HopeSpring
Child & Family Clinic, LLC

INFORMED CONSENT, POLICIES, & FINANCIAL RESPONSIBILITY

General Information: The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

Counseling Relationship: While we work together, usually we will meet weekly for approximately 50-55 minutes sessions. This counseling relationship is a professional relationship. It should not, therefore, become a social or business relationship at any time. This would be detrimental to the purposes of counseling and would contaminate the process. As such, I would request that my clients do not invite me to social events or solicit me for business. I will do the same. If I encounter clients outside of the counseling setting, I will not acknowledge the existence of any relationship.

The Therapeutic Process: You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and my lead to major changes in your life perspectives and decision. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve that best possible results for you.

Client Right: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful. I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know.

TeleHealth: I understand that Telehealth services are used when mental health staff cannot be physically present with me to evaluate my mental health needs and, if appropriate, prescribe medications. Mental health staff may be present at another location and available to serve me through newly available technology. Instead of talking to someone on the phone at another location, Telehealth services use a video camera and computer to send both voice and personal images (pictures) between my mental health staff and me so not only can we talk to each other, but we can also see each other. This allows mental health staff to make a better evaluation of my needs.

I understand I have the following rights with respect to Telehealth:

1. I have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

3. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

4. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

5. I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

6. There is no permanent video or voice recording kept of the Telehealth service's session.

7. I understand that if I am in need of emergency mental health services, I may call 911, or contact my local emergency room.

Payment of Fees: *HopeSpring* Child & Family Clinic, LLC (*HopeSpring*) operates three different payment options to meet clients' needs. **Accepted Insurance Plans:** My practice is insurance friendly and I do my best to help you use your insurance benefits. In order to receive coverage for therapy services, insurance companies typically require a psychiatric diagnosis and will often determine the type of treatment and duration of services allowed for a specific diagnosis. Additionally, some personal information needs to be shared in order to process individual claims. HopeSpring may accept assignment of insurance after confirming coverage. However, confirmation or authorization of benefit is not a guarantee of payment for services. In the event that your insurance company rejects the claim or does not pay in full for all services rendered, you are responsible for payment in full. You are responsible for non-covered services, deductibles, co-insurance, and co-payments. You are also responsible for notifying your psychotherapist if your insurance coverage changes. I submit billing to insurances to reduce the cost to you. Please contact me for details regarding insurance panel. **Out-of-Network Insurance Benefits:** If you have Out-of-Network Benefits with any other insurance company not listed above and if you decide to use Out-of-Network benefit, you need to self-pay for your session and I will give you a receipt. Then you can submit to your insurance company and the insurance company will later reimburse you directly. Most insurance plans provide opportunity to apply for reimbursement for therapy services received from out-of-network providers. **Out-of-Pocket:** Many of my clients prefer to pay out-of-pocket and NOT use their insurance benefits. This allows such clients to fully protect all information disclosed in therapy. You should be aware that your insurance company requires me, as a contracted provider, to release information relevant to the services rendered to you. This typically includes: a clinical diagnosis, a treatment plan, or even copies of your entire clinical record. This is why to

fully protect their confidentiality, many of my clients prefer to disregard their insurance benefits and pay out-of pocket.

Fees: HopeSpring Child & Family Clinic, LLC operates on a direct payment policy if you choose to pay Out-of-Pocket or use Out-of-Network benefit. HopeSpring Child & Family Clinic, LLC asks that you provide payment in full at the time of service.

Psychotherapy Services	Length	Fee
Diagnostic Interview	**60 minutes**	**$400.00**
Individual / Family (Couple) Therapy (50min)	**50 minutes**	**$200.00**
Individual / Family (Couple) Therapy (90min)	**90 minutes**	**$300.00**
Play Therapy	**50 minutes**	**$200.00**
Parent Education / Child Parent Relationship Therapy (Filial Therapy)	**50 minutes**	**$200.00**
Professional Consultation	**50 minutes**	**$200.00**
Supervision	**60 minutes**	**$200.00**
Group Therapy*	**Varies**	**Varies**
School Meeting	**50 minutes**	**$200.00**
School Observation	**50 minutes**	**$200.00**

Other Services		Fee
Copy of Diagnostic Interview Report		**$ 30.00**
Additional Copies of Payment Receipt		**$ 30.00**
Additional Copies of Health Information* **		**$ 30.00**
Court Preparation, Testimony, & Related Activities	**Per hour**	**$ 300.00**

***Please contact HopeSpring Child & Family Clinic, LLC for details ,**
****Required Appropriate Written Authorization by the client or client's parent/legal guardian**

Financial Responsibility Policy: This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance. I understand that the therapist or HopeSpring staff has the right to seek legal recourse to collect any unpaid balance. In pursuing this, the therapist or HopeSpring staff will only disclose necessary biographical information and the amount owed, in order to ensure confidentiality. **1. Credit Card Authorization**: You understand that you are (your child is) a new client of HopeSpring Child & Family Clinic, LLC. You hereby appoint your (your child's) therapist/billing staff of HopeSpring Child& Family Clinic, LLC to charge mental health/professional services and related fees to your credit card. You agree that you will pay for all such services and will not hold HopeSpring Child & Family Clinic, LLC and its therapists/staffs responsible for any actions pursuant to this agreement. You agree that you will provide your credit card information and notify your therapist/staff with updated credit card information if there are any changes, and understand that your information will be saved to a file for future transaction on your account. **2. Credit Card Payment**: You understand that HopeSpring Child& Family Clinic, LLC only accepts credit cards.

Cancellation Policy: Since the scheduling of an appointment involves the reservation of time specifically for you, please note that any cancellation must be made 24 hours in advance in order to avoid incurring the customary hourly charge for the time reserved for your appointment. Sessions, which missed without this advance cancellation, will be billed at fully charge. If you are late for a session, you may lose some of that session time.

No Show & Late Cancellation Policy: Insurance companies do not pay for missed appointment. If you or guardian (in case of minor) do not appear for your child's or your scheduled appointment (No Show - no notice and missed appointment), or cancel with less than 24 hours advance notice (Late Cancellation), you will be charged $50.00 as a No Show/Late Cancellation fee. The fee must be paid in full before future appointments will be

scheduled. Fees for the no show or late cancellation will be charged on your credit card. If you are in a situation where you cannot use a credit card, you may pay by cash only prior to your next appointment. Non-compliance to this policy, and second No Shows or Late Cancellations may result in termination of services. You agree that you will pay for the no show or late cancellation fees and will not hold *HopeSpring* Child & Family Clinic, LLC responsible for any actions pursuant to this agreement. You understand and agree that your psychotherapist makes a photocopy of both the front and rear of your credit card.

Confidentiality: The content of therapy sessions and written records will remain confidential. No information may be released without express written authorization by the client or client's parent. Confidentiality is a key part of the counseling relationship. It is not, however, absolute. I will discuss the ethical and legal limits of confidentiality. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name. If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Emergency Situations: If an emergency situation for which you feel immediate attention is necessary, please contact emergency services (911) immediately, or go to your nearest hospital emergency room.

Referrals: Should the client and/or I believe that a referral would be appropriate during the course of the counseling relationship, I will take the responsibility of identifying referral services and assist in making the referral. Referrals may be made for a number of reasons, including the client's or my identifying any source of conflict in the relationship, a client need which requires a greater degree of expertise or a different area of counseling specialization, or a need for medical or psychiatric attention. Referrals will be discussed openly and the transfer completed to the best of my ability.

Licensing Board: The name, address, and phone number of the state licensing agency is: Virginia Board of Counseling, 9960 Maryland Drive, Suite 300 Henrico, VA 23233. Maryland Board of Professional Counselors and Therapists, 4201 Patterson Avenue Baltimore, MD 21215. If a conflict arises in the course of the counseling relationship, it is my desire to discuss this with the client as a part of the counseling process. It is my desire to provide services in a professional manner consistent with accepted legal and ethical standards. If the client is dissatisfied or has a complaint, I would request that he/she discuss the issue with me. If I am not able to resolve the concerns, the client has the right to contact the licensing agency noted above.

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 appropriate discussion with you and a termination process 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.

Informed Consent: I affirm that prior to becoming a client, I was given sufficient information to understand the nature of counseling. The information included the nature of the agency, the counselor's professional identify, possible risks and benefits of counseling, nature of confidentiality including legal and ethical limits, and alternative treatments available. My signature below affirms my informed and voluntary consent to receive counseling.

Minor Client: I affirm that I am the legal guardian of _____. With an understanding of the above information and conditions, I do grant permission for my child to participate in counseling.

SUBMITTING THIS DOCUMENT DOES NOT MEAN THAT YOU BECOME THE CLIENT AT HOPESPRING CHILD AND FAMILY CLINIC, LLC. Also, submitting this document without showing up for the first appointment will result in the forms in submitted document being voided and being charged full amount of $100 for 50--60 minutes or $300 for 2 hours on your credit card based on the duration of first scheduled appointment.

BY SIGNING ON THE BELOW I AM AGREEING THAT I HAVE READ THE INFORMED CONSENT, POLICIES, AND FINANCIAL RESPONSIBILITY, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____	_____
Client's Name	**Date**
_____	_____
Parent/Legal Guardian's Name	**Date**
_____	_____
Parent/Legal Guardian's Signature	**Date**