HEALING RECOVERY THERAPY, LLC

715 W 1st St #5 Cedar Falls, IA 50613-2617
Sandy Healey, LISW #03550, IAADC, SAP

Informed Consent Contract

This agreement is intended to provide you with important information regarding services and office policies. Please read the entire document carefully and ask your therapist any questions regarding its contents prior to signing it.

Confidentiality
Therapy is both a confidential and professional relationship. What you communicate during the course of treatment is protected by legal, professional, and ethical standards. Information gathered during the course of treatment may not be released without your prior written consent. However, Iowa Law has placed specific limits on the confidentiality of the therapeutic relationship.

According to Iowa State Law, this Therapist and Practice has a legal obligation to breach confidentiality under the following circumstances:
1. If the therapist determines, or has reasonable cause to believe, the client is in such mental or emotional condition as to be dangerous to him/herself or to the person or property of another and the disclosure of confidential information is necessary to prevent the threatened danger.
2. If a therapist knows or reasonably suspects a child is being abused or neglected.
3. If a therapist has reasonable knowledge or suspicion that a person over age 65 or a dependent adult has been physically abused.
4. In cases of threatened suicide, the therapist has a legal duty to take reasonable steps to prevent it.
5. If requested by the client or compelled by Judicial court order.

Contacting Us
We are often not immediately available by telephone. We do not answer our phones while we are with clients or otherwise unavailable. At these times, you may leave a confidential voicemail message and we will get back to you as soon as possible, but it may take a day or two for non-urgent matters. Please be aware there are confidentiality risks associated with communicating via text and email.

Record Keeping and Emergencies
Records of conversations either in person, on the phone, or by electronic communication such as email or text messaging include a brief synopsis of the conversation. A judge can subpoena your records for a variety of reasons, and if this happens, confidentiality cannot be ensured for any form of communication through electronic media, including text messages. As a result, text messages are only regarding your appointment times. No response will be given to text messages that are clinical in nature; these issues will be discussed in person only.

We are unable to provide 24-hour crisis service. In the event that you are feeling unsafe or require immediate medical or mental health assistance, please be aware of the following resources:
- 911 or go to the nearest emergency room
- 24-Hour Crisis Line: 1-800-332-4224 or 319-362-2174
- Crisis Text Line: Text “start” or “go” to 741741
- National Suicide Prevention Lifeline: *988

Social Media Policy
We will not friend or follow you on social media platforms. We also will not accept any friend/follow requests from clients or client’s family members in order to protect confidentiality and ensure appropriate boundaries are maintained.

Professional Consultation and Supervision
Professional consultation is an important component of a healthy therapy practice. As such, therapists regularly participate in clinical, ethical, and legal consultations with appropriate professionals. Additionally, in accordance with Iowa State Law Licensing Regulations, all pre-licensed therapists receive individual and group supervision. Therefore, confidentiality will not be maintained.

Rights
If at any time, you have questions or concerns regarding the services you receive, we strongly encourage you to discuss them with your therapist. If a reasonable resolution has still not been achieved, you have the right to request a meeting with the supervisor to discuss your concerns.

Termination of Treatment
You have the right to decide to end treatment. If you are thinking about ending therapy, we encourage you to discuss this with your therapist so that they may minimize terminating treatment against medical advice. If termination of treatment is indicated, we can provide you with names of other mental health providers. Your therapist has the right to terminate therapy due to, but not limited to, the following reasons: untimely payment of fees, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy, a client’s needs are outside the therapist’s scope of competence or practice, or a client is not making adequate progress in therapy, threats of violence or harm to therapist in any way including legal action. Services can be terminated if there is concern for dual relationship such as intimacy or sexual relationship initiated by the client.

Non-Subpoena Policy
No Party shall attempt to subpoena records for a deposition or court hearing of any kind for any reason. All Parties acknowledge that the goal of psychotherapy is the amelioration of psychological distress and interpersonal conflict, and that the process of psychotherapy depends on trust and openness during the therapy sessions.

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Telehealth Consent

1. The laws that protect the confidentiality of medical information also apply to telehealth. As such, information disclosed during the course of therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality. Refer to the Informed Consent Contract for details regarding confidentiality. The dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without written consent.

2. There are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of medical information could be disrupted or distorted by technical failures; the transmission of medical information could be interrupted by unauthorized persons; and/or the electronic storage of medical information could be accessed by unauthorized persons.

Telehealth-based services and care may not be as complete as face-to-face services. If my therapist believes that treatment may be better served by another form of therapeutic services (e.g., face-to face services), appropriate referrals will be made to a provider in my area. Finally, there are potential risks and benefits associated with any form of therapy, including the possibility of experiencing some discomfort and unpleasant feelings. There may be benefits from telehealth, but that results cannot be guaranteed or assured.

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Notice of Privacy Practices for Protected Health Information

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as their rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information. See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in plain language that describes:

- How the covered entity may use and disclose protected health information about an individual. • The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any website it maintains that provides information about its customer services or benefits.

Health Plans must also:

- Provide the notice to individuals then covered by the plan and to new enrollees at the time of enrollment.
- Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
- Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.

Covered Direct Treatment Providers must also:

- Provide the notice to the individual no later than the date of first service delivery and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document their efforts to obtain the acknowledgment and the reason why it was not obtained.
- When first service delivery to an individual is provided over the Internet, through email, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
- In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
- Make the latest notice available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

A covered entity may email the notice to an individual if the individual agrees to receive an electronic notice.
See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

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Acknowledgement of Informed Consent Contract

I have read the Informed Consent Contract fully and completely, I have discussed any questions I had about the information with my therapist, and I understand the information. I consent to my therapy treatment and I agree to the terms and conditions.

_____ _____
Signature (client) Date

Acknowledgment of Telehealth Consent

I have received and hereby consent to engaging in telehealth as part of my therapy. I understand that telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth could also involve the communication of my medical/mental health information, both orally and visually, to health care practitioners located in Iowa or outside of Iowa with a signed release.

_____ _____
Signature (client) Date

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this form, I acknowledge that I have received the Notice of Privacy Practices (NPP).

_____ _____
Signature (client) Date

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Client Registration Information

Client Name: _____ Date of Birth: _____
Home Address:_____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____Email: _____
Gender: _____
Marital Status: _____

Employment: Employed Student Unemployed/Retired

Complete if client is a minor:
Caregiver's Name: _____Date of Birth_____
Caregiver's Name:_____Date of Birth: _____
Complete for each additional client:
Name: _____Date of Birth: _____
Relationship to Client: _____Phone: _____

Primary Insurance Information:
Insurance Type: _____Relationship to Insured: _____
Insured's ID Number: _____Group Number: _____
Employer/School:_____
Plan Name: _____Effective Date:_____
Copay Amount: _____Deductible Amount: _____

Responsible Party for Billing:_____
Primary Care Physician: _____Psychiatrist:_____

Secondary Insurance Information:
Insurance Type: _____Relationship Insured:_____
Insured's ID Number: _____ Group Number:_____
Copay Amount: _____ Deductible Amount: _____

How did you hear about us? Psychology Today/Internet/Family/Friend/Provider (who?)
_____

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Insurance and Financial Agreement

Session Information
Each therapy session lasts between 45-60 minutes. Typically, sessions are 50 minutes in length and take place on a weekly or biweekly basis, at a mutually agreed date and time.

All fees are to be paid at the time of service. Upon verification of your eligibility and benefits, your insurance carrier will be billed for you, and your therapist will be paid directly by the carrier. You are responsible for any applicable deductibles, co-payments, co-insurance, or session fees that are not covered by your carrier *at the time of service. This includes full fee for service when deductibles are being met.*

Certain insurance plans have pre-determined fee arrangements that may be different than the amounts mentioned in this agreement. Please be aware that if you are being seen with your out-of-network benefits, some insurance carriers may send you the session payment directly. This payment is to be given to your provider for payment of services rendered.

It is the responsibility of the insured to present secondary or tertiary coverage at the time of initial visit. If not presented at the initial visit, the client will be responsible for filing secondary claims themselves. The client is also responsible for keeping track of changes, including visit limitations. Any information or statements written here are not a guarantee to make benefits and/or payment and are subject to payment of premiums, as well as, policy limitations and exclusions outlined in your plan guidelines. The information above including our network status was obtained based on the questions asked of your Insurance Carrier when checking benefits. Network status is based on information given to the practice by your insurance carrier when verifying benefits. It's recommended that you check with your insurance directly to obtain network status. No insurance carrier will guarantee benefits until a claim is received in their office and reviewed for medical necessity. Please note any insurance carrier has the right to deny any type of claim including therapy, other services or supplies for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Also, there is a sliding scale out-of-pocket fee offered on a case-by-case basis. If you feel a reduction is warranted, please ask your therapist. A superbill can be provided upon request; however, there is no guarantee that your insurance plan will reimburse you for the session.

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No-Show and Cancellation

Once your appointment is scheduled, you are required to cancel directly with your therapist 24 business hours prior to your scheduled session. If your appointment is on a Monday, you must cancel on Sunday before 3pm to be within policy. Please contact your therapist directly for all communication, scheduling, and cancellations. If you no-show or cancel less than 24-hour notice, you may be responsible for the entire cost of the session which includes the amount billed to insurance, co-payments, coinsurance, and deductibles as insurance plans do not reimburse for missed and canceled appointments. Payment for no-show or late cancellation is due prior to scheduling another session. Mitigating circumstances may be considered.

There are waiting lists and thus, no-shows or late cancellations take away from other clients seeking treatment. We understand that certain emergencies arise that are beyond your control, however, if excessive no-shows or late cancellations occur, this will result in a termination of treatment. Please discuss any concerns with your therapist in these circumstances.

Automatic payments (Auto-pay)
Simple Practice (EHR that I utilize) allows for automatic payment of deductibles and fees invoiced. Payment for co-pays and other services are expected at time of service. Auto-pay allows you to simplify this process for your convenience.

Private Pay Fee schedule:
50-60 minutes: $125
40-49 minutes: $100
30 - 39 minutes: $75

Other Services/Fees
- Returned Check Fee $20
- Document Copy Services $20 + 25 cents per copy
- Written reports and/or letter $80-$160
- Professional Consultation (responding to Subpoenas, Doctor, Lawyer, etc.) $80- $160/hour

Delinquent Accounts
Any unpaid balances past 30 days will result in a delinquent account and collection procedures may begin. If collection procedures are initiated, an attempt to contact you directly will occur. If your account remains delinquent, past 90 days, an outside collection agency may be used. In such cases, non-clinical information (as given on the New Client Information form) may be released to assist in the collection of the amount due.

I authorize you to bill my private insurance plan: _____

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OR

Private Pay and Fee Agreement

I am responsible to pay fees for each session in accordance with the patient responsibility listed on the Explanation of Benefits, which is issued by my private insurance carrier, including copays and deductibles. If my insurance carrier denies the claim, I am financially responsible for the billed amount.

_____
Client Name

_____ _____
Name of Responsible party Date

Credit Card Authorization
All private pay clients are required to keep a valid credit card on file. For your convenience, this credit card will only be used as a form of payment for fees incurred for services.

Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express Card Number:

_____ Exp. Date: _____ CVV Code: _____

Name as Printed on Card:
_____
Billing Address:
_____
Street and Number, City, State, Zip

I agree that all the information provided is accurate and complete. With my signature, I certify that I am an authorized signer on the above credit card account. I authorize charges to my credit card for services rendered according to the terms specified in this Agreement.

_____
Authorized Cardholder

Signature _____Date _____

Print Client Name _____

Signature of Person Financially Responsible_____Date_____