Illumine Counseling LLC
Counseling Agreement/Informed Consent

Welcome to Illumine Counseling LLC. This document contains important information regarding office policies, your rights and expectations. Please feel free to discus any questions you may have about any of the below information with your therapist, Amy Honsberger, LISW-S.

PAGES 1-4 Return to Amy PAGES 5-7 ARE FOR YOUR RECORDS

Confidentiality

The information you share in counseling is confidential. Your therapist will not release it without your written permission. Exceptions to confidentiality include:

- Legally: As a Licensed Independent Social Worker I am mandated by law to report: **(1)** If I believe you are in imminent danger of harming yourself; **(2)** If I believe you will harm another person; **(3)** If I believe a child or vulnerable adult is being abused or neglected.
- Family and Group Counseling: Clients engaging in family and group counseling are obligated to respect the confidentiality of others. While such confidentiality is expected, it cannot be guaranteed and secrets cannot be kept from others involved in your treatment.
- Minors: When working with your child/adolescent, I maintain their confidentiality as a part of their therapeutic process as I would any adult client. Parents of clients under the age of 18 do have the legal right to examine their child's treatment records and therefore clients under the age of 18 cannot be assured of unconditional confidentiality from their parents. If a parent desires such information, the request must be made in writing and a recommendation made on clinical judgment to move forward with such a request will be discussed in consultation with the parents.
- Cell Phone Communication: Cell Phones can be intercepted by third parties. If cell phone communication is utilized outside of scheduled sessions, confidentiality cannot be assured and your therapist is not responsible for any information intercepted by third parties.
- Email Communication: Emails cannot be assured of confidentiality and therefore your use of such forms of communication constitutes implied consent for reciprocal use of electronic mail.
- Legal Proceedings: As your therapist, protecting your confidentiality is very important to me. I do not make a practice of testifying in court and if you are in need of a therapist for forensic reasons, I can refer you.

Additional exceptions to confidentiality and uses/disclosures of Protected Health Information such as uses for insurance benefits, billing, or in the case of legal proceedings can be found in detail in the *Notice of Privacy Practices* and *Client Rights Statement.*

By signing below, I acknowledge I have read and understand the above guidelines of confidentiality. I have been given the opportunity to read and/or received a copy, read, and understand the *Notice of Privacy Practices & Client Rights Statement.*

_____ _____ Date: ____/ _____/____

(Signature of Client) (Print Name)

_____ _____ Date: ____/ _____/____

(Minor Client: Signature of Parent/Legal Guardian) (Print Name)

Contacting Me/Emergencies

I am not always immediately available by phone. If unavailable, voice messages are monitored and I will make every effort to return your call within 24 hrs. of the day you made it, with the exception of weekends and holidays. Illumine Counseling is not a crisis center. If you are experiencing a life threatening emergency and/or feel that you need immediate attention please call: **Netcare (614) 276-2273, OSU crisis line (614) 293-8205, 911or go to your nearest emergency room.**

Therapeutic Relationship

A therapeutic relationship is one that works in part because of clearly defined boundaries, rights and responsibilities of both therapist and client. This framework helps build a strong, therapeutic relationship where clients feel safe and supported in taking risks that bring about desired changes. To maintain an appropriate therapeutic relationship is important to our work together. Therefore, ethical standards require that your therapist not engage in an outside personal or business relationship with you. At times we may happen to see each other in a public or social setting. If this occurs, I will not initiate communication or social interaction in order to protect your confidentiality.

Consultation While I work individually in private practice, I do not work in isolation. To provide quality care and maintain standards of practice I consult with other mental health professionals. Client's identifying information (such as, name, employment, and contact information) is kept confidential during professional consultation.

Appointments
Your initial assessment appointment will average 45-50 minutes in length. Subsequent therapy sessions are 45 minutes in length (unless scheduled differently with your therapist to meet identified clinical needs). Please arrive on time. Your therapist makes efforts to stay on schedule for your appointment. If you are late for your appointment, please understand that we will conclude at the originally scheduled time. A 24 hour notice of cancellation of your appointment is required to avoid a late cancellation fee (with the exception of illness). There is a no show and late cancellation fee of $50.

Treatment and The Therapeutic Process
Therapy services begin with an evaluation of your needs. After completing an evaluation, we will discuss how our work together will proceed, and begin to develop a plan for treatment incorporating your goals for counseling. There are different treatment methods we may use to help with the difficulties you wish to address. As therapy progresses, you may find your goals change. We will regularly review your progress and facilitate adjustments in goals and/or treatment modalities as needed.

The therapeutic relationship is a collaborative one, thus, we will work together to meet your goals. However, the responsibility for taking action and making choices that initiate change is yours and calls for an active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and in-between sessions.

The counseling process can have benefits and the potential for emotional risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. It is important that you consider carefully whether these risks are worth the benefits to you of changing.

Most individuals, who take these risks, find that therapy can be helpful and often leads to better relationships, solutions to specific problems, a decrease in harmful behaviors, improved self-image and confidence, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience or that treatment will give you the results you are seeking. Please feel free to discuss any questions or concerns you may have at any point during treatment.

Eating Disorder Treatment
If you are seeing me for help with an eating disorder, I may recommend that you also work with a dietician and/or physician. Referrals can be provided if needed.

Termination
You are free to stop therapy at anytime. If you make the decision to terminate services it is appropriate to meet for a final session. If at anytime you feel you are in need of additional services or an alternate therapist, a referral will be made to fit your needs. If after the initial interview appointment or at anytime during the course of treatment, in my judgment I feel your needs would be better served elsewhere, or that you are not complying with treatment recommendations, I will inform you of this and an appropriate referral will be provided.

Agreement

I have read (or have had read for me) and understand the information outlined in this document pertaining to confidentiality, emergency contact, therapeutic relationship, consultations, appointments, counseling process and termination. I have had all of my questions answered fully. My signature below indicates my agreement to comply with the above policies and procedures and to participate in therapy.

_____ _____ Date: ____/ _____/_____
(Signature of Client) (Print Name)

_____ _____ Date: ____/ _____/_____
(Spouse, if couple counseling) (Print Name)

_____ _____ Date: ____/ _____/_____
(Signature of Parent/Legal Representative) (Print Name)

Therapist's Signature:_____ Date: ____/ _____/_____
Amy Honsberger, LISW-S

I have received a copy of "HIPAA Notice of Private Practice" initals: _____

Illumine Counseling, LLC
Primary Insurance Information

Date: ____/____/_____

Client DOB: __/____/_____

Client Name: _____

Primary Insurance Company Name: _____

Identification Number on Card: _____

Group Number (if applicable): _____

Subscriber's Name: _____

(The person who holds the policy)

Subscriber's Address: _____

Subscriber's Phone: _____

Client's Relationship to Subscriber: _____

Subscriber's DOB: _____/_____/_____

Subscriber's Employer: _____

Subscriber's Work Phone: _____

Co-payment: _____

Client Agreement & Release of Information Authorization for Third Party

The above information is current and correct to the best of my knowledge. I understand my insurance coverage as noted above and that I am responsible for paying my co-payment, if required, and or the amount not covered by my insurance policy. This agreement also grants authorization to Illumine Counseling, LLC, to release/disclose such information as may be necessary to the third-party payer or insurance company listed on the Primary Insurance Information Form for the purpose of receiving payment reimbursement directly to Illumine Counseling, LLC for services rendered. I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

_____ ____/_____/_____

Signature Date

_____ ____/_____/_____

Witness Date

**** I have received a copy of "HIPAA Notice of Private Practice" (see attached) initals: _____**

Illumine Counseling, LLC
Statement of Fees and Payment Policy

Payment for Services:
Payment, including co-payments if utilizing in-network benefits, is expected at the end of each session. Payment may be made in the form of cash, check, credit card, or Health Savings Account (HSA) cards that bear a MasterCard or Visa logo. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minor s may be denied non-emergency service unless charges have been pre-authorized to an approved credit plan, charge card or payment at the time of service.

Standard Fee Rate:

- Individual: Initial Session: $175.00; 50 – 55 Minute Session: $150.00; 40 - 50 Minute Session: $120.00
- Family: Initial Session: $200.00; 50 – 55 Minute Session: $175.00; 40 - 50 Minute Session: $145.00

In-Network-Insurance*:*
If Illumine Counseling LLC is a provider for your insurance plan, we will submit claims for reimbursement. Co-payments are required to be paid in full each session. Any appointment fees applied to your deductible are required to be settled upon notification by EOB. If your insurance either terminates or changes during the course of treatment and Illumine Counseling, LLC does not have a contract with your new insurer, the below out-of-network-insurance policy applies.

Out-of Network-Insurance:
Payment in full is expected at the time of your visit. Depending on your plan, some insurance companies will reimburse you a percentage of the cost of your session. Documentation may be provided to you by your therapist for you to submit to your insurance company for reimbursement. Upon your request, a copy of the "HCFA1500" form will be provided to you for each date of service. Illumine Counseling, LLC will provide *one follow up contact* upon your request with your insurance company to confirm any additional needed information.

Cancelations and No Shows:
If you need to cancel an appointment please do so no later than 24 hrs. prior to your scheduled appointment. Failure to provide at least 24 hours cancellation notice (unless due to illness or emergency) will result in a $50.00 fee. This is billed to you personally and is not covered by insurance. You are responsible for paying this fee by the end of your next scheduled appointment. If you choose to set up credit authorization, your card will be billed for any missed appointments that fit the 24 hr. cancellation policy. A bill may be mailed directly to clients who do not show up for, or cancel an appointment.

Miscellaneous and Paperwork Fees:
The below fees are not covered by insurance and are the responsibility of the client.

- Paperwork such as filling out forms or writing letters at the request of the client will incur an additional client fee for service billed at $75.00 per half hour of therapist's time.
- There is a $20.00 fee for any returned checks.
- Please note: In the event your therapist is subpoenaed by the court, a fee of $175.00 per hour will be charged for your therapist's time in preparing for, and participating in, such legal action. These include (but not necessarily limited to): responding to a subpoena, written reports, consultation, travel and wait time involved in attending deposition, hearing or trials. Additionally, the client is responsible for any legal fees incurred by your therapist due to involvement in such legal actions.

Agreement

I have read (or have had read for me) and understand the information outlined in this document pertaining to all applicable fees & payments for services. My signature below indicates my agreement to comply with the above policies and procedures.

_____ _____ Date: ____/ _____/____
(Signature of Client) (Print Name)

_____ _____ Date: ____/ _____/____
(Spouse) (Print Name)

_____ _____ Date: ____/ _____/____
(Signature of Parent/Legal Guardian) (Print Name)

Therapist's Signature:_____ **Date: ____/___/____**

Illumine Counseling, LLC
Statement of Fees and Payment Policy

This page is for your records

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If Illumine Counseling LLC is a provider for your insurance plan, we will submit claims for reimbursement. Co-payments are required to be paid in full each session. Any appointment fees applied to your deductible are required to be settled upon notification by EOB. If your insurance either terminates or changes during the course of treatment and Illumine Counseling, LLC does not have a contract with your new insurer, the below out-of-network-insurance policy applies.

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Payment in full is expected at the time of your visit. Depending on your plan, some insurance companies will reimburse you a percentage of the cost of your session. Documentation may be provided to you by your therapist for you to submit to your insurance company for reimbursement. Upon your request, a copy of the "HCFA1500" form will be provided to you for each date of service. Illumine Counseling, LLC will provide *one follow up contact* upon your request with your insurance company to confirm any additional needed information.

Cancelations and No Shows:
If you need to cancel an appointment please do so no later than 24 hrs. prior to your scheduled appointment. Failure to provide at least 24 hours cancellation notice (unless due to illness or emergency) will result in a $50.00 fee. This is billed to you personally and is not covered by insurance. You are responsible for paying this fee by the end of your next scheduled appointment. If you choose to set up credit authorization, your card will be billed for any missed appointments that fit the 24 hr. cancellation policy. A bill may be mailed directly to clients who do not show up for, or cancel an appointment.

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- There is a $20.00 fee for any returned checks.
- Please note: In the event your therapist is subpoenaed by the court, a fee of $150.00 per hour will be charged for your therapist's time in preparing for, and participating in, such legal action. These include (but not necessarily limited to): responding to a subpoena, written reports, consultation, travel and wait time involved in attending deposition, hearing or trials. Additionally, the client is responsible for any legal fees incurred by your therapist due to involvement in such legal actions.

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_____ _____ Date: ____/ _____/____
(Signature of Client) (Print Name)

_____ _____ Date: ____/ _____/____
(Spouse) (Print Name)

_____ _____ Date: ____/ _____/____
(Signature of Parent/Legal Guardian) (Print Name)

Therapist's Signature:_____ **Date: ____/ ___/____**
Amy Honsberger, LISW-S

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Effective as of May 1, 2010

Use and Disclosure of Your Protected Health Information for the Purposes of Providing Services

Illumine Counseling, LLC have the limited right to use and/or disclose of your protected health information (PHI) for the purpose of providing treatment, payment and conducting healthcare operations. These are all necessary activities for quality care and state and federal laws allow us to use and disclose your health information for these purposes:

I. Uses and disclosures for treatment, payment, and health care operations include:

- *Treatment* - Use and disclose PHI to provide treatment, consult with other practitioners, manage or coordinate care treatment or other services related to your health care. An example of treatment consulting may include your primary care physician, another practitioner, or mental health provider.
- *Payment* - Use and disclose PHI to obtain reimbursement for your healthcare. Examples of payment are when: TPCC discloses your PHI to your health insurer to obtain reimbursement or to determine eligibility or coverage; or a request has been made by a client for completion of a Superbill in order for the client to process claim and collect reimbursement from their insurance and to collect fees.
- *Healthcare Operations* – Use and disclose PHI for review of treatment procedures, review of business activities, certification, compliance and licensing activities.
- *Appointment Reminders* - Unless you provide us with alternative instructions, we may send appointment reminders, bills, and other similar materials to your home address.

II. Uses and disclosures requiring authorization:

- The use or disclosure of PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained.
- Separate authorization from you will be obtained before releasing your psychotherapy notes. Psychotherapy notes are notes made about conversations during a private, joint, group, or family counseling session and are kept separate from the rest of your medical record.
- Authorization from you will be obtained before releasing results of any testing.
- You may revoke an authorization, in writing, of PHI, psychotherapy notes, or testing.
- You may not revoke an authorization to the extent (1) Your therapist has relied on that authorization; (2)If the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

III. Uses and disclosures with neither consent nor authorization as required by law include:

- *Abuse of Children and Vulnerable Adults*- If this therapist in a professional capacity knows or suspects due to a client's statements or suggestions that he/she is abusing a child (or vulnerable adult), has recently abused a child (or vulnerable adult) or a child (or vulnerable adult) is in danger of abuse; this therapist is required to report this information (disclosure of relevant confidential information) to the appropriate social service and/or legal authorities.
- *Duty to Warn and Protect*-. When a client discloses intentions or a plan to harm another person, this therapist is required to warn the intended victim and report this information, (disclosing relevant confidential information), to the intended victim, other professionals, and the legal authorities. In cases in which the client discloses or implies a plan for suicide, this therapist is required to notify, (disclosing relevant confidential information), legal authorities, other professionals, and make reasonable attempts to notify the family of the client.
- *Prenatal exposure to controlled substances***-** Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- *Minor/guardianship* **-** Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.
- *Legal or Court Proceedings* - Information about your evaluation, diagnosis, treatment and records thereof is privileged under state law and will not be releases without written authorization or a court order.
- *Insurance Providers* (when applicable) - Insurance companies and other third-party payers are given information that they request regarding services to clients. This information may include type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

CLIENT RIGHTS STATEMENT

In the Notice of Privacy Practices counselors are required to inform clients as to their rights under state and federal law. If you have any questions regarding the rights listed below please feel free to ask for clarification.

Right to request where we contact you

- The Client Information form will allow you to indicate where and how you would like to be contacted.

Right to release your clinical records

- When information for purposes outside of treatment, payment, and health care operations are needed, a consent for Release of Information must be signed by you.
- You may revoke a Release of Information in writing.
- Revocation is not valid to the extent that you have acted in reliance on such previous authorizations.

Right to inspect and copy your clinical records

- You have the right to reasonable access to your PHI and billing records upon written request, unless access is restricted under certain circumstances or for documented treatment reasons. Your therapist will respond to your request within 30 days.
- Your therapist may deny access. If access is denied, you will receive written reasons for the denial.
- You may request, in writing, a copy of you PHI. There will be a fee imposed for such services

Right to add information or amend your medical records

- You may request to amend your PHI if you believe there is a mistake or missing information in our record. A request that information be added to or corrected on your PHI is to be made in writing and will be responded to within 60 days of receiving such request.
- Your therapist may deny the request.
- If denied, you have the right to file a disagreement statement, which will be added to your response and filled in your record.

Right to accounting of disclosures

- You have a right to receive an accounting of disclosures of your PHI for which you have neither provided consent or authorization. A request must be made in writing and a response will be given within 60 days of receiving it.

Right to request restrictions on uses and disclosures of your healthcare information

- You have the right to request, in writing, restrictions on how PHI is used or disclosed.
- Your request will be considered, but your therapist is not legally bound to agree to the restrictions and cannot agree to limit uses/disclosures that are required by law.

Right to complain

- You have the right to file a complaint if you believe your privacy rights have been violated or you disagree with a decision made about access to your PHI.
- Please contact your therapist initially to communicate your concerns. If together the situation cannot be resolved you have the right to file a written complaint with the Secretary of the Department of Health and Human Services. If a complaint is filed, no retaliatory action will take place against you.

Right to receive this notice and changes in policy

- You have the right to receive a copy of this notice and to request any future revised copies of this notice. Additional copies may be requested by contacting your therapist.

****Please INITIAL PAGE 3 that you have received your copy of this document.**