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COUNSELING, CONSULTING & TRAINING, LLC

AGREEMENT AND CONSENTS

Welcome to Phelps Counseling and Consulting! We are committed to providing you with the highest quality care, which begins with a clear understanding of our services. You will find below a brief description of our office, privacy, and financial procedures. Please initial where appropriate and sign at the bottom of the page. I will be happy to discuss any question you might have.

SCHEDULING AND CANCELLATIONS

Sessions are typically 50-55 minutes long. Please be aware that any appointment that cannot be kept must be canceled no less than 24 hours before the appointment time. Appointments that have not been properly canceled are eligible to be charged half the full fee of the session the first time and the full fee for any further late cancellation or no shows. Insurance companies will not pay for the missed sessions, so payment for these will be your sole responsibility.

CREDIT CARD AUTHORIZATION

As a convenience to both parties, a credit card may be kept on file in an encrypted electronic billing system. If you provide permission with a signature, you will provide a credit card at the onset of treatment for future out of pocket session charges, copays, deductibles, and late cancels/no shows which will eliminate the need to send and receive bills and invoices. Please choose the maximum amount you are authorizing without contacting the responsible party (must be at least $150.00 in the event of a no show/late cancellation fee). You may revoke this at any time or agree to provide updated information as necessary.

Name on Card: _____
Credit card number: _____ Exp: _____ Security Code: _____
BillingStreetAddress_____
MaximumAmountAuthorized:_____
Signature: _____

FINANCIAL POLICIES

By the end of your first session, I will explain your financial obligations, based upon your particular insurance plan or lack thereof, as well as answer any questions you may have regarding the cost of and payment for treatment. If I am submitting claims to your insurance company, you authorize us to receive the reimbursement directly. If I am not contracted with your insurance company, the agreed upon fee will be required at the time of service. I can provide you a "superbill" with the information necessary to submit to your insurance company for reimbursement. If you are not submitting your claims to an insurance company, the agreed upon fee will be due at the time of service.

____I have read the financial policies, including the cancellations policy above, and I understand my responsibilities. I will not hesitate to seek any clarification from Nancy.

CONFIDENTIALITY AND ITS LIMITS

Ethically and legally, I will protect your confidentiality and adhere to my Notification of Privacy Practices (NPP), which is detailed in a separate document, HIPAA Notification of Privacy. Iowa Law mandates that I break your confidentiality if I have reason to believe that you are in imminent danger of harming yourself or someone else. While it is common for a depressed person to have suicidal thoughts or plans, if I believe that you are going to carry out these plans imminently (or acts of hart to others) I will be required to share this information to prevent you from doing so. Also, if I am in direct contact with a minor or dependent adult who discloses to me that she or he is being abused, I am mandated by Iowa Law to report this abuse to the Department of Human Services. Please feel free to discuss confidentiality and its limits with me at any time.

____ I understand my confidentiality and its limits.

____ I understand the other business I understand that two mental health businesses share this space and although charting is not accessible by the other business, in rare instances there may be clinical consultation or emergency back-up form.

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COMMUNICATION POLICIES

My general policy is to leave our office name and phone number when we return phone messages. Please initial if you give consent for me to leave more detailed treatment information on the voicemail of your choice:

____ I authorize Phelps Counseling, Consulting & Training to leave treatment information on my voicemail at the following number (_____) _____-_____.
I provide free appointment reminders via text, email or voicemail. Please initial below for consent. Many of my clients like to communicate via email. By initialing below, you acknowledge that text and email is not a secure form of communication and confidentiality cannot be guaranteed.
____ I authorize Phelps Counseling, Consulting & Training to send appointment reminders. Please refer to Appointment Reminder agreement on following page to indicate how you wish to be notified.
____ Please initial here, acknowledging that, in an emergency, you agree to call 911 or go to your nearest emergency room. You may also contact the Crisis Line at Robert Young at (309)779-2999, the Genesis Crisis Line at (563)421-2975, or the National Suicide Hotline at (800)273-8255.

SOCIAL MEDIA

The Iowa Board of Social Work considers it unethical for Licensed Independent Social Workers to interact and "friend" clients on social media. Please understand that if you send me a friend request to my personal social media pages, I will not respond per my ethics board. I do have professional social media pages to promote my business. If you choose to post on my business pages, please be aware that it opens the possibility that the general public may discover that you are a client.

_____ I understand the limitation of communication and contact on social media with Nancy Phelps, LISW, LCSW.

CONSUMER RIGHTS

Since you are a consumer of psychotherapy services, it is your right to discuss any questions you have about the services you are receiving with me. I invite you to communicate openly and directly with me about your thoughts and reactions to therapy.
____ I have read and agree to this statement of standard care.

INFORMED CONSENT/WAIVER FOR NON-COVERED, NON-THERAPY, OR UNUSUAL SERVICES

I would like you to know that not all services I provide are covered by insurance and would like you to be aware of my policies regarding these services. I will do my best to remind you if I receive a request to provide any services of this nature. I will not release any information without proper signed releases of information from all parties involved in therapy. I may also request that you sign a separate consent for certain specific services.

Please be advised, that legal involvement is not part of the services that I offer. If such a situation does arise, please let me know in advance and we can discuss my role, if any. Should an unusual circumstance arise, and I agree to assist in such services, please be aware of the following: Due to complexity and difficulty of legal involvement, court involvement (including preparation, portal-to-portal time, and court attendance) is billed at a separate rate of $200 per hour.

In addition to therapy sessions, please be aware that you will be charged a fee (not covered by insurance) prorated at the hourly out of pocket rate for work conducted between sessions. This includes, but is not limited to: phone, email or text conversations which exceed 15 minutes in length.

Other non-therapy requests for report writing, meetings with schools, etc. will be discussed on a case by case basis and will also be billed at a rate of $200 per hour, paid in advance.

____ I understand that I will be billed for my time and I acknowledge responsibility for paying for these services in full.

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FINANCIAL RESPONSIBILITY AGREEMENT

I offer two plans for payment of fees. Please check the payment plan you would like to use.

____Plan A: Private pay which means you pay in full at each appointment by cash, check or credit card. The agreed upon amount for psychotherapy services is $175 for 50 - 60 minute psychotherapy sessions.

____Plan B: Bill our insurance company and you pay your co-pay at each visit.

It is my policy to bill your insurance company as a courtesy. Please remember that you are responsible for fees not covered by your insurance company. If paying by check, please write your check in advance so that time during our session will not be taken up with preparing payment.

GUARANTOR

The financial guarantor is the person responsible for payment of the account. Complete this form in its entirety if the financial guarantor for this account is someone other than the client listed on the registration information form.

Name of Guarantor: _____ DOB: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Relationship to Client: _____

As a guarantor for this account, I acknowledge my responsibility for payment of this account, until revoked in writing by me. I understand that, if I am using insurance Phelps Counseling & Consulting will submit claims on my behalf. I am responsible for any and all balances on this account (i.e., any charges not reimbursed by the insurance company). If I have questions regarding the payment of claims, I will contact my insurance company for clarification.

Guarantor's Signature: _____ Date: _____

PRIVACY AND CONFIDENTIALITY POLICIES

_____ I have received the Notice of Privacy Practices, describing how my confidential information may be used and disclosed.
_____ I consent to the use of disclosures of any information in the patient record for the purpose of conducting treatment, payment, or health care options. I understand this consent is valid until revoked by me.

I understand and take full responsibility for the information above.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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APPOINTMENT REMINDERS

You will receive an appointment reminder to your cell phone (via text message), your email address or your home phone (via a voice message) before your scheduled appointments.

Your Name: _____

Your email address: _____

Your home phone number: _____

Your cell phone number: _____

How would you like to receive appointment reminders? (Check one)

____ Via text message on my cell phone (normal text message rates will apply)

____ Via an email message to the address listed above

____ Via an automated telephone message to my home phone.

Appointment information is considered to be "Protected Health Information" under HIPPA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above.

_____ _____

Signature Date