

# Informed Consent Service Agreement

Welcome to Blackburn Counseling. This document 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 about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations.

Although these documents are long and sometimes complex, it is very important that you understand them. Signing this document represents an agreement between us. We can discuss any questions you have when you sign or at any point in the future.

## **I. PSYCHOLOGICAL SERVICES**

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each party. As a client in psychotherapy, you have certain rights and responsibilities. There are also legal limitations to those rights you should be aware of. As your therapist, I have responsibilities to you, as well. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

## **II. APPOINTMENTS**

Appointments will ordinarily be 60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone.

If you need to cancel or reschedule a session, I ask that you provide 24-hour notice. If you miss a session without canceling, or cancel with less than 24-hour notice, my policy is to collect \$50 (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment.

You're also responsible for coming to your session on time; if you are late, your appointment still needs to end on time.

### **III. PROFESSIONAL FEES**

The standard fee for the initial intake and each subsequent session is \$120. You are responsible for paying at the time of your session unless prior arrangements were made.

Any checks returned to my office are subject to an additional fee of up to \$15 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

### **IV. INSURANCE**

To set realistic treatment goals and priorities, it is important to evaluate your resources available to pay for your treatment. If you have a health insurance policy, it may provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of healthcare, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require your authorization to provide a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-IV. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable). Sometimes I must provide additional clinical information such as treatment plans or summaries or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

If you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee.

Many policies leave a percentage of the fee (co-insurance) or a flat dollar amount (co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by cash, check, or credit/debit card. Some insurance companies may also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year.

Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

#### **V. PROFESSIONAL RECORDS**

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records.

Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me or have them forwarded to another mental health professional to discuss the contents.

If I refuse your request for access to your records, you have the right to have my decision reviewed by another mental health professional. We can discuss upon your request. You also have the right to request that a copy of your file be made available to other health care providers.

#### **VI. CONFIDENTIALITY**

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices provided to you. Please remember that you may reopen the conversation at any time during our work together.

#### **VII. PARENTS & MINORS**

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent.

For children 14 and older, I request an agreement between the child and parents to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication requires the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions). In this case, I will make every effort to notify the child of my intention to disclose information and handle any objections raised.

#### **VIII. CONTACTING ME**

The best way to contact me is via email: seanblackburn.counseling@gmail.com

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voicemail and your call will be returned as soon as possible. It may take a day or two for non-urgent matters.

If, for unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or feel unable to keep yourself safe, please go to your local hospital Emergency Room or call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

**IX. OTHER RIGHTS**

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or former clients.

**X. CONSENT TO PSYCHOTHERAPY**

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

# HIPAA Notice of Privacy Practices

## **Your Information. Your Rights. Our Responsibilities.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

“Protected health information” (PHI) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payment for the provision of health care.

## **Your Rights Regarding Your PHI**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we’ve shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

## **Our Uses and Disclosures**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with laws that may be in place now or in the future

## **Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

#### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

#### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us at **seanblackburn.counseling@gmail.com**
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- You can contact the Texas Board of Examiners of Professional Counselors at 1-800-942-5540.
- We will not retaliate against you for filing a complaint.

#### **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Sharing of psychotherapy notes

## **Our Uses and Disclosures**

### **IF you give us permission, how would we typically use or share your health information?**

We typically use or share your health information in the following ways.

#### **Treat you**

- We can use your health information and share it with other professionals who are treating you.

*Example: Your physician and I may need to coordinate your care.*

#### **Run our organization**

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### **Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information

see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

#### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

#### **Do research**

- We can use or share your information for health research.

#### **Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### **We can use or share health information about you:**

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

#### **Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order

### **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**For more information,** see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website, [blackburncounseling.com](http://blackburncounseling.com).

**Acknowledgement**

I hereby acknowledge receiving a copy of this notice.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Authorization for Electronic Communication

As a convenience to me, I authorize Sean Blackburn to communicate with me regarding my treatment via electronic communications (email or text message) and to transmit my protected health information electronically as described below.

I understand there are risks inherent in the electronic transmission of information by email or text message:

- Such communication does not provide a completely secure means of communication.
- Any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted.
- Electronic transmission of information cannot be guaranteed to be secure or error-free.
- Data may be vulnerable to access by unauthorized third parties.

As such, Blackburn Counseling shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Blackburn Counseling to me.

Text Communication:  Yes  No  
Authorized phone number(s): \_\_\_\_\_

Email Communication:  Yes  No  
Authorized email address(es): \_\_\_\_\_

Other:  Yes  No  
Authorized service(s): \_\_\_\_\_

Your treatment does not depend on consent. You have the right to terminate or amend this agreement at any time.

I understand that Blackburn Counseling may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to Blackburn Counseling in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

Sean Blackburn, LPC

New Patient Intake Information

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

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**Full Name**

**Date of Birth**

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**Address**

**City/State/Zip Code**

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**Email Address**

**Phone Number**

**Preferred Contact (Email or phone)**

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**Insurance**

**Insurance ID#**

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**Gender**

**Ethnic Background**

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**Spiritual/Religious Orientation (if any)**

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**Occupation**

**Employer/School**

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**Marital Status**

**Spouse/Partner's Name**

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**Name of Previous Therapist and Dates seen**

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**Names, dosage, frequency of medications you are taking**

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**Emergency Contact (Name, relationship, phone number)**

**Please briefly describe the concerns that bring you here:**

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## Credit Card Authorization Form for Ongoing Therapy Sessions

You have the option of keeping a card on file to use for ongoing sessions. If you would like to do so, please fill out this form and return it to me. All information will remain confidential.

I, \_\_\_\_\_, give Blackburn Counseling permission to charge the following credit card, debit card, flexible spending card, or health savings account.

Name on card: _____
Card Number: _____
Exp. Date: _____
Billing Zip Code: _____
Security Code: _____

Please initial the following:

\_\_\_\_\_ I agree to pay the amount of: \$\_\_\_\_\_ for each therapy session.

\_\_\_\_\_ I agree to pay a fee of \$50 for a missed or cancelled appointment without 24 hours' notice.

\_\_\_\_\_ I understand that all credit cards are subject to a \$3 convenience fee. I understand that this fee will be applied to each transaction on my card.

*\* If, for any reason, multiple "charges" are processed as one single transaction – e.g., accrued charges/past due balances, multiple family members paying for individual sessions in a lump sum payment – one (1) \$3 convenience fee would be applied for the transaction.*

**Card holder: Print Name, Sign, and Date below:**

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

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