HMStherapy

HMS Therapy Services Informed Consent

Thank you for engaging in counseling. Please read carefully the policies and procedures of HMS Therapy Services.

1. INFORMED CONSENT AND RELEASE OF INFORMATION

All information obtained/derived by the course of treatment is fully confidential; disclosures you share with your therapist are confidential unless you have SIGNED a consent form to release part or all of the information. Therefore, to either release or obtain information from a specific individual or agency, a Release of Information must be obtained. Exceptions to this guideline include instances when 1) the patient is a clear danger to (a) themselves or (b) others and, 2) instances when the patient is a minor (under the age of 18) and reports that he or she is or has been a victim of physical, emotional or sexual abuse. Please sign and date all Release of Information documents. Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's normal hourly rate for time involved in preparing for and giving testimony. Such payments are to be made at the time or prior to the time the therapist renders the services. Your signature on this form will allow this process to proceed smoothly.

2. TELEPHONE CALLS

Occasionally the need to talk to your counselor may arise between normally scheduled sessions; your counselor will respond to your call within 24 hours, during his or her normal business hours. If you require more than a five minute conversation, and you decide your issue or concern cannot wait until your next scheduled session, your phone call will count as a phone session and you will be billed at the rate of $2.00 per minute after the first five minutes. If you prefer, your counselor may schedule a telephone session with you at a later time and a full session fee will be applied.

In the event of a psychiatric emergency, do not phone your counselor. Instead, call 911 or go immediately to your local Emergency room. Then you should call your counselor. If your counselor is unable to be reached, please leave a message and your counselor will contact you as quickly as possible.

3. LENGTH OF SESSION

The psychotherapy session is 50 minutes in length beginning at our appointed time and concluding after 50 minutes.

75 minutes sessions may be prearranged with your Therapist on a self-pay basis. Therefore, it is to your benefit to arrive a few minutes in advance of the appointment time. Since your therapist has sessions scheduled after yours, the sessions must end 50 minutes after the appointment time regardless of your arrival time, and the full fee for the session will be charged.

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4. FEES AND PAYMENT

All payments are due at the time of service. We accept cash or check made payable to Carisa Oyebanjo, LCPC, NCC. A $25.00 service charge will be levied on all checks returned by a bank for insufficient funds or if a credit card or debit card is declined. If any or all outstanding balances are not paid, HMS Therapy Services reserves the right to release a client's name and address to a collection agency. The fees for services range from $100 to $150 per hour.

5. INSURANCE

Your *Information* will be used and disclosed, as needed, to obtain payment for your mental health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the mental health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. If more than one, third party payer is responsible for payment for your health care, HMS Therapy Services may disclose your *Information* to more than one health plan and those health plans may share your *Information* with each other. Your *Information* may also be used and disclosed as needed to obtain payment for mental health care services rendered to you by other providers.

If you prefer **to not use your** insurance. We will provide you with a receipt for payment and a treatment plan if necessary, so you may request reimbursement from your insurance company for payment. We will not bill your insurance company. Please note that you are responsible for all payments for sessions.

6. CANCELLATIONS AND MISSED APPOINTMENTS

When an appointment is scheduled, that time is reserved for you. If the appointment is missed or cancelled without sufficient notice, the therapist is unable to make use of that time. Therefore, sessions must be cancelled 24 hours in advance or a $50.00 fee will be charged. Please note that most insurance carriers do not cover missed appointments.

This is to certify that I have read and understand this document.

_____

Client Signature Printed Name Date

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HIPPA Privacy Notice of HMS Therapy Services

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA) that prescribes legal duties and privacy practices to protect the privacy of your individual identifiable health information; this is, *Protected Health Information (PHI)*, as that term is defined in the HIPPA under *Information*.

THE EFFECTIVE DATE OF THIS NOTICE IS November 1, 2010. HMS Therapy Services is required to follow the terms of this Notice until it is replaced. HMS Therapy Services may make changes to the terms of this Notice at any time. **Upon your request**, we will provide you with a copy of the current Notice. HMS Therapy Services reserves the right to make the changes apply to your *Information* maintained in my files before and after the effective date of the new Notice. The following is a general description of how Federal and State law permits me to use and disclose your *Information*.

Purposes for which HMS Therapy Services *May Use or Disclose Your Mental Health Information with your Consent* HMS Therapy Services **may request your consent** for the use and/or disclosure of your *Information* for *treatment*, *payment* or *health care operations* as described below:

- *Treatment*. HMS Therapy Services will use and disclose your *Information* to provide, coordinate, or manage your mental health care and any related services. HMS Therapy Services may disclose your *Information* to physicians, therapists, other mental health providers, or other health care providers who are treating you or assisting in your diagnosis, treatment, or recovery.

- *Payment*. Your *Information* will be used and disclosed, as needed, to obtain payment for your mental health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the mental health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. If more than one, third party payer is responsible for payment for your health care, HMS Therapy Services may disclose your *Information* to more than one health plan and those health plans may share your *Information* with each other. Your *Information* may also be used and disclosed as needed to obtain payment for mental health care services rendered to you by other providers.

- *Mental Health Care Operations*. HMS Therapy Services may use or disclose, as needed, your *Information* in order to support my delivery of mental health care services. HMS Therapy Services may call you by name in the waiting room area. HMS Therapy Services may use or disclose your *Information*, as necessary, to contact you to schedule an appointment or remind you of your appointment.

HMS Therapy Services may share your *Information* with third party Business Associates who perform various administrative services. For example, those within HMS Therapy Services, or with whom HMS Therapy Services contracts, who perform billing services, transcription services, record retention, or other professional consultants. Whenever an arrangement between a Business Associate and me involves the use or disclosure of your *Information*, we will have a written contract that contains terms that will protect the privacy of your *Information*.
Health Care Services. Your *Information* may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

Uses and Disclosures With Your Verbal Consent
Your *Information* may be disclosed to a family member, friend, or other person designated by you or as designated by the law, if you verbally agree.

Uses and Disclosures with Your Written Authorization
Except as provided below, your *Information* will not be used for any non-routine purposes unless you give your written authorization to do so. If you give written authorization to use or disclose your *Information* for a purpose that is not
described in this Notice, then, with certain exception, you may revoke it in writing at any time. Your revocation will be effective for the *Information* HMS Therapy Services maintains, unless HMS Therapy Services has taken action in reliance on your authorization.

Uses and Disclosures Without Your Consent
As required by law;
To comply with legal proceedings, such as a court or administrative order or subpoena;
To law enforcement officials for limited law enforcement purposes;
To a coroner, medical examiner, or funeral director about a deceased person;
To avert a serious threat to your health or safety or the health or safety of others;
To a governmental agency authorized to oversee the mental health care system or government programs;
To federal officials for lawful intelligence, counterintelligence, and other national security purposes; and
To public mental health authorities for public health purposes.

Your Rights
You may make a written request to me to do one or more of the following concerning your *Information*:
Put additional restrictions on use and disclosure of your *Information*.
Communicate with you in confidence about your *Information* by a different means than HMS Therapy Services is currently doing.

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PRIVACY NOTICE ACKNOWLEDGEMENT

As a client of HMS Therapy Services, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by HMS Therapy Services.

Client Name or Guardian _____

Client Signature _____ Date _____

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