale fee as indicated on intake form and have been pre-approved for this fee by the Outpatient Coordinator. *If you want more information regarding AFGC's sliding scale policies, please contact the Outpatient Coordinator at (703) 425-9200.*
- I am aware of the standard fee associated with seeing a mental health professional who is receiving clinical supervision while working towards licensure. I also understand that I will not be able to use insurance for this service.

The fee for your sessions is \_\_\_\_\_ per session.

It is AFGC Outpatient policy not to testify in court unless subpoenaed. Fees for court appearances (including preparation and travel time) and court reports will cost \$120.00 per hour; a \$300.00 retainer is due up front and will be applied to any incurred court costs. Court costs are not generally insurance reimbursable. This policy applies regardless of the party pursuing the subpoena.

### **Insurance Reimbursement**

Our providers are credentialed with some insurance companies. Prior to your first appointment, you were asked to send us a copy of your insurance information, so that your benefits and co-pay information could be verified. (Please check one of the following)

- Our contact with your insurance company indicates your co-pay amount per session is \_\_\_\_\_. Our contact with your insurance company indicates you have \_\_\_\_\_ approved sessions.
- Since your insurance benefits could not be verified prior to your first appointment, you may be responsible for the full fee of your sessions (\$120-135 per session) until your benefits can be verified.

For those insurance companies with whom our providers are not credentialed, our services are generally reimbursable by most insurance companies through out-of-network benefits. Insurance carriers vary therefore, it is very important that you find out exactly what mental health services your insurance policy covers. If you are uncertain, you can call your plan administrator and inquire. AFGC will provide you with a bill that will include a clinical diagnosis and standard billing codes used by insurance carriers. Unless we make another explicit arrangement, you are responsible for filing insurance claims. Please be advised that insurance companies will not reimburse services provided by a master's level therapist. If you are being seen by a master's level therapist, you will be offered a reduced fee for services.

### **Cancellation Policy**

Clients are expected to keep appointments as scheduled. If an appointment is cancelled or missed with less than 24 hours notice, the client will be charged a \$50.00 missed session fee. Payments for late cancelled appointments will be expected at the end of your next appointment. Fees for missed sessions will generally not be reimbursed by insurance companies. Therapists may use discretion in deciding if a cancellation fee is applicable.

### **Contact**

You may reach your therapist about general issues, scheduling, or billing by calling your therapist's work cell phone. Unfortunately, your therapist will not always be available to answer your call. Please be advised that calls received after business hours will be transferred to your therapist's confidential voicemail. Please include your name and number, and your therapist will return your call as soon as possible.

### **Emergencies**

Please note that AFGC Outpatient is not an emergency service. If you are experiencing a mental health emergency and cannot speak directly to your therapist, please call 911, or go directly to the nearest hospital emergency room and ask for the psychiatrist on-staff.

### **Client Feedback / Surveys**

AFGC works hard to be sure it's programs and services are helping clients to reach their goals. We value each client's feedback about his/her experience with AFGC, and would welcome comments and suggestions about how to improve our program. As part of our effort to be sure our programs are working for clients, we complete client surveys on an annual basis and at the conclusion of treatment. These surveys are completely

confidential, and will not require you to list your name in order to participate. If you would be interested in participating in the survey, please initial below giving AFGC permission to contact you, and any forwarding contact information you would like us to have.

- I grant permission for AFGC to contact me for the purpose of follow up and feedback on services***
- I acknowledge receipt of AFGC HIPAA and Privacy policy.***
- I understand that I am seeing a mental health professional supervisee and I have received information regarding their clinical supervisor.***

**Consent for Treatment**

I have read and understood the preceding statements. I have had an opportunity to ask questions about them, and agree to enter a professional relationship with AFGC Outpatient Program and agree to abide by the terms of this contract. In the event that a person other than you is responsible for paying the bill, please have the party read this document and sign. Thank you.

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION:**

**To enable AFGC to file insurance claims on my behalf, I certify that the information provided is correct and I authorize the following:**

- **The release of any medical or necessary information to process insurance claims**
- **Payment of medical benefits to AFGC for care provided**
- **A copy of this authorization may be used in place of the original**
- **This authorization may be revoked at any time in writing**

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

## **HIPPA NOTICE OF INFORMATION PRACTICES AND PRIVACY STATEMENT**

### **Purpose**

The following privacy policy is adopted to ensure that Adolescent and Family Growth Center (AFGC) comply fully with all federal and state privacy protection laws and regulations. Protection of client privacy is of paramount importance to this organization. Violations of these provisions will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution.

It is AFGC policy that a notice of privacy practices be published and that this notice be provided to all subject individuals at the first patient encounter or as soon as possible, and that all uses and disclosures of protected health information be done in accord with AFGC's Notice of Information Practices and Privacy Statement.

### **How We Collect Information About You**

AFGC and its employees and volunteers collect data through a variety of means including but not necessarily limited to interviews, letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

### **What We Do Not Do With Your Information**

Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

### **How We Do Use Your Information**

Information is only used as is reasonably necessary to provide you with mental health or counseling services. All routine and recurring uses and disclosures of personal health information This may require communication between AFGC and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance,

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or

attorneys or other legal professionals, as well as any other information as permitted by law.

There is a specific person within this agency who has been assigned the responsibility of implementing and maintaining the HIPAA Notice of Privacy Practices Statement. It is the policy of this agency that the responsibility for designing and implementing procedures to implement this policy lies with this person. It is the policy of this agency that the identity of all persons who request access to protected health information (PHI) be verified before such access is granted.

It is the policy of this agency that appropriate physical safeguards will be in place to reasonably safeguard PHI from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule. These safeguards will include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection. These safeguards will extend to the oral communication of PHI. These safeguards will extend to PHI that is removed from this agency.

It is the policy of this agency that all members of our workforce have been trained on the policies and procedures governing PHI and how this agency complies with the HIPAA Privacy and Security Rules. It is also this agency's policy that new members of our workforce receive training on these matters within a reasonable time after they have joined the workforce. It is our policy to provide training should any policy or procedure related to the HIPAA Privacy and Security Rule materially change.