Harle Counseling & Assocoates, LLC

524 W. Broad St. & 511 W. Broad St. License #s available at
request Quakertown, PA 18901 215-527-8012

PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

Welcome. 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 with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. **The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session**. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between you and your therapist and you may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it; if there are obligations imposed on me 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.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the provider and patient, and the particular problems you are experiencing. There are many different methods I may use to address the problems that you are experiencing. Psychotherapy is not like a medical doctor visit as it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our session and at home.

CLIENT RESPONSIBILITIES

By signing your treatment contract with this group you are agreeing to the following responsibilities:

1. To abide by the following rules, infractions of which will be reviewed by the therapist during peer supervision and may result in administrative discharge from treatment:
   A. No use of alcohol or illicit drugs at Harle Counseling or during scheduled sessions/visits.
   B. No violence or threats of violence against Harle Counseling, staff or property.
   C. No firearms, pellet guns, air rifles, knives or other weapons at Harle Counseling.

2. To report to my therapist any changes in my condition, employment, living arrangements,other support systems, or other personal situations, that may affect my treatment.

3. To treat other clients with dignity and respect and preserve their confidentiality by not disclosing names during or after treatment.

4. To attend and participate in all sessions and to work sincerely toward my treatment goals.

5. To contact your counselor 24 hours in advance for cancellation of any session. If I give less than 24 hours notice I realize I will be charged for the session missed. This cannot be submitted to insurance and will be out of pocket.

When clients receive services through their local government, repeated absences will be reported to the referring worker. Termination of treatment may occur as a result of repeated, unannounced absences.

6. To comply with the no smoking requirements of Harle Counseling.
7. To dress in appropriate street clothing for sessions.
8. To encourage my spouse, significant other, or parents/guardians (as appropriate) to participate in the educational and support programs provided or recommended.
9. To treat staff members and this therapist with courtesy and respect, understanding that I retain the right to voice objection to the therapist's behavior or file a grievance as described under the client's rights.
10. To abide by Harle Counseling's payment arrangement as described in the policies and procedures I have previously signed.

<u>CLIENT RIGHTS</u>

All of your rights are important when you enter into treatment. You are further protected by the following rights:

- To maintain the legal rights entitled to you under the Laws of Pennsylvania or the United States including but not limited to: the right to dispose of property; the right to execute legal instruments; the right to buy or sell; the right to enter contractual relationships; the right to register to vote and vote; the right to marry and obtain a separation, divorce or annulment; the right to hold a professional, occupational, or vehicle license.
- To not be denied treatment of services on the basis of race, national origin, sex, age, religion or handicap.
- To be treated with dignity and respect.
- To participate in the development of your treatment plan and any changes that may occur during review of the plan.
- To receive confidential treatment and to have information about you maintained in a confidential manner within the limits of the law.
- To receive services according to the law, and sound therapeutic practice.
- To give consent for treatment.
- To express preferences and have them incorporated into your treatment plan and discharge plan consistent with your condition and need for treatment.
- To inspect, copy and correct your records subject to and in accordance with the provisions of PA Law.
- To be fully informed of treatment involving significant risk.
- To receive treatment/services in the least restrictive environment.
- To be informed of your responsibilities with regard to receiving treatment with this therapist prior to the start of treatment.
- To apply for other services to which you are entitled.
- To be informed of your rights, to ask questions about your rights, to receive help with your rights, and to have complaints addressed.

<u>IF YOU FEEL THAT YOUR RIGHTS ARE BEING VIOLATED YOU MAY TALK WITH:</u> Jill K Harle, LPC: 215-527-8012

<u>IF YOU NEED OUTSIDE ASSISTANCE, CONTACT THE LOCAL MENTAL HEALTH ENTITY ADVOCATE</u>:

Lenape Valley Foundation: 215-345-5300

Notice of HIPAA Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in

accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment.
Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating or managing your health care treatment and related services. This includes consultation with clinical supervisors, peer consultants and/or other treatment team members. I may disclose PHI to any other consultant only with your authorization. I may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing, office management or typing services) provided that I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Public Health. If required, I may use or disclose you PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process.

Verbal Permission. I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI I maintain about you. To exercise any of these rights, please submit your request in writing.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI

will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement and will provide you with a copy.

Right to Request of Disclosures. You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. More under confidentiality.

CONFIDENTIALITY

The confidentiality of the material discussed in therapy will be upheld at all times. As a general rule, as your mental health provider, I will not release any information without your written consent.

THERE ARE SOME EXCEPTIONS TO THE CONFIDENTIALITY RULE:

When a child is in treatment and the parents are divorced, and the parents have joint custody, the PA Attorney General's Office has advised us that we are obligated to ***inform both parents*** that the child is in treatment and the nature and course of treatment.

If a therapist suspects that child abuse or neglect has occurred, the law requires that it be reported to the proper authorities. Child abuse includes sexual exploitation and physical or mental injuries that result in impaired functioning. Child neglect includes failure to provide for the basic needs of the child (including medical care) and inappropriate discipline.

If a therapist believes you to be ***a clear and imminent danger to yourself or another person***, steps to prevent that occurrence must be taken. *These steps may require breaking confidentiality.*

In a legal proceeding, client-therapist communications are privileged. A judge can, however, order the therapist to divulge confidential information if this information is deemed necessary for the proper administration of justice. Your records can be released without your consent to prove to the appropriate agencies that as your mental health provider, I am in compliance with federally mandated HIPAA privacy laws. Your records can be released without your consent upon request from the military for purposes of national security.

Filing insurance always requires giving the insurance company, or third party payor, a diagnosis and the date of service. If you are covered through an employee group health plan, this information may come back to an insurance administrator at your place of employment. Sometimes insurance companies or third party payers require more extensive information, such as progress notes, before processing claims. This does not usually come back to the employer. If you are concerned about this, you should check to see how your company protects insurance information.

If the use of a collection agency or attorney is necessary to collect a past due balance, your right to confidentiality is curtailed. While ***no clinical information would be revealed***, your name, your employer, etc. and the amount owed, becomes available to these agents.

If you have any concerns regarding confidentiality, please feel free to discuss them with your therapist. Understand that sessions that have been either authorized through an EAP or approved through a Managed Care Insurance program.

This may mean that sessions are free of charge to me, or at reduced rates and/or copayments. The client agrees to pay all appropriate copayments as well as applicable deductibles and for services disallowed for any reason by the EAP/MC program or insurance company. If paying by check, the account will be debited electronically for both the face amount and returned check fee ($25.00) if it is returned unpaid. The client will be financially responsible for any collections fees/court costs involved in collecting a past due account. The client is financially responsible for all phone calls longer than 15 minutes. Payment is required at the time service is provided; however, insurance information will be obtained at the first session and insurance will be filled as a courtesy to me for sessions following the initial intake session.

Release and Assignment: Signing this contract will authorize any plan benefits to be paid directly to Harle Counseling, LLC. Clients will be financially responsible for non-covered services, including those for which authorization or payment has been denied, either by me EAP/Managed Care plan or other payor. If a claim is made by the patient, therapist, or a business associate providing billing services to any insurance company or companies, or to any other third party payor, the client does not object to the release by mail, fax, telephone or computer modem, any records or other information about the client, or child, or the services which are provided, including without limitation, the complete case record, information concerning any personal, psychological and medical history, information concerning diagnosis and treatment by Harle Counseling, LLC and information concerning billing and payment for such services. All such information shall be subject to review by such insurance company or third party payor during the period of me or my child's treatment by Harle Counseling, LLC or at any other time thereafter.

If the parents of a child are separated or divorced and there is joint custody, the other parent's notification of treatment of my child as advised by the PA Attorney General's office.

CELLULAR PHONE, EMAIL, AND FAX COMMUNICATION FORM

I give consent for Harle Counseling, LLC to send by electronic transmittal or communicate by cellular phone, with appropriate release of information, confidential information concerning my/my child's diagnosis, care, testing records, treatment plan and goals. I am fully aware that electronic transmittal and wireless telephone communication is subject to difficulties. I understand that Harle Counseling, LLC, will exercise all reasonable precautions, and I will in no way hold Harle Counseling, LLC, liable for any difficulties resulting to me or any other family member from the communication of confidential information by means of fax, email, or cellular phone.

FEES: My usual and customary fees are $175 for an initial intake, $140 per 50-minute individual session, and $150 per 50-minute session for 2+ people. Payment is requested at the time services are rendered by personal check, credit card, or cash. I will also charge $140 per hour for court testimony, including travel time and preparation. A $3.00 fee will be added to all credit or debit card transactions.

INSURANCE: As a courtesy, I am able to file your insurance for you. However, the client is expected to pay for non-covered services and deductibles, as well as co-payments, at the time services are rendered. If the insurance payment is not received within 90-days after a claim is filed, the client will become responsible for payment of the total amount due. It is your responsibility to follow-up with your insurance carrier for delayed payments or other concerns.

BILLING: Bills are mailed monthly after insurance has been filed. This is a reminder of your balance due and is an informational statement to keep you up-to-date regarding the status of your account. Our usual and customary collection procedures will be followed in order to collect unpaid balance and copayments due.

MISSED APPOINTMENTS:

IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, PLEASE NOTIFY THE OFFICE AND LEAVE A

MESSAGE. IF AN APPOINTMENT IS CANCELED OR MISSED WITHOUT A 24-HOUR ADVANCED NOTICE, YOU WILL BE CHARGED FOR THIS SESSION TIME. YOU MAY LEAVE A MESSAGE 24-HOURS A DAY, SEVEN DAYS A WEEK. INSURANCE DOES NOT PAY FOR MISSED APPOINTMENTS; THEREFORE, YOU WILL BE FINANCIALLY RESPONSIBLE FOR THE FULL FEE.

RESPONSIBILITY: The client or referring parent (in the case of minors) is considered responsible for payment of the professional fee. It is the client's responsibility to know the amount of their deductible or co-payment. When we are requested to bill a third party, such as a divorced spouse, relative, or insurance company, and that third party fails to make timely payments, payment is expected from the referring parent that signed the consent for services. The client will be responsible for claims that are denied due to "filing past the insurance carriers time limit" or that are the result of failure by the client to inform this office of changes in insurance coverage. If you have questions or concerns, please discuss them with us.

I hereby give consent that artwork in its original form or digital images of artistic expressions as well as case material, or my child, in evaluation/intervention may be used by therapists employed at Harle Counseling and Associates for the following purposes: Consultation Sessions with mental health professionals relevant to treatment, Education and training of mental health students or professionals, Publication in professional journals, Presentation at professional conferences, Posting on professional websites.
I understand that no reference will be made to the identity of myself or my child. Any and all identifying information will be redacted (removed or edited out) in compliance with Public Law 104-191 Health Insurance Portability and Accountability Act (HIPAA) standards. I understand that at any time I can retract this release and a copy is always stored in your record.

NO SURPRISES ACT (2022)

Good Faith Estimates.

The statute requires that good faith estimates of the costs of services be included in the notice to fully inform patients of their potential out-of-pocket costs if they continue with care from out-of-network providers or facilities. The law further instructs such good faith estimates be conveyed using the expected billing and diagnostic codes for items and services. The standard form also requires that good faith estimates reflect the amount the out-of-network provider or facility expects to charge for furnishing such items or services, as well as include the service codes.

Under the new rule, psychologists and other providers must take the following steps for their uninsured or self-pay patients:

Ask if the patient has any kind of health insurance coverage, and if so, whether the patient intends to submit a claim to that insurance for the service.
Inform all uninsured and self-pay patients that a good faith estimate of expected charges is available in a written document that is clear, understandable, and prominently displayed; orally provided when the service is scheduled or when the patient asks about costs; and available in accessible formats, and in the language(s) spoken by the patient.
Provide a good faith estimate of expected charges for a scheduled or requested service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service." That estimate must be provided within specified timeframes. **If the service is scheduled at least three business days before the appointment date, no later than one business day after the date of scheduling; If the service is scheduled at least 10 business days before the appointment date, no later than three business days after the date of scheduling; or if the uninsured or self-pay patient requests a good faith estimate (without scheduling the service), no later than three business days after the date of the request. A new good faith estimate must be provided, within the specified timeframes if the patient reschedules the requested item or service.**
If any information provided in the estimate changes, a new good faith estimate must be provided no later than 1 business day before the scheduled care. Also, if there is a change in the expected provider less than one business day before the scheduled care**, the replacement provider must accept the original good faith estimate as their expected charges.**

Please refer to www.cms.gov/nosurprises for more information.

CREDIT CARD ON FILE

Due to this new regulation, we are asking clients to file a card online so that billing issues can be dealt with and receipts given at the time of the appointment. It would be the preference of the company to complete each scheduled appointment that is private pay to close out the active invoice and avoid late fees, collections, and any other costs. This allows for billing to be completed and peace of mind to occur at the date and time of session. If clients are using insurance, the card on file will only be used when fees are indicated by the insurance company. These charges will result in a receipt and be confirmed by your Explanation of Benefits sent directly from your insurance company. If a card is not on file, the clinician has the right to refer or discharge the client. A card on file can be switched or removed at any time but a replacement will be requested. Clients may opt to pay by cash or check, but their card will remain on file in the case of missed payment.

TELEHEALTH ADDENDUM

All services are provided using the rules and guidelines indicated in the intake. The following only apply to Telehealth sessions:

-If technical difficulties end or interrupt the session, the clinician will provide alternatives to continue the session. The client is only entitled to the 50 minutes scheduled despite difficulties and interruptions. The client is still responsible for the session cost. If there is not a useful alternative, sessions will be submitted at 30 min increments.

-No shows are logged by the clinician after 15 minutes of sending an invite or log on. The fees for a missed appointment is outlined in the fee schedule.

- The clinician will not record any sessions without permission or consent from the client and/or other participants.

-The clinician is responsible for the security of the telehealth program they choose to do business with but is not responsible for outside breaches that should be secured by the program. The client uses services with the understanding that information is less secure using computers and telephones.

-The client is responsible for their own privacy while engaged in a session in their chosen location.

PATIENT INFORMATION

Name:____Pronouns_______________DOB: __________________

Address: ____

City:___________________________ State: ________ Zip Code: _________

Parents/Guardian Name(s)____

Client Phone (14+): _____________________________ Is it okay to leave messages?__________________

Alternate Phone______________________________Name:_________________________Ok to leave a message?________

Email Address:____Ok, communicate via email?_______________

INSURANCE INFORMATION

Did you call for Pre-Authorization? NO YES Pre-Authorization #:______________________

MANY INSURANCE COMPANIES REQUIRE PRE-AUTHORIZATION FOR MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES. IF THIS IS REQUIRED BY YOUR INSURANCE CARRIER AND YOU DID NOT CALL, BE AWARE THAT YOU MAY BE PENALIZED WITH DENIAL OR REDUCED BENEFITS. I will gladly file your insurance for you as a courtesy. However, the FULL INSURANCE INFORMATION BELOW MUST BE COMPLETED It is up to the client to know his/her insurance coverage, including knowledge of co-payment amounts and yearly deductibles. I cannot verify this information to you. If payment of the bill has not been satisfied by the insurance company within 90 days, it is the responsibility of the client or parent/guardian to pay the bill in full. Copayments and deductibles are always due at the time of service.

Client's Name:____Relationship to insured: __________________________

Insured's Name: ____

Insured's Address: ____

City:____State:___________Zip: ____________________

Insured's DOB:_______________________Gender: Male Female Specify:__________________

INSURANCE COMPANY:____

Policy Number:_________________________________Group Number: ______________________________

MEDICAL EMERGENCY INFORMATION FORM

Emergency Contact Name:____Relationship:_________________________

Address:____

Phone #:______________________________________Alternate #:___________________________________

Physician's Name:______________________________________Phone #: _____________________________________

INITIAL INTERVIEW and ASSESSMENT

Name:____Date:________________DOB: _____________

Gender Identity:_____Female_____Male_____Other Marital Status: ______________

Current Issues / Status:

____
____
____
____

Clinical Symptoms:

DEPRESSION (check all that apply):

_____Depressed mood	______Irritability	______Restlessness
_____Weight loss	_____Crying spells	_______Loss of Interest
_______Weight gain	______Sleep disturbance	______Social isolation
______Increased sleep	______Loss of energy	______Decreased sleep
_____Indecisiveness	______Thoughts of death	_____Lack of motivation
_____Thoughts of suicide	______Difficulty concentrating	______Decrease in sex drive

ANXIETY (check all that apply):

_____Nervousness	______Excessive worry	_____Easily fatigued
_____Unable to control worry	______Muscle tension	_____Feeling edgy
_____Sweating / trembling / shaking	______Pounding / racing heart	_____Shortness of breath
_____Abdominal distress	`______Lightheaded, dizzy, faint	______Chest pain / tightness
_____Fear of losing control	______Chills or hot flashes	

MANIA (check all that apply):

_____Period of at least 3 days with an elevated mood ______Inflated self-esteem or grandiosity
_____Decreased need for sleep ______More talkative than usual / pressure to keep talking
_____Racing thoughts _____Distractibility ______Increase in goal-directed activities
_____Psychomotor agitation ________Excessive involvement in activities that have potential for pain

PSYCHOSIS (while NOT under the influence of drugs / alcohol):

_____Hallucinations ______Delusions Explain if yes:

____

Have you ever been assaultive toward others or the environment? Yes / No Expalin if yes:

____

Ever have any self-mutilating behaviors:________Cutting_____Hair pulling____Burning Explain if yes:

____

Previous counseling experiences: Yes / No

Date/Place/Type of Treatment Outcome:

____
____
____

Have you ever been diagnosed with a Learning Disability? Yes / No When Dx? ______________________________

If Yes, type:

Treatment received: ____

Family History of Mental Illness / Addiction: Family Member Nature of Problem

____

____

Any family history of suicide? Yes / No If Yes, describe:

____

____

Legal History:

Any arrests / DUI / probations? ____

Family of Origin:

Mother:_____Living_______Deceased (Date of death:______________________/ Age:__________)

Describe relationship:

____

Father:_____Living________Deceased (Date of death:______________________/ Age:___________)

Describe relationship:

____

Who were you raised by? Siblings? Yes / No

____

Sibling(s) Name Age Relationship with you

____

____

Abuse History (circle and describe):

Physical / Emotional / Verbal / Sexual

Perpetrator____Reported? Y / N Date:___________________

Description:

____

____

Relationship History:

Current relationship: ____

Past Relationship(s):____

____

Children? Yes / No Name(s) and Age(s):

____

____

Leisure / Recreational Activities:

____

____

More information required that you prefer to not write down? Y / N

Are you currently taking any medication? Y/N If yes, please list:

Med	Dosage	Frequency	Start date

Allergies (please list): ____

Do you currently use any alcohol or other substances; if yes, please state substance, frequency, amount, most recent use and age at which you started using substance:

____

____

Any other important medical information

____

____

Preferred Hospital: ______________________________________

ART THERAPY RELEASE

I hereby give consent that artwork in its original form or digital images of artistic expressions as well as case material, or my child, in evaluation/intervention may be used by therapists employed at Harle Counseling and Associates for the following purposes: Consultation Sessions with mental health professionals relevant to treatment, Education and training of mental health students or professionals, Publication in professional journals, Presentation at professional conferences, Posting on professional websites.

I understand that no reference will be made to the identity of myself or my child. Any and all identifying information will be redacted (removed or edited out) in compliance with Public Law 104-191 Health Insurance Portability and Accountability Act (HIPAA) standards. I understand that at any time I can retract this release and a copy is always stored in your record.

Cient (14+) ____

Parent/Guardian ____________________________________

CREDIT CARD ON FILE

In the event that payments are not received or a payment schedule is not agreed upon, I give consent for Harle Counseling & Assoc. to charge the below credit card. If the card will be processed, the client or cardholder will be informed and provided a receipt.

Credit Card Information:

Please add your credit card to the schedulicity program or upon receipt of your first invoice. These sites are confidential and regulated. Providers will prompt this at time of session.

Acknowledgement of Client Contract

Please initial, sign, and date the following:

_______ I have read and understand the client service agreement, including the client's rights and responsibilities during their treatment under Harle Counseling, LLC.

_______I have read and understood the privacy practices outlined by HIPAA.

_______I understand and agree to the rules and limits of confidentiality.

_______I have read and understand the information regarding insurance claims, copayments, and fees.

_______I understand the 24 hour cancellation policy and the client's responsibility to fees and appointments.

_______I understand the limits to confidentiality when dealing with media, electronics, email, and other electronic based correspondence.

_______I have been provided an opportunity to discuss the documents with my therapist or any associate at Harle Counseling, LLC about any questions regarding this contract and the contents within.

_______I understand that accounts are sent to collections after 90 days if no payments are received. A 30% charge will be added to any and all accounts sent to collections.

_______I accept and approve a $3.00 transaction fee when using a credit or debit card.

_____ I have read and I understand the art release. This is only for clients engaged in art therapy.

_____ I understand the limits of confidentiality and the clinical billing differences when choosing telehealth services.

Your signature below indicates that you have read the agreement and understand and agree to its terms. You may request a copy of these notices. We recommend printing these forms for your records.

Signing below indicates that you have read, understand, and agree with the Fee information guidelines outlined above.

____ ________________

Client (14+) or Parent/Guardian Signature Date

____ ________________

Parent/Guardian Signature Date

Therapist assigned: ____

Fee Schedule

Intake session 90791	150.00

Individual Session: 90837

Intern 50 min	0.00 or Donation
Masters 50 min	100.00
Masters Prelicense 50 min	120.00
Licensed 50 min	130.00
Licensed Supervisor 50 min	150.00

Specials/Extras:

EMDR Certified 50 min	140.00
DBT Certified	Add on 20.00
Art Therapy 50 min	Add on 20.00
Couples therapy	Add on 20.00
Family therapy	Add on 40.00
Coparenting	150.00

90834:

Intern 30 min	0.00 or Donation
Masters 30 min	50.00
Masters Pre-License 30 min	60.00
License 30 Min	70.00
Licensed Supervisor 30 Min	80.00

Documents/Paperwork:

Diagnostic summary	100.00
Letter to verify services	30.00
Surgery Letter	50.00
HRT Letter	50.00
Service animal Letter	50.00
Records request	.50 per page -shipped
College disability request	50.00/100.00 est.

Court appearance:

Per hour	150.00
Stand by retainer	1000.00