Informed Consent – Policies & Procedures
HIPPA Privacy Notice

NOTICE:
E-Signature: All information may be electronically entered. E-Signature is considered legally binding. I additionally request that all signature fields must be completed using the "Draw" feature with your regular signature. Your signature represents agreement of terms.

For additional support and return Email: MoreMHCounseling@gmail.com

Date: _____

Client information:
Name: _____
Age - Date of Birth: _____

Introduction – Please read the contents of this Agreement carefully and in its entirety.

Goals of Counseling: There are many goals in counseling that may include decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior, processing relationships/issues. All goals are established by the client. The counselor may make suggestions on appropriate goals and ways to achieve them, but you are personally responsible for all of your decisions and behaviors that result from your attempts to achieve your goals.

Risks/Benefits: More MH Counseling, LLC. can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve quality of life. It can help you learn to manage anger, learn to live in the present and many other advantages. Mental Health Counseling is an intensely personal process, which can bring unpleasant memories or emotions to surface. There are no guarantees that the process will work for you. Clients can sometimes make improvements, only to go backwards after a time. Progress may happen slowly. It also requires a very active effort on your part. To be most successful, you will have to work on things we discuss outside of sessions, which may include homework assignments.

Education and Qualifications: Amy Moreira, LMHC is a Licensed Mental Health Counselor in the State of Massachusetts and Rhode Island. I speak English, Portuguese, and Spanish. I have earned a Masters Degree in Clinical Psychology and a Bachelors Degree in Criminal Justice. I have competencies in various areas and psychological skills in a variety of settings. As a mental health professional, I adhere to the statues of the State of Massachusetts and Rhode Island and the ethical principles of the profession.

CANCELATION POLICY

Please make every effort to be available for treatment at the time of scheduled appointment. Notification allows other appointments to be made in replacement. Clients who consistently miss or reschedule appointments without notification may have services terminated or restricted. I reserve the right to end therapy sessions and treatment if substance abuse is suspected.

24-hour notice is required for cancelation of an appointment. If 24 hours is not provided, you agree to pay for **50%** of the session fee prior to further sessions. In the case of a Monday appointment, the expectation is to cancel on the Friday prior to the missed appointment. Please leave a voice-mail message. If you are running more than 15 minutes late, it will be of discretion if you will still be seen. The outcome may be that the session time is reduced or you may be responsible to pay for 50% of the missed session.

I agree by signing below abide to the cancelation policy and accept any and all fees associated with services rendered by More MH Counseling, LLC.

____ If a credit card is stored on file, I agree that my missed fee appointment may be charged to my credit card.

_____

Signature Date

PAYMENT POLICY

The following information is provided to explain More MH Counseling's payment policy and to avoid any misunderstanding or disagreement concerning payment for professional services. Specific fee information will be contracted in the Treatment Agreement in which the full contents of this Informed Consent and review of Policies and Procedures applies.

- Clients paying fee-for-service basis, and not billing any insurance company are expected to pay in full at time of service unless other arrangements have been made.
- Parents/guardians are financially responsible for the treatment of minors.
- In the event of a check returned, unpaid from the bank, I acknowledge that a service charge of $35.00 will be incurred for each incidence

Insured Clients

- Please verify with your company the amounts of coverage for outpatient psychotherapy. If your policy requires pre-authorization to receive services, this is your responsibility and needs to be handled before your first visit.
- Our office will bill your insurance company for services provided. You are responsible for any costs that are not covered by your health insurance. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment, deductible, and insurance claims on your account.

- The billing of your insurance company requires the release of your mental health diagnosis, and further information regarding your mental health including all records.
- Clients are personally responsible for all payment of fees, including those not paid by their insurance carrier within 30 days after the rendering of services.
- The client portion (co-pay) of fees is expected at the time of service. Co-pays are not negotiable. Failure to pay your part may jeopardize your benefits.
- Some insurance have out-of-network insurance options, I may provide you with a receipt for you to claim reimbursement. It will be your responsibility for reimbursement.

I hereby assume financial responsibility and agree to the above statements. I further understand that More MH Counseling, LLC reserves the right to charge interest and/or pursue delinquent accounts via third party collection agencies or attorneys and that I am responsible for any fees and/or court costs incurred by More MH Counseling during the collections process.

I assume financial responsibility for additional services such as phone calls, letter writing, completion of forms and administrative meetings in or out of the office. I understand that claims for these services will be billed at the therapist's usual rate, will not be billed to my insurance carrier and remain my obligation to pay.

In the event that a lawsuit is filed to collect my debt, I expressly waive privileges concerning disclosure of all information necessary to proceed with collection activities and acknowledge that an itemized account history, setting forth services rendered, fees charged and payments received shall be filed as an exhibit.

I agree to notify More MH Counseling, LLC of any changes in my billing address or telephone. This entire authorization is valid for all episodes of care rendered by More MH Counseling, LLC. I permit a copy of this authorization and agreement to be used in place of the original.

_____

Signature Date

_____

Signature Date

CLIENT RESPONSIBILITIES

You are financially responsible for all fees assessed. No balance is to be remaining at any time. Please refer to Financial Agreement for full responsibilities. You are expected to arrive for appointments without being under the influence of drugs or alcohol.

Ending Therapy: The length of therapy and eventual termination depends on the specifics of your individual treatment plan and the progress you achieve. Your participation in therapy is voluntary and you have the right to end therapy whenever you choose to. I encourage the end of therapy to be discussed prior to your last session, so that we can review what we've done and to offer feedback to each other. Likewise, at my discretion, I reserve the right to end our therapy work together and provide you with some appropriate referrals, for reasons including, but not

limited to, failure to participate in therapy, conflicts of interest, untimely payment of fees, not keeping scheduled appointments, or my belief that I may not be the best person for your needs.

Couples and Families: I have a "No secrets policy" when working with couples or families. This means I encourage you to discuss any thoughts and feelings directly during our sessions and not privately with me. I reserve the right to disclose or encourage disclosure of any secrets shared outside of the family/couple session.

HIPPA NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that provides new privacy protections and patient/client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and healthcare operations. HIPAA requires that we provide you with a Notice of Privacy Practices and Patient Rights (the *Notice*) for use and disclosure of PHI for treatment, payment, and healthcare operations. The *Notice* explains HIPAA and its application to your personal health information. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. You can discuss any questions you have about the procedures with your therapist. When you sign the Acknowledgement form, the Therapist–Client Services Agreement will represent a formal agreement between you and your therapist You may revoke this *Agreement* in writing at any time. That revocation will be binding the therapist has taken action in reliance on it; if there are obligations imposed on the therapist by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Record Keeping: HIPPA requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronic, on paper, or orally, are kept properly confidential. HIPAA gives you, the client, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

Each time you meet with your therapist, an electric record is made which may contain personal information. This may include information regarding your symptoms, diagnoses, treatment, a plan for future treatment, and billing-related information. If you prefer paper records, we can discuss this option at an additional cost.

For more information regarding the federal HIPPA Privacy Law visit:
https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

PATIENT RIGHTS

As of April 14, 2003, HIPAA provides several rights with regard to your *Clinical Record* and disclosures of Protected Health Information (PHI). These rights include requesting that your therapist amend your record; requesting restrictions on what information from your *Clinical Record* is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about the therapist's policies and

procedures recorded in your records; and the right to a paper copy of this *Agreement* and the HIPAA *Notice*. Discuss any questions you may have about these documents with your therapist.

CONFIDENTIALITY

- The law protects the privacy of all communications between a client and psychotherapist. In most situations, your therapist can only release information about your treatment to others if you sign a written *Authorization* form that meets HIPPA legal requirements.
- Consultation with Professionals: More MH Counseling may find it helpful to consult other health and mental-health professionals. The other professionals are also legally bound to keep the information confidential.
- Court: If you are involved in a court proceeding and a request is made for information concerning the professional services provided to you by your therapist, such information is protected by the psychotherapist-client privilege law. Your therapist cannot provide any information without your written *Authorization*, or a court order. 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, your therapist may be required to provide it for them in certain circumstances.
- You information may be used in e-mailing, texting, phone, voicemail, etc. More MH Counseling may contact you/leave message to provide appointment reminders.
- Outside contact. If we happen to run into each other in public, I will only acknowledge you if you acknowledge me first. This protects your confidentiality.
- Social Media. As an ethical guideline, I refrain from connecting with clients, both past and present, through Facebook, LinkedIn, or other online sites.
- Treating a Minor: When treating a minor, it is preferred to have consent from all legal guardians for those under 12. In the case of separation or divorce, please provide documentation and a signature from the legal guardian of the minor. The same limits of confidentiality apply to minors.

PROFESSIONAL RECORDS

HIPAA regulations, requires your therapist to keep Protected Health Information (PHI) about you in two sets of professional records. You *Clinical Record* includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that are set for treatment, your progress towards those goals, your medical and social histories, your treatment history, any past treatment records that were received from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone. You may examine and/or receive a copy of your *Clinical Record* if you request it in writing. Because these are professional records, they can be misinterpreted and/or potentially be upsetting to untrained readers. For this reason, I recommend that we initially review them together, or I can forward them to another mental-health professional so you can discuss the contents. I charge a retrieval and copying fee of $15 for the first five pages of a record and 25 cents per page thereafter.
Records must be maintained for a minimum of 7 years following the date of termination.

In addition, your therapist may also keep a set of *Psychotherapy Notes*. These notes are for his/her own use and are designed to assist him/her in providing you with the best treatment. While the contents of *Psychotherapy Notes* vary from client to client, they can include the

contents of your conversations with the therapist, his/her analysis of those conversations, and how they impact your therapy. They also contain particularly sensitive information that you may reveal to the therapist that is not required to be included in your *Clinical Record*. They also include information from others provided to the therapist confidentially. These *Psychotherapy Notes* are kept separate from your *Clinical Record* and are not available to you; neither can they be sent to anyone else, including insurance companies, without your written, signed *Authorization*. Insurance companies cannot require your *Authorization* as a condition nor penalize you in any way for your refusal to provide it.

EXCEPTIONS TO CONFIDENTIALITY

More MH Counseling, LLC may disclose your personal information without your consent or authorization in the following circumstances:

- Child Abuse: Evidenced child or dependent child or elder abuse and maltreatment will be reported to the local child and/or elder protective services agency.
- Health Oversight: If there is an inquiry or complaint about my professional conduct to the Board of Mental Health Counselors, More MH Counseling, LLC may disclose relevant confidential information for protection as needed.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order.
- Serious Threat to Health or Safety: Your confidential information may be disclosed to protect you or others from a serious threat of harm by you. This may include seeking hospitalization or contacting emergency contact/family members for your protection.
- Worker's Compensation: If you file a worker's compensation claim, and I am treating you for the issues involved with that complaint, then I may be required to release records which contain information regarding your psychological condition and treatment.
- If a client files a complaint or lawsuit against More MH Counseling, LLC. or Amy Moreira, LMHC, your information may be disclosed in order to defend the organization.

If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and endeavor to limit disclosure to only what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have now or in the future with your therapist. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

CONTACTING MORE MH COUNSELING, LLC.

Cell: (508) 499-8525
My voicemail is available 24/7. There may be times that I do not answer my phone. I do not answer phone calls when I am in a session with a client or otherwise unavailable. Leave a voicemail as I check my messages often, and I will return your call as soon as I can.

I cannot ensure the confidentiality of any form of communication through electronic media including text messaging, e-mails, and voicemails.

Emergencies: If you are experiencing an emergency, the best course of action is usually to call 911. In an emergency situation, it may benefit you more to call 911 or access your nearest emergency room or and then follow up with me in the morning

ACKNOWLEDGEMENT OF CONSENT

Please do not sign if you do not agree to any of the above

I _____, consent to treatment with MH Counseling, LLC. I/we have read and accept all aspects of this document. I have received a copy of the notice of HIPPA Privacy Notice and Clients Rights documents. I understand that if I have any questions regarding the Notice of my privacy rights, I can ask MH Counseling, LLC. for more information.

_____

Signature Date

_____

Signature Date

MINORS

All therapists seek to work with the parents (or primary caretakers) of minors to coordinate treatment of the child. However, parents of clients under 18 years of age should be aware that older adolescents (i.e., 16 or 17 years old) are permitted in MA to give independent consent to psychotherapy if they are sufficiently mature to understand and make judgments about the risks and benefits of such treatments to themselves. In this instance, their parents do not necessarily have access to their records. Because parental involvement in treatment is important and because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is the policy to request agreement from all parties with regard to what information parents can have access. If those involved agree, the therapist will provide the parents with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the child's consent or authorization, unless the therapist feels that the child is in danger or is a danger to someone else. In this case, the therapist will notify the parents of the concern. Before giving parents any information, the therapist will discuss the matter with the child, if possible, and attempt to handle any objections she/he may have.

CONSENT FOR TREATMENT OF MINORS:

I/we consent that _____ may be treated as a client by More MH Counseling, LLC. I have read the above Policies and Procedures and agree to abide by the contents of this Agreement. By signing below I am stating that I am the guardian responsible.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____