



## **INFORMED CONSENT, GENERAL INFORMATION, AND FEE STRUCTURE**

The following is an overview of psychotherapy services and clinical fee structure. This is used to provide a clear and mutual understanding of the professional and business aspects of my services. Please read this information carefully and feel free to ask me about anything that is unclear to you and/or to share concerns about those issues.

**CONFIDENTIALITY:** All client information is confidential and will be protected under the HIPAA Privacy Policy. A copy of my privacy policy will be made available to you online through my website or in print. Generally, issues discussed in therapy are important and are generally legally protected as both confidential and “privileged.” **However, there are limits to the privilege of confidentiality.** These situations include:

- 1) suspected abuse or neglect of a child, elderly person or a disabled person,
- 2) when I believe you are in danger of harming yourself or another person or you are unable to care for yourself,
- 3) if you report that you intend to physically injure someone the law requires me to inform that person as well as any legal authority,
- 4) if I am ordered by a court to release information as part of legal involvement in company litigation, etc.
- 5) when your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
- 6) in natural disasters whereby protected records may become exposed, or
- 7) when otherwise required by law.

You may be asked to sign a Release of Information so that I may speak with other mental health professionals or to family members.

In order to assist with insurance reimbursement, diagnosis, treatment plans, and progress, information may be requested by your insurance carrier. Be advised some insurance companies are requesting detailed information.

To enhance the quality of treatment services, other mental health professionals are periodically consulted regarding specific cases. They may also provide coverage during my absence. These professionals are bound by ethical and legal standards regarding confidentiality, and information will not be used for any public or media purpose. If this arrangement raises concerns for you or violates your sense of privacy, please discuss this with me.

**CLIENT RIGHTS:** You have the right to end therapy at any time without moral, legal, or financial obligation beyond payment due for completed sessions or any missed appointments for which you are responsible. Therapy termination can sometimes be the result of misinterpretation, miscommunications, and the painfulness of the material being dealt with. Should you decide between sessions to withdraw from therapy, I ask that you attend one more session to discuss your reasons prior to making a final decision. If you decide to terminate, yet desire to continue therapy elsewhere, I will be able to provide you with names of other qualified therapists. You have the right to ask questions about philosophy of therapy, assessment findings and results, experience with your presented issues, treatment plans, and procedures used.

### **FEE STRUCTURE**

(unless insurance restrictions apply)

INITIAL EVALUATIONS:	\$160 per 60 minute session
INDIVIDUAL THERAPY:	\$115 per 45 minute session \$160 per 60 minute session
FAMILY THERAPY:	\$115 per 45 minute session \$160 per 60 minute session
GROUP THERAPY:	\$60 per 90 minute session \$40 per 60 minute session
TRAVEL TIME:	\$25 per 10 minute increment

**MISSED APPOINTMENTS:** A \$40 cancellation fee will be charged if the cancellation is not received within 24 hours of the scheduled appointment time. **PLEASE NOTE: Insurance companies do not pay for missed sessions.** If there are numerous missed or cancelled sessions, with notice or without, this will be discussed during the following therapy session for solutions.

**TELEMENTAL HEALTH:** Most insurance companies allow telemental health. Sessions will be billed at the same rates above, unless there is another arrangement. Should your insurance company decide not to cover telehealth sessions, you will be responsible for the unreimbursed session rate.

**PHONE CALLS:** If it is necessary to provide frequent intervention by phone, calls will be billed at the usual rate of \$115 per 45 minute session. **PLEASE NOTE: Insurance companies do not pay for sessions conducted over the telephone.**

**INSURANCE/SCHOOL REPORTS:** Billed at \$160 per hour.

**COURT FEES:** \$200 per hour (paid in advance). This includes preparation, travel and waiting times. There will be a cancellation fee of \$200 for court appearances cancelled less than 48 hours prior to the scheduled time.

Special requests for letters to employers, attorneys, physicians, etc. will be billed at \$160 per hour of preparation.

**UNPAID BALANCES:** All fees are payable at each session. Please notify me when financial circumstances make it difficult to pay your bill on a weekly basis. Large balances may result in straining our relationship and the work we do together. All balances due after 30 days will be subject to a 1.5% monthly charge (18% annually).

**COLLECTIONS POLICY:** In the event that therapy is ended and a bill is left unpaid, your name, address, and phone number, and possibly social security number, will be given to a collection agency in order to collect payment. ***A collection fee of 50% will be passed on/added to the past due amount to cover the cost of the collection agency fee.***

**EMAIL AND TEXT MESSAGING COMMUNICATIONS:** A secure messaging function, similar to text messaging, is available through the Simple Practice portal and is the preferred method of communicating. Sometimes, this function is not available to every client; therefore, email and text communications can provide a great deal of convenience both to the patient/patient's family and myself. Please be aware, however, non-encrypted email and text messaging are NOT considered confidential nor secure. Further, neither non-encrypted email nor text messaging meet HIPAA standards for confidentiality of protected healthcare information. Please decide the following:

I authorize New Day Counseling, LLC/Perette Halpin, LCSW-C to communicate by non-encrypted **email** with me as necessary for my/patient's health care and treatment. I agree that non-encrypted **email messages** may include protected healthcare information about me/the patient whenever necessary.

\*If AGREE, please identify preferred **email** address and initial below:

\_\_\_\_\_ Initials: \_\_\_\_\_

If DISAGREE, please initial here: \_\_\_\_\_

I authorize New Day Counseling, LLC/Perette Halpin, LCSW-C to communicate by **text message** with me as necessary for my/the patient's health care and treatment. I agree that **text messages** may include protected healthcare information about me/the patient whenever necessary.

\* If AGREE, please identify preferred phone number for **texting** and initial below:

\_\_\_\_\_ Initials: \_\_\_\_\_

If DISAGREE, please initial here: \_\_\_\_\_

By signing below, I hereby release New Day Counseling, LLC/Perette Halpin, LCSW-C, representatives, and agents from any and all liability that may arise from the release of information as I have directed in the preceding two sections of this document. I understand I have the right to revoke any Authorization at any time. If I want to revoke any Authorization, I must do so in writing to New Day Counseling, LLC/Perette Halpin, LCSW-C. I understand that if I revoke any Authorizations, it will not

apply to information released as a result of this Authorization. I understand I/patient cannot be denied or refused treatment if I refuse to sign for these authorizations.

\*Signature of Authorization \_\_\_\_\_

## **INSURANCE**

Initial preauthorization for services is the client's responsibility. Each client is responsible to learn the details of their insurance policy and to comply accordingly. Failure to obtain authorization for services will result in client's responsibility for the full fee. I will provide necessary information and statements for insurance reimbursement.

I am currently paneled with most plans within BlueCross/BlueShield and Carefirst, Cigna, Johns Hopkins, Medicare, TRICARE, U.S. Family Healthcare, and the following EAPs: Cigna and Behavioral Health Services (BHS). If your company is not listed here, call Member Services to see if you have "out-of-network" benefits. A "superbill" can be provided if you wish to submit to your insurance company for reimbursement.

## **OFFICE INFORMATION**

In order to keep costs to a minimum, a confidential voice mail is utilized which is routinely screened during the work day, Monday through Friday. Although my goal is to return calls as soon as possible, all calls will be returned within 48 hours or the following business day.

This practice cannot provide 24-hour emergency service. If there is a crisis or emergency situation, please utilize your local hospital emergency room, psychiatrist, physician, etc. Hotline numbers are: Crisis Text Line 741741; 800-SUICIDE (784-2433); 800-273-TALK (8255); or 800-422-0009 (Maryland only). Frederick County Mental Health Association provides a range of services, including walk-in services during the week. Visit <https://fcmha.org/how-we-help/behavioral-health> for more information. Persons who require frequent crisis intervention or hospitalization for major mental illness where symptoms include frequent suicide attempts or suicidal/homicidal ideation, and psychotic thought processes such as auditory or visual hallucinations will only be accepted if client is in active treatment with a psychiatrist. Otherwise, referral options will be discussed. Weekend and holiday coverage are provided on a very limited basis. Vacation coverage is arranged through an agreement with each individual client.

I have read and understand the terms listed in the Informed Consent, General Information, and Fee Structure form.

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Printed Name of Client and/or Parent/Guardian

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Signature

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Date