Ascendant
Counseling Services

410-455-0098

AscendantCounseling@gmail.com

CLIENT INFORMATION

This information is provided to help you understand our policies and practices. Please read this statement carefully as it contains important information about your treatment.

CONFIDENTIALITY

Your right to confidentiality is provided under Maryland law. In general, everything discussed will remain confidential subject to limitations imposed by State law. Limitations to confidentially include the following: the obligation of the therapist to take action to try to protect the client or potential victim if a client is likely to cause serious harm to him/herself or others; the obligation of the therapist to report all cases of child abuse to the appropriate authorities; if a client authorizes the therapist to testify in a court case, the therapist may be compelled to testify on any issue discussed in therapy and not necessarily just what the client wished to have discussed; when ordered by a court of law to testify, a therapist can be required to do so.

In instances where you request information to be released concerning your treatment a written release will need to be signed by you. Although this can be inconvenient, it is designed to protect you from unauthorized release of your personal information. In the event of an emergency where it is not possible to obtain a signed release, a verbal authorization will be required.

IN THE EVENT OF AN EMERGENCY

An emergency is a situation where therapeutic intervention is necessary to prevent dire consequences such as: one causing harm to themselves or others, where a client is out of control and needs immediate intervention to prevent a breakdown in their functioning. In the event of an emergency you may do the following:

1. Call the main office number, follow directions to the appropriate therapist's voice mail box and follow the instructions for an emergency. If you have not received a response within 30 minutes call again.
2. If the emergency cannot wait until your therapist or an associate has called you, you can obtain emergency psychiatric assistance through the emergency room of your closest hospital.

FEE AGREEMENT AND FINANCIAL POLICY

Please review this Fee Agreement and Financial Policy (the "Agreement and Policy"), which describes our schedule of fees for therapy services, charges not covered by insurance, and additional fees effective November 16, 2015. Please be sure you understand the policies regarding cancelations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions about anything, please ask prior to signing this Agreement and Policy.

Therapy rates and corresponding health insurance billing codes (numbers starting with '90')

90791	Initial Consultation - Individual (50-60 min.)	$125.00
90837	Individual Therapy (60 min.)	$120.00
90834	Brief Individual Therapy (45 min.)	$110.00
99404	Employee Assistance Plan (EAP)	$0.00

Charges not covered by insurance:

Records Requests	$15.00
Case Management*	$120.00 (pro-rated per 15 min.)
Phone Consultations (11-60 min)	$120.00 (pro-rated per 15 min.)

*Case Management includes indirect services provided outside of session times such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), coordinating adjunct services, and completing forms or reports.

Additional fees:

Late cancelations - fewer than 24 hrs. prior to appointment	$20.00
Missed appointment (first time)	$40.00
Missed appointment (after first time)	$65.00
Non-sufficient funds (bounced) check	$25.00
Past-due accounts - over 90 days	$25.00 per month

PAYMENT:

You will be expected to pay for either • each session in full or • your insurance co-payment at the time of services. Accepted methods of payment are cash, check, or credit cards.

CANCELATIONS & MISSED APPOINTMENTS:

Insurance carriers will not pay for late cancelations or missed appointments. Once an appointment is scheduled, that time is reserved specifically for you. Cancelations must be made at least 24 hours in advance. Although 24 hours is the minimum, if you need to cancel or reschedule please give as much notice as possible. You may notify the office of cancelation by phone or e-mail. Late cancelations (fewer than 24 hours before the appointment) will incur a fee of $20. Missed sessions will incur a fee of $40 for the first missed session and $65 for subsequent missed sessions. The office will notify you of any late cancelation or missed session fees that you incur, which will charged to your credit card on file.

PAST DUE ACCOUNTS:

Amounts past due by more than 30 days will incur a late fee of 1.5% for each month the balance remains unpaid. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, Ascendant Counseling Services, LLC may resort to legal means to secure payment. This may involve hiring a collection agency, an attorney or going through small claims court. If such legal action is necessary, you will be responsible for those costs.

CREDIT CARD ON FILE:

Upon scheduling your first appointment you are asked to provide either credit card information (or e check, see below) which will be kept on file (stored electronically with secure, encrypted, HIPAA-compliant software) to be used for charges incurred for late cancelations, missed appointments, returned checks, or past due account balances. If your card on file is charged, you will be notified of the reason for the fee and the amount charged. A receipt will be e-mailed to you at the address you specify below. You may also request that the credit card on file be used as your preferred method of payment at the time of service.

Type of card
(circle one):

VISA MASTER CARD

Credit Card #:_____

Expiration Date:_____ CVV:_____

Name on card:_____

I, _____, authorize Ascendant Counseling Services, LLC to charge this credit card as needed according to the terms specified in the Agreement and Policy.

E CHECK ON FILE:

You may elect instead of having a credit card on file, to provide your Banking Account Routing Number and Account Number. (See terms listed above in Credit Card On File).

Type of Account

(Circle one): Checking Savings

Bank Routing Number:_____

Bank Account Number:_____

Name on Bank Account:_____

I, _____, authorize Ascendant Counseling Services, LLC to debit this bank account as needed according to the terms specified in the Agreement and Policy.

I have read the Agreement and Policy above, and I have been offered a copy for my records. I understand the policy and by my signature below I agree to be bound by its terms in association with outclient services provided to me by Ascendant Counseling Services, LLC. Any and all negotiated exceptions or special arrangements are listed below.

Client name (printed):_____

Client signature: _____ Date:_____

Parent/Guardian signature:_____ Date:_____

Witness:_____ Date:_____

Relationship to client _____ Date:_____

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INSURANCE BILLING

If we are billing your insurance for any portion of our fee, please be aware that you are ultimately responsible for payment of the fee if your insurance company does not pay. We require that co-payments be paid at the time of service. We require you to call your insurance company to request authorization, if required by your carrier. If you do not obtain authorization as required by your insurance carrier, you will be responsible for full payment.

Signature Date

Witness Date

Insurance Company Policy or Member #

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INSURANCE REIMBURSEMENT

I authorize and understand:

- That claims be submitted directly to my health insurance carrier
- My insurance carrier to pay charges directly to Ascendant Counseling Services, LLC
- My insurance carrier may request treatment reports or other information to document my treatment
- I need to call my carrier to request the initial authorization for treatment
- Ascendant Counseling Services, LLC to release this information to my health insurance carrier, and release Ascendant Counseling Services, LLC from any liability for doing so
- that if my therapist is a contracted provider with my HMO or insurance plan that the terms of the provider contract with my carrier will apply to eligible charges.

Signature Date

Policy Holder's Name/Date of Birth

Employer Name

Insurance Company Insurance Phone #

Policy Number or Member Number Group #

Street Address City/State/Zip

Primary Contact Phone Number Email Address

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AUTHORIZATION TO RELEASE AND RECEIVE RECORDS

In order to provide well-coordinated health care, it is important for Ascendant Counseling Services, LLC to communicate with your primary health care provider. Please complete the following consent form so that we can communicate our findings and recommendations.

Client Name Date of Birth

Specific information to be disclosed: Results of evaluation and recommended treatment

Purpose for disclosure: To coordinate care

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I hereby release Ascendant Counseling Services, LLC any liability that may arise from the disclosure of confidential Information. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically 1 year from signature date.

I, _____ hereby authorized to release and receive information (checked above) to:

(Name): _____

Address Phone

Signature (Client/Parent/Legal Guardian) Date

Witness Date

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CLIENT'S RIGHTS AND RESPONSIBLITIES

Clients have the right to

- be treated with dignity and respect
- fair treatment --this is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- have their treatment and other client information kept private.
- only in an emergency, or if required by law, can records be released without member permission.
- information from staff/providers in a language they can understand.
- have an easy to understand explanation of their condition and treatment.
- information about providers and to list certain preferences in a provider.
- know the clinical guidelines used in providing their care.
- know about: State and Federal laws that relate to their rights and responsibilities.
- know of their rights and responsibilities in the treatment process.
- share in the formation of their plan of care.
- easily access timely care in a timely fashion and know about their treatment choices regardless of cost or coverage by the benefit plan.
- share in developing their plan of care, to know of their rights and responsibilities in the treatment: process, to receive services that will not jeopardize their employment and to freely file, a complaint or appeal and learn how to do so.
- ask/give input on the Members' Rights and Responsibilities policy, know about advocacy and community groups and prevention services.

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Clients have the responsibility to:

- give providers information they need. This is so they can deliver the best possible care.
- let their provider know when the treatment plan no longer works for them.
- follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
- treat those giving them care with dignity and respect.
- keep their appointments. Clients should call their providers as soon as possible if they need to cancel visits.
- ask their providers questions about their care so they can understand their care and their role in that care.
- let their provider know about problems with paying fees.
- follow the plans and instructions for their care. The care is to be agreed upon by the member and provider.
- keep current with their fees,
- report abuse and fraud.
- openly report concerns about the quality of care they receive.

I have read the above rights and responsibilities. I understand and agree with them.

Client Name (Print) Signature Date

If Minor, Print Guardian Name Guardian Signature (Relationship to Client) Date

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Notice of Ascendant Counseling Services' Policies and Practices
to Protect the Privacy of Your Client Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions.

"PHI" refers to information in your health record that could identify you.

"Treatment, Payment, and Health Care Operations"
Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychotherapist.

Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"Use" applies only to activities within our practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.

"Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes your therapist has made about your conversation during a private, group, joint, or family counseling session, these notes are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that

(1) we have relied on that authorization; or
(2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If we have reason to believe that a child has been subjected to abuse or neglect, we must report this belief to the appropriate authorities.
- Adult and Domestic Abuse: We may disclose protected health information regarding you if we reasonably believe that you are a victim of abuse, neglect, self-neglector exploitation.
- Health Oversight Activities: If we receive a subpoena from the therapist's licensing board because they are investigating our practice, we must disclose any PHI requested by the Board.
- Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: If you communicate to me a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.

IV. Client's Rights and Psychotherapist's Duties Client's Rights

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, we will send your bills to another address.)
- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of your PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You have the right to inspect or obtain a copy (or both) of Psychotherapy Notes unless we believe the disclosure of the record will be injurious to your health. On your request, we will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes. If you request copies of your record we will charge you a $15.00 service charge, plus $0.50 per page duplication fee, plus any applicable postage charges.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- Right to a Paper Copy - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide you with a revised notice either in person or by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Ascendant Counseling Services, LLC, 410-455-0098.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on October 1, 2013.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice either in person or by mail.

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Notice of privacy practices acknowledgement

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

Name (Printed)	Birth date
Signature	Date