Empower COUNSELING, PC
1443 Crossings Centre Drive Suite A
Forest VA 24551

Phone 434-219-5621 Fax 434-305-1072

CLIENT SERVICES AGREEMENT

1. FEE SCHEDULE. Payment for services is required at each session. The fees are as follows:

Intake (First Session) $143.00
Therapy Session.....$139.00 (60 minutes)
Therapy Session.....$93.00 (45 minutes)
Therapy Session.....$70.00 (30 minutes)
Therapy Session Family w/client.....$106.00
Therapy Session Family without client.....$102.00
Resident Session.....$65.00 (self-pay)
Nutritionist Intake ..... $175.00 (self-pay)
Nutritionist Follow Up ..... $125.00 (self-pay)
Telephone consultations exceeding 15 minutes not covered by insurance.....$20.00 per 15 minute
Increments for telephone consultations exceeding 15 minutes. Not covered by Insurance.
Report Writing for Schools, Physicians, or other correspondence.....$35.00

-Court appearances and contacts with attorneys follow the fee guidelines established by the Lynchburg Bar Association and the Lynchburg Academy of Medicine. Guidelines are available upon request.
-Insurance reimbursement is the client's responsibility. However, our office will provide assistance with filing claims as needed. Please note: Insurance companies do not reimburse for court appearances, phone consultations, /calls, or missed appointment fees.

2. COLLECTION OF FEES. Any expenses incurred in the collection of fees are the sole responsibility of the client. Such expenses may include, but are not limited to, attorneys' fees or collection agency fees. There is a charge of $25.00 for any returned check.

3. MISSED APPOINTMENTS OR LATE CANCELS. There is a charge of $100.00 ($65.00 for Residents) for any appointment not canceled 24 hours in advance or if you fail to show without notice. To cancel a Monday appointment and avoid this charge, you must call by 5:00pm on the previous Friday. Our office **requires** a credit card to keep on file for the charge of missed appointments.

4. EMERGENCIES. In the event of a true emergency after hours, you may call Trish McCoy Kessler, LPC, CEDS-S/Owner on her cell phone: (434) 238-5975. Please leave a message. If you do not hear back from her or your therapist within 15 minutes, please contact your family physician, psychiatrist, the Lynchburg General Hospital Emergency Room at (434) 200-3033 or call 911. If she is out of town or otherwise unavailable, emergency coverage will be provided by a licensed colleague acting on her behalf.

CLIENT SERVICES AGREEMENT cont.

____ ***If*** using insurance benefits. I also hereby give my permission to release my name, Social Security number, address, and financial information to insurance companies for billing purposes, and to collection agencies, if needed to collect any unpaid bills. (Insurances billable by **Residents** are: Cigna, Anthem Healthkeepers Plus Medicaid, Sentara Medicaid and Aetna PPO only. Otherwise the fee is the $65.00 self-pay.)

Insurance Company _____ ID#_____

Group#_____ Copay Amount _____

____***If*** self-pay account, I understand that discounted fees are not eligible for submission to any third-party payer (i.e. insurance company, public, or private agency/department). I also hereby give my permission to release my name, Social Security Number, address, and financial information to collection agencies, if needed to collect on any unpaid bills.

I have read the above terms and agree to them.

_____
Date

x_____
Signature of Client (or Legal Guardian)

x_____
Signature of Client (if age 14-17)

x_____
Printed Name of Client

SSN# _____

X_____
Signature of Witness

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Payment Policy and Procedure Agreement

If you are unable to keep your scheduled appointment, please call 24 hours in advance to cancel. **There will be a $100.00 ($65.00 for Residents) missed appointment OR late cancel fee charged for less than 24 hours notice or if you fail to show with no notice**. We require keeping a credit card on file to be charged in case of these events.

- **Payment is required at the time of service.**
- **We will be unable to keep appointments without payment.**
- **Please initial here if you would like to have this card charged for copays, co-insurance or deductibles. _____**

Client Signature Date

Credit Card Information

Master Card Visa Discover AMEX Other _____

IS THIS AN HSA/FSA ACCOUNT? YES OR NO

Cardholder Name _____

Card Number _____ CRV _____

Expiration _____ Zip _____

Client Signature _____

_____ I decline to give my credit card information.

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Personal History Form

Name: _____ Social Security #_____

Gender: F ____ M ____ Date of Birth: _____

Address: _____ City:_____ State:____ Zip:_____

Phone (Home):_____ (work):_____ ext:_____ (Cell): _____

Email: _____ Preferred Method of Contact: _____

Person responsible for bill:_____ Phone:_____

Email:_____ May we send statements to this email or the above email? Yes or No

Family Members Living in the Household

Relationship	Name	Age	Phone (If Applicable)

Medical/Physical Health

Primary Physician: _____

Address: _____ Phone:_____

List any current health concerns: _____

List any recent health or physical changes: _____

Please list any head injuries/TBI: _____

Please check if there have been any recent changes in the following:

_____Sleep Patterns _____Eating Patterns ____Behavior ____Energy Level

____Physical Activity Level ____General Disposition _____Weight ____Nervousness/Tension

Describe changes in areas in which you checked above: _____

Marital Status (more than one answer may apply)

_____Single _____Married _____Separated ____Divorce in Process _____Divorced (Date:_____)

_____Unmarried, living together Total marriages: _____

Assessment of current relationship (if applicable): Good Fair Poor

Legal

Are you involved in any active cases (traffic, civil, criminal) _____Yes _____ No

If Yes, please describe: _____

Education

Fill in all that apply: Years of education: _____ Currently enrolled in school? Yes____ No____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Currently: ____FT ____PT ____Temp ____Laid-off ____Disabled ____Retired

____Social Security ____Student ____Other (describe):_____

_____

Chemical use History

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

____Yes ____No If yes, describe: _____

_____

Medication

Current prescribed medications Dose Dates Purpose Side Effects

_____

_____

_____

Medication allergic reactions: _____

Prior Counseling Experiences

Psychiatric Treatment: ____Yes ____No

When: _____ Where: _____

Reaction or Overall Experience: _____

_____

Counseling: ____Yes ____No

When: _____ Where: _____

Reaction or Overall Experience: _____

_____

Suicidal thoughts/attempts: ____Yes ____No

When: _____ Where: _____

Reaction or Overall Experience: _____

_____

Drug/Alcohol Treatment: ____Yes ____No

When: _____ Where: _____

Reaction or Overall Experience: _____

_____

Hospitalizations: ____Yes ____No

When: _____ Where: _____

Reaction or Overall Experience: _____

_____

Do you feel suicidal at times? ____Yes ____No

Do you/Have you had suicidal thoughts ? Plans? Attempts? Is so, please explain: _____

_____

_____

_____

_____

_____

_____

Please check behaviors and symptoms that occur to you more often than you would like the to take place:

___Aggression ___Elevated Mood ___Fears ___Alcohol Dependence ___Feeling Tired

___Recurring Thoughts ___Anger ___Gambling ___Sexual Addiction ___Sick Often

___Feelings of Sadness ___Hallucinations ___Sexual Difficulties ___Anxious/Worried

___Heart Palpitations ___Avoiding People/Places ___High Blood Pressure ___Sleep Problems

___Chest Pain ___Feelings of Hopelessness ___Speech Problems ___Breathlessness

___Impulsivity ___Suicidal Thoughts ___Loss of Interest ___Irritability ___Disorientation

___Thoughts I Can't Control ___Judgement Errors ___Trembling ___Difficulty Concentrating

___Loneliness ___Withdrawing ___Dizziness ___Forgetful ___Repeated Checking

___Drug Dependence ___Mood Shifts ___Eating Disorder ___Panic Attacks

___Other (specify): _____

_____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Additional information that would assist me in understanding your concerns or problems: _____

Describe your support system: _____

What are your goals for therapy? _____

_____ _____

Signature **Date**

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Client Name: _____

Date: _____

Date of Birth: _____

Telehealth Informed Consent Form

Definition of Telehealth:
Telehealth involves the use of electronic communications to enable Empower Counseling, PCs' mental health professionals to connect with individuals using HIPAA compliant interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of the client.

By signing this form, I understand the following:
I understand that the laws that protect privacy and the confidentiality of medical information also apply to Telehealth, and that no information obtained in the use of Telehealth which identifies me will be disclosed to any other entities without my written consent.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future treatment.

I understand that telehealth may involve electronic communication of my personal medical information.

I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to- face" psychotherapy.

I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

I understand that it is the client's responsibility to secure a confidential private location while meeting with my counselor through Telehealth appointments. There are limitations to confidentiality based on client's environment during appointment.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

I understand that Telehealth is being offered as a temporary measure to provide a continuum of care during the current state of emergency in Virginia. Telehealth can be discontinued at any time based on my counselor's discretion.

By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services

Empower Counseling, PC will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual can opt to pay out of pocket. Co-pays/ payments will be obtained at time of service. We will provide you with a statement of service to submit to your insurance company if you wish.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.
By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____
Client (Print Name)

_____
Client's Signature Date

_____
Parent or Guardian Signature Date

Please return this form by fax at 434-305-1072 or email directly to your counselor. Email consents or photographs of this form are permitted.

Please call the office prior to your session to make payment for your telehealth service at 434-219-5621.

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HIPAA

Consent to use and disclose your health information

This form is an agreement between you, _____, and _____, and your Empower provider. When I use the word "you" below, it will mean you, your child, relative or other person if you have written his or name here:_____.

When I evaluate, diagnose, treat, or refer you I will be collecting what the law call Protected Health Information (PHI). I need to use this information here to decide what treatment is best for you and to provide that treatment. I may also be required to share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions. My standard procedure is to ask for your written consent prior to providing PHI because in addition to the following HIPPA guidelines, I also follow professional guidelines that are more restrictive.

The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent form.

According to HIPAA policy, if you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future, I may change how I use and share your information and so may change my Notice of Privacy Practices. If I do change my notice, you request a copy from our privacy officer by calling 434-219-5621.

If you are concerned about some of your information, you have the right to ask me not to use or share some or all your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____ I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

Continued>

I have received the Notice of Privacy Practices and have been given an opportunity to review it.

Client Name: (Please print): _____ Birth Date: _____

Client Signature: _____ Date: _____

OR

Printed Name of Guardian or Representative: _____ Relationship to Client: _____

Signature of Guardian or Personal Representative: _____ Date: _____

Therapist Signature: _____ Date: _____

Date of NPP copy reviewed by guardian: _____

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Confidentiality Agreement

Although therapists must always honor your privacy by maintaining confidentiality about your disclosures and securely preserving your records, there are exclusions to this rule. Therapists can (or must) break confidentiality, and take other appropriate actions, as warranted, for the following reasons:

Consent—A clinician may release confidential information with the consent of the patient or a legally authorized surrogate decision maker, such as a parent, guardian, or other surrogate designated by an advance medical directive.

Minors/Guardianship – Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Court Order—A clinician may be required to release confidential information upon the receipt of an order by a court of competent jurisdiction.

Continued Treatment—A clinician may release confidential information necessary for the continued treatment of a patient (to insurance companies, referring physician) and to receive payment for necessary services.

Abuse of Children and Vulnerable Adults – If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social services department.

Duty to Warn and Protect – When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

-It is an important part of the therapeutic process for you to share your thoughts and feelings on your treatment goals and progress. Therapy is meant to be interactive between client and therapist.

Confidentiality Agreement (continued)

-If I see you of the office setting, I will wait for you to speak first to protect your confidentiality.

(Clients seeing Residents in counseling will be discussing cases with Trish McCoy Kessler, LPC, CEDS-S as she is under her supervision and will continue to be confidential.)

I have been informed of the limits of confidentiality.

Client or Guardian Signature _____ Date _____

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RELEASE OF INFORMATON TO PHYSICIAN

Your physician is the medical representative responsible for coordination of your total care. Therefore it is appropriate for him or her to be aware of the therapy taking place under my care. With your permission, I would like to communicate basic treatment information to your physician.

Client Name_____ Date of Birth_____

Please DO NOT contact my physician: _____

Physician Name: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

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HIPAA RELEASE OF INFORMATON

With your permission, I would like to communicate basic treatment information to individuals per your request. Please identify individuals for correspondence of your (your child's) care.

Client Name: _____ Date of Birth_____

Name: _____

Address: _____

Phone: _____ Fax: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES
Acknowledgement of Notice

I hereby acknowledge that I have been given an opportunity to read a copy of this offices' Notice of Privacy Practices stated below.

This privacy policy sets out how Empower Counseling, PC uses and protects any information that you provide Empower Counseling, PC and www.empowercounseling.info when you use the web site, or communicate with us. Effective 06/01/2016.

Our Commitment To Privacy
Your privacy is important. Empower Counseling; PC is committed to ensuring that your privacy is protected. Should we ask you to provide certain information by which you can be identified; you can be assured that it will only be used in accordance with this privacy statement and to provide the utmost care. Empower Counseling, PC will never share your personal information, including your email address, with anyone except as required to complete a communication or except as required by law.

The Information Collected
We may collect your name, e-mail, insurance information, and phone number only as supplied by you with your consent. Empower Counseling, PC will also ask you to sign a release of information to those you wish to be involved in your, or your child's treatment.

How We Use the Information Collected
We use email addresses and phone numbers to answer and / or reply to the communications received. Phone numbers will be used to schedule appointments and to coordinate care with those who have been designated by you with a sign of release such as doctors, guidance counselors or additional guardians. We do not share this information with outside parties except as required by law.

(continued)

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NOTICE OF PRIVACY PRACTICES cont'd

Security
To prevent unauthorized access, maintain data accuracy, and ensure the correct use of information, we have put in place appropriate physical, electronic, and managerial procedures to safeguard and secure any information that may be collected from the website.

Privacy Policy Changes
Should the need to change any of the above stated policies arise; the new policy will be posted.

_____

Signature of Patient/Client Date

_____

Signature or Patient, Guardian or Personal Representative Date

_____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____ Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member Date

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TREATMENT CONTRACT

I/we give permission for the above named therapist to provide counseling services to my child, _____.

In providing this informed permission, I/we understand that it would impede the counseling process if the therapist and/or the clinical records are requested or required by subpoena to be presented to the Court or any attorney. Therefore, I/we agree that I/we will not request or require the therapist to testify in court matters regarding my family, nor will I/we request or require (by subpoena) that the therapist's records be presented to the Court or attorneys involved with the family. If I refuse to sign this contract, I/we understand that the therapist has a right to refuse treatment to my child with the understanding that quality service cannot be provided under these conditions.

I/we understand that this agreement may only be negated by the therapist if the therapist believes it would be in the best interest of my child to testify in Court or present clinical records to the Court.

_____ _____

PARENT/GUARDIAN PARENT/GUARDIAN

_____ _____

THERAPIST DATE