Client Name: _____ **Date:** _____

Emotional and Behavioral Therapy Agreement for Service

PAYMENT AND INSURANCE INFORMATION

Emotional and Behavioral Therapy (EBT or Provider) will bill your insurance company at a rate of $175 per session. This is considered reasonable and customary. We are in network with most major insurance companies. This means that whatever We bill to them, they only pay the rate we have contracted with them. If you wish to know that amount, we will tell you. This also means that we are not allowed to balance bill you for the difference. Your copayment plus amount the insurance company sends us is equal to all clients in that plan. If you have any questions regarding this fee, please let us know and we will discuss it. If you are self-pay (not using insurance) your session rate is $what is agreed upon between you and EBT per session. You decide how many sessions you may need and when you are done with therapy, unless the therapist feels you are not a good match for her/his scope of practice.

If you have an emergency, please call 911 or go to your nearest emergency room. Another option if you just need to talk to someone is to call Mobile Crisis at 865-539-2409. We are not an on-call therapist provider; please respect our time as we do our best to respect yours.

FINANCIAL AGREEMENT

IF YOU MUST CANCEL OR CHANGE YOUR SCHEDULED APPOINTMENT, AT LEAST 24 HOURS PRIOR NOTICE IS REQUIRED TO AVOID BEING CHARGED FOR THE MISSED SESSION

~FEES:

PLEASE BE ADVISED THAT FEES MUST BE PAID AT THE TIME SERVICES ARE RENDERED, THE DAY OF, OR WE MAY BILL YOUR COPAY THAT MORNING.

~The fee for individual sessions is the amount agreed upon between you and EBT per session. Per your agreement with your insurance company, you are responsible for your copayment/co-insurance payment to be paid to EBT. If you cancel your appointment with less than 24 hours of notice or do not show up you will be charged $50 for the appointment.

~You must have a credit card on file. Please fill out the Credit Card Authorization Form included in the intake documents.

~You agree to allow EBT charge your credit card for each appointment scheduled for copays, deductibles your insurance company is applying the payment toward, co-insurance, missed appointments, etc.

~We provide teletherapy and use ZocDoc, PsychologyToday, Doxy.me, or other HIPAA compliant software telehealth platform. We make sure your session is confidential in our office; it is your responsibility to be in a confidential setting to protect your personal information.

~We do not do telephone, text, or email therapy. You are welcome to email your provider, if your provider invites you to do so, with any issues you have to discuss in your next session, but understand, she/he may not respond. Please understand HIPAA privacy when emailing or texting. EmailsI and text are not secure. If you choose to email, it is with your understanding that your personal information may not be protected.

~Additional Fees:

~Providers of EBT do not partake in court proceedings. Should provider be subpoenaed or **required** to participate in any sort of legal matters (including but not limited to appearances, correspondence, consultations with attorneys, expert opinions, or creation of any documents which will be used for legal purposes), the client (NOT the insurance company) will be billed at a rate of $350 per hour and a NONREFUNDABLE two hour minimum per day fee which must be paid 1 week prior to service. This per scheduled date fee will be billed for each date the provider has to block their schedule for legal services.

~Non-legal documents which the provider agrees to complete will be billed at $50 per document

~Medical records can be provided upon request. A rate of $20 for the first 5 pages and $.50 per page thereafter. Please allow up to 1 week for records to be obtained.

~A missed or cancelled session in less than 24 hours will be charged a $50 fee

~Fees for service are due at the time service is rendered. This includes all self-pay, copays, etc. If you are using insurance, per your agreement with your insurance company, copays cannot be waived or adjusted. A credit card will be kept on file for the purpose of collecting fees. If a credit card charge is disputed by you or your bank, you are giving permission for proof of payment to be disclosed. This includes your consent to waive your privacy rights.

~Fees will be charged the day of your appointment.

FEES AND PAYMENT FOR SERVICES

You may be required to pay for services and other fees. You will be provided with these costs prior to beginning therapy, and should confirm with your insurance if part or all of these fees may be covered. You should also know about the following:

No-Show and Late Cancellation Fees

• If you are unable to attend your therapy session, you must contact EBT 24 hours before your session. Otherwise, you will be subject to fees outlined in this fee agreement. Insurance does not cover these fees.

Balance Accrual

• Full payment is due at the time of your session. If you are unable to pay, tell EBT. If not, your Provider may refer you to other low- or no-cost services. Any balance due will continue to be due until paid in full. If necessary, your balance may be sent to a collections service.

Administrative Fees

• EBT or your Provider may charge administrative fees for writing a letter or report at your request; consulting with another healthcare provider, or other professional outside of normal practices or for preparation, travel, and attendance at a court appearance. These fees are listed in the fee agreement. Payment is due in advance.

Insurance Benefits

Before starting therapy, you should confirm with your insurance company if:

• Your benefits cover the type of therapy you will receive;
• Your benefits cover in-person and telehealth sessions;
• You may be responsible for any portion of the payment; and
• EBT or your Provider is in-network or out-of-network.

Sharing Information with Insurance Companies

• If you choose to use insurance benefits to pay for services, you will be required to share personal information with your insurance company. Insurance companies keep personal information confidential unless they must share it to act on your behalf, comply with federal or state law, or complete administrative work.

Covered and Non-Covered Services

• When EBT or your Provider is in-network, they have a contract with your insurance company. Your insurance plan may cover all or part of the cost of therapy. You are responsible for any part of this cost not covered by insurance, such as deductibles, copays, or coinsurance (not balance billing). You may also be responsible for any services that are provided that not covered by your insurance.

• When EBT or your Provider is out-of-network, they do not have a contract with your insurance company. You can still choose to see your Provider; however, all fees will be due at the time of your session to EBT. EBT will tell you if they can help you file for reimbursement from your insurance company. If your insurance company decides that they will not reimburse you, you are still responsible for the full amount.

Payment Methods

• EBT requires that you keep a valid credit or debit card on file. This card will be charged for the amount due at the time of service and for any fees you may accrue unless other arrangements have been made with EBT ahead of time. It is your responsibility to keep this information up to date, including providing new information if the card information changes or the account has insufficient funds to cover these charges.

GOOD FAITH ESTIMATES

- You will only owe for the sessions you attend. If you cancel within less than 24 hours for your appointment or don't show up you will owe $50 for the missed session.
- Charges per session: $175 is billed to insurance. You are only responsible for the amount in your agreement with your insurance company (copayment, amounts applied to your deductible, co-insurance, etc.), or what is agreed up between EBT and yourself.
- Itemized description of each item/service: 53-minute session (procedure code 90837, 90847, 90846) billed to insurance at $175 per session.
- Most common diagnosis code(s) itemized: Major Depressive Disorder (F32.9), Anxiety Disorder (F41.9), Adjustment Disorder (F43.20), and Post-Traumatic Stress Disorder (F43.10)

Provider: Licensed Professional
Company: Emotional and Behavioral Therapy
NPI: 1356610919
TIN: 863733196
At: 915 Eagle View Dr Kodak, TN 37764

- This Good Faith Estimate (GFE) is only an estimate of items/services reasonably expected to be furnished at the time and final items, services, or charges may differ. If there is a price increase you will be notified 1 month in advance.
- Additional recommended items or services may be part of the course of care but are not reflected in the GFE
- You have a right to initiate the patient-provider dispute resolution (PPDR) process if the actual billed charges are substantially greater than the estimated charges

Disputes

- Although the information provided in the GFE is only an estimate, and the actual items, services, or charges may differ from what is included in it, uninsured or self-pay individuals may challenge a bill from a provider through a new patient-provider dispute resolution (PPDR) process if the billed charges substantially exceed the expected charges in the GFE. "Substantially exceeds" means an amount that is at least $400 more than the expected charges listed on the GFE.
- This estimate is not a contract and does not require the individual to obtain the items or services from any of the providers or facilities identified.

CONFIDENTIALITY STATEMENT/HIPAA/NOTICE OF PRIVACY PRACTICES

All therapy sessions are to be considered strictly confidential except when the law regarding confidentially takes precedence or overrules this right to privacy. Such occasions may include, and are not limited to:
~A subpoena or other form from the court
~Report or suspicion of child, elderly, or other vulnerable person abuse or neglect
~Your informed consent in writing to share therapeutic information. This consent is subject to revocation in writing at any time except to the extent that action has been taken in reliance thereon
~Provider may share your information with a peer support when needed and is subject to confidentiality
~A crisis situation (Report of suspicion to hurt self or others)
~For reimbursement purposes (i.e.: insurance, etc.)
This information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. The information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

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

EBT and your Provider is committed to protecting your privacy. EBT and your Provider is required by federal law to maintain the privacy of Protected Health Information ("PHI"), which is information that identifies or could be used to identify you. EBT and your Provider is required to provide you with this Notice of Privacy Practices (this "Notice"), which explains EBT's and your Provider's legal duties and privacy practices and your rights regarding PHI that we collect and maintain.

YOUR RIGHTS

Your rights regarding PHI are explained below. To exercise these rights, please submit a written request to EBT or your Provider at the address noted below.

To inspect and copy PHI.

• You can ask for an electronic or paper copy of PHI. EBT and your Provider may charge you a reasonable fee.
• EBT and your Provider may deny your request if it believes the disclosure will endanger you or another person. You may have a right to have this decision reviewed.

To amend PHI.

• You can ask to correct PHI you believe is incorrect or incomplete. EBT and your Provider may require you to make your request in writing and provide a reason for the request.
• EBT and your Provider may deny your request. EBT and your Provider will send a written explanation for the denial and allow you to submit a written statement of disagreement.

To limit what is used or shared.

• You can ask EBT and your Provider not to use or share PHI for treatment, payment, or business operations. EBT and your Provider is not required to agree if it would affect your care. If you choose this option you are responsible for payment in full.
• If you pay for a service or health care item out-of-pocket in full, you can ask EBT and your Provider not to share PHI with your health insurer.
• EBT and your Provider will only share information with family or friends IF YOU request it and sign a Release of Information/Consent to Share Information. You can ask for EBT and your Provider not to share specific PHI with family members or friends by stating the specific restriction requested and to whom you want the restriction to apply.

To obtain a list of those with whom your PHI has been shared.

• You can ask for a list, called an accounting, of the times your health information has been shared. You can receive one accounting every 12 months at no charge, but you may be charged a reasonable fee if you ask for one more frequently.

To receive a copy of this Notice.

• You can ask for a paper copy of this Notice, even if you agreed to receive the Notice electronically.

To choose someone to act for you.

• If you have given someone medical power of attorney or if someone is your legal guardian or conservator, that person can exercise your rights without your consent.

To file a complaint if you feel your rights are violated.

• You can file a complaint by contacting EBT or your Provider using the following information:

Emotional and Behavioral Therapy
915 Eagle View Dr Kodak, TN 37764
865-851-1414

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
• EBT and your Provider will not retaliate against you for filing a complaint.

To opt out of receiving fundraising communications.

OUR USES AND DISCLOSURES

1. Routine Uses and Disclosures of PHI

EBT and your Provider is permitted under federal law to use and disclose PHI, without your written authorization, for certain routine uses and disclosures, such as those made for treatment, payment, and the operation of our business. EBT and your Provider typically uses or shares your health information in the following ways:

To treat you.

• EBT can use and share PHI with other professionals who are treating you ONLY WITH your consent.
• Example: Your primary care doctor asks about your mental health treatment.

To run the health care operations.

• EBT and your Provider can use and share PHI to run the business, improve your care, and contact you.
• Example: EBT uses PHI to send you appointment reminders if you choose.

To bill for your services.

• EBT and your Provider can use and share PHI to bill and get payment from health plans or other entities.
• Example: EBT gives PHI to your health insurance plan so it will pay for your services.

2. Uses and Disclosures of PHI That May Be Made Without Your Authorization or Opportunity to Object

EBT and your Provider may use or disclose PHI without your authorization or an opportunity for you to object, including:

To help with public health and safety issues

• Public health: To prevent the spread of disease, assist in product recalls, and report adverse reactions to medication.
• Required by the Secretary of Health and Human Services: We may be required to disclose your PHI to the Secretary of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.
• Health oversight: For audits, investigations, and inspections by government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
• Serious threat to health or safety: To prevent a serious and imminent threat.
• Abuse or Neglect: To report abuse, neglect, or domestic violence upon vulnerable persons.

To comply with law, law enforcement, or other government requests

• Required by law: If required by federal, state or local law.
• Judicial and administrative proceedings: To respond to a court order, subpoena, or discovery request.
• Law enforcement: For law to locate and identify you or disclose information about a victim of a crime.
• Specialized Government Functions: For military or national security concerns, including intelligence, protective services for heads of state, or your security clearance.
• National security and intelligence activities: For intelligence, counterintelligence, protection of the President, other authorized persons or foreign heads of state, for purpose of determining your own security clearance and other national security activities authorized by law.

• Workers' Compensation: To comply with workers' compensation laws or support claims.
To comply with other requests
• Coroners and Funeral Directors: To perform their legally authorized duties.
• Organ Donation: For organ donation or transplantation.
• Research: For research that has been approved by an institutional review board.
• Inmates: EBT and your Provider created or received your PHI in the course of providing care.
• Business Associates: To organizations that perform functions, activities or services on our behalf.

3. Uses and Disclosures of PHI That May Be Made WITH Your Authorization or Opportunity to Object
Unless you object, EBT and your Provider may disclose PHI:
-To your family, friends, or others **if** PHI directly relates to that person's involvement in your care.
-If it is in your best interest because you are unable to state your preference.
-In a crisis situation.

4. Uses and Disclosures of PHI Based Upon Your Written Authorization
EBT and your Provider must obtain your written authorization to use and/or disclose PHI for the following purposes:
-Marketing, sale of PHI, and psychotherapy notes.

You may revoke your authorization, at any time, by contacting EBT or your Provider in writing, using the information above. EBT and your Provider will not use or share PHI other than as described in the Notice unless you give your permission in writing.

OUR RESPONSIBILITIES
• EBT and your Provider is required by law to maintain the privacy and security of PHI.
• EBT and your Provider is required to abide by the terms of this Notice currently in effect. Where more stringent state or federal law governs PHI, EBT and your Provider will abide by the more stringent law.
• EBT and your Provider reserves the right to amend this Notice. All changes are applicable to PHI collected and maintained by EBT and your Provider. Should EBT and your Provider make changes, you may obtain a revised Notice by requesting a copy from EBT or your Provider, using the information above, or by viewing a copy on the website ebtherapy.org, click on 'Forms' and 'Client Information – Complete Agreement'.
• EBT and your Provider will inform you if PHI is compromised in a breach.

INSURANCE AGREEMENT

If we bill your insurance, we will verify it and let you know how or if they will pay to the best of our ability. You must meet your deductible and out of pocket expenses per your agreement with your insurance company. Until then, payment is due in full upon services rendered. Copay is always due at the time of the appointment. Credit card on file will be billed if other arrangements are not made in advance. Unfortunately, insurance companies are not always accurate when called to get eligibility and copay information. We will do our best to get the correct amount of your copay but we do not know the exact amount until we receive the Explanation of Benefit from your insurance company, which could take a month or more. So, the amount you are initially quoted may change.

Your signature acknowledges that you (the client, parent, or legal guardian) are responsible to EBT for all charges incurred. You agree that your insurance will send payment to EBT and you understand the privacy laws and HIPAA policies. If your insurance is billed and does not pay, you will be responsible for the payment. This also acknowledges your receipt and understanding of your Legal and Human Rights and HIPAA information.

ASSIGNMENT OF BENEFITS

We require insured clients to complete assignment of benefits authorizing Insurance to remit payment to provider's office. You hereby assign all medical benefits to include major medical benefits to which w EBT and your Provider is entitled, private insurance, and any other health plans to EBT. This assignment will remain in effect until revoked by you in writing. A photocopy of this assignment is to be considered as valid as an original. You understand that you are financially responsible for all charges whether or not paid by said insurance. You hereby authorize said assignee to release all medical information necessary to secure the payment.

Acknowledgement

You authorize EBT and your Provider to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf. This authorization extends to the extent necessary to obtain payment for the services provided, and includes authorization to release information about mental health, substance use, or other diagnoses as required. In consideration of the services provided, you assign all benefits to EBT if accepted, and authorize your insurance company(ies), Medicare, or other third-party payers to make payments directly to EBT and its affiliates. You understand that you remain responsible for all amounts due, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by your insurance plan (including those that fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary.

CONSENT FOR SERVICE

EBT and your Provider collects information from you and stores it in written and electronic formats. This is your information. The information is the property of EBT and your Provider, but the information is accessible to you. EBT and your Provider protects the privacy of your information. The law permits EBT and your Provider to use or disclose your health information for the following purposes:
• Service: Your health information can be used or disclosed by EBT and your Provider to enable her/him to provide you with service.

• Payment: Your information can be used or disclosed by EBT and your Provider to enable receipt of payment.
• Operations: Your information can be used or disclosed by EBT and your Provider for operational purposes.
Once you sign this agreement, it will be in effect indefinitely until you revoke your general written consent. You may revoke your general written consent at any time (in writing), except to the extent that we have already relied upon it. For example, if we provide you with service before you revoke your general written consent, we may still share your information in order to obtain payment for that service. To revoke your general written consent, please write to EBT.
I hereby authorize EBT and my Provider:
~ To access information from my history and records.
~ To share my information with peer supports as needed, confidentiality applies.
~ To administer and perform any examinations, services, or diagnostic procedures deemed necessary.
I understand
~ I may be asked to give specific consent for certain procedures.
~ I have the right to refuse diagnostics, services, or to revoke this consent in writing.
~ In order to provide the best possible service, my therapist may consult with other professionals (peer supports) about issues directly related to my service, confidentiality applies.
~ On occasion students and other Social Workers or professionals are supervised. It is my choice if I want them present in my session.
~ Any information, which is part of my record with EBT and your Provider will be treated with strictest confidentiality.
~ Service may be discontinued at any time by either the client or therapist for any reason.
~ Treatment plans and/or attendance will be reviewed periodically for update and termination procedures. After 2 missed appointments or late cancellations with less than 24 hours of notice a termination of treatment letter will be sent and services will no longer be rendered.
~ I also understand that there are important legally mandated exceptions to confidentiality. These include:
1. Threat of immediate or imminent danger to self or others, such as suicide, homicide, other physical abuse, neglect, or mal-service;
2. Any incidence of suspected elder, child, or other vulnerable person abuse, neglect, or mal-service;
3. In legal cases, the court may subpoena clinicians or clinical records.
4. I also understand that in the event of a medical emergency, information necessary to provide appropriate service may be disclosed. For HIPAA and privacy information please visit my website at emotionalandbehavioraltherapy.org and click the 'Forms' tab. Or you may visit https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-healthinformation/index.html.

By signing this agreement, you are acknowledging that you have read and understand the above material regarding EBT and your Provider procedures. You hereby authorize EBT and your Provider and its staff to use and disclose your personal health information, as necessary, for the purposes of obtaining service, facilitating the payment for such service, for normal business operation, and as required by laws. EBT and your Provider and its associates are not responsible for any articles left behind, lost, or broken. You agree that you are working with EBT and your Provider by your own consent and are not being forced or coerced to do so. You may discontinue services at any time with or without written notice to EBT and your Provider. Additionally, EBT and your Provider may also terminate services with you at any time for any reason.

THE THERAPY PROCESS

Therapy is a collaborative process where you and your Provider will work together on equal footing to achieve goals that you define. Therapy generally shows positive outcomes for individuals who follow the process. Better outcomes are achieved with a good relationship between a client and their Provider. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit.

Therapy begins with the intake process. First, you will review your EBT's and your Provider's policies and procedures, talk about fees, identify emergency contacts, and decide if you want health insurance to pay your fees depending on your plan's benefits. Second, you will discuss what to expect during therapy, including the type of therapy, the length of treatment, and the risks and benefits. If your Provider is providing supervision of another professional, your Provider will tell you about the nature of their supervision. It is your choice if you would like this supervisee to remain in the room or not. Third, you will form a treatment plan, including the type of therapy, how often you will attend therapy, your short- and long-term goals, and the steps you will take to achieve them. Over time, you and your Provider may edit your treatment plan to be sure it describes your goals and steps you need to take as they evolve. After intake, you will attend regular therapy sessions at your Provider's office or through video, called telehealth. Participation in therapy is voluntary - you can stop at any time. At this time, you will review your progress, identify supports that will help you maintain your progress, and discuss how to return to therapy if you need it in the future. This procedure is not always followed to the letter, it is used as a guide in a process that is individual to you.

IN-PERSON VISITS & SARS-CoV-2 ("COVID-19")

When guidance from public health authorities allows, and EBT and your Provider offers, you can meet in-person. If you attend therapy in-person, you understand:
• You can only attend if you are symptom-free (For symptoms, see: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html); If you are experiencing symptoms, you can switch to a telehealth appointment or cancel. If your provider is experiencing symptoms, she/he may switch you to a telehealth appointment of cancel.
You must follow all safety protocols established by EBT and your Provider, including:
• Following the check-in procedure;
• Washing or sanitizing your hands upon entering EBT or your Provider's office;
• Adhering to appropriate social distancing measures;
• Wearing a mask, if required;
• Telling EBT and your Provider if you have a high risk of exposure to COVID-19, such as through school, work, or commuting; and
• Telling EBT and your Provider if you or someone in your home tests positive for COVID-19.

Your Provider may be mandated to report to public health authorities if you have been in the office and have tested positive for infection. If so, your Provider may make the report without your permission, but will only share necessary information, and only if mandated by law. EBT and your Provider will never share details about your visit. Because the COVID-19 pandemic is ongoing, your ability to meet in person could change with minimal or no notice. By signing this Consent, you understand that you could be exposed to COVID-19 if you attend in-person sessions. If a member of EBT or your

Provider tests positive for COVID-19, you will be notified. If you have any questions, or if you want a copy of this policy, please ask.

TELEHEALTH SERVICES

To use telehealth, you need an internet connection and a device with a camera for video. Your Provider can explain how to log in and use any features on the telehealth platform. There are some risks and benefits to using telehealth:

Risks

• Privacy and Confidentiality. You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your Provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards and HIPAA compliant.

Technology.

At times, you or your Provider could have problems with your internet, video, or sound. If you have issues during a session, your Provider will follow the backup plan that you agree to prior to sessions. If that plan fails your Provider will contact you.

Crisis Management.

It may be difficult for your Provider to provide immediate support during an emergency or crisis. You and your Provider will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services.

An emergency contact is required. If you end the session abruptly and your Provider cannot contact you, your emergency contact will be called for your safety.

Benefits

Flexibility.

You can attend therapy wherever is convenient for you. Please make sure it is confidential.

Ease of Access.

You can attend telehealth sessions without worrying about traveling, meaning you can schedule less time per session and can attend therapy during inclement weather or illness.

Note: Some states have laws that limit teletherapy when not in your home state. Your Provider will advise you if this is an issue.

Recommendations

• Make sure that other people cannot hear your conversation or see your screen during sessions.

• Do not use video or audio to record your session unless you ask your Provider for their permission in advance.

• Make sure to let your Provider know if you are not in your usual location before starting any telehealth session.

CONFIDENTIALITY

Your Provider will not disclose your personal information without your permission unless required by law. If your Provider must disclose your personal information without your permission, your Provider will only disclose the minimum necessary (need to know) to satisfy the obligation. However, there are a few exceptions.

• Your Provider may speak to other healthcare providers involved in your care or for consultation purposes.

• Your Provider may speak to emergency personnel.

• If you report that another healthcare provider is engaging in inappropriate behavior, your Provider may be required to report this information to the appropriate licensing board. Your Provider will discuss making this report with you first, and will only share the minimum information needed while making a report. If your Provider must share your personal information without getting your permission first, they will only share the minimum information needed.

• If your Provider believes there is a specific, credible threat of harm to someone else, they may be required by law or may make their own decision about whether to warn the other person and notify law enforcement. The term specific, credible threat is defined by state law. Your Provider can explain more if you have questions.

• If your Provider has reason to believe a minor, elderly, or other vulnerable individual is a victim of abuse or neglect, they are required by law to contact the appropriate authorities.

• If your Provider believes that you are at imminent risk of harming yourself or another, they may contact law enforcement or other crisis services. Your provider has the ability to have law enforcement detain you until you are safe. However, before contacting emergency or crisis services, your Provider will work with you to discuss other options to keep you or others safe.

RECORD KEEPING

Your Provider is required to keep records about your treatment. These records help ensure the quality and continuity of your care, as well as provide evidence that the services you receive meet the appropriate standards of care. Your records are maintained in an electronic health record. Your provider has several safety features to protect your personal information, including advanced encryption techniques to make your personal information difficult to decode, firewalls to prevent unauthorized access, and a team of professionals monitoring the system for suspicious activity.

COMMUNICATION

You decide how to communicate with your Provider outside of your sessions. You have several options:

Texting/Email

• Texting and email are not secure methods of communication and should not be used to communicate personal information. You may choose to receive appointment reminders via text message and/or email. You should carefully consider who may have access to your text messages or emails before choosing to communicate via either method.

Secure Communication

• Secure communications are the best way to communicate personal information, though no method is entirely without risk. Your Provider will discuss options available to you.

Social Media/Review Websites

• If you try to communicate with your Provider via these methods, they will not respond. This includes any form of friend or contact request, @mention, direct message, wall post, and so on. This is to protect your confidentiality and ensure appropriate boundaries in therapy.

• Your provider may publish content on various social media websites or blogs. There is no expectation that you will follow, comment on, or otherwise

engage with any content. If you do choose to follow your Provider on any platform, they will not follow you back.
• If you see your Provider on any form of review website, it is not a solicitation for a review. Many such sites scrape business listings and may automatically include your Provider. If you choose to leave a review of your Provider on any website, they will not respond and you do so knowing the risk to your confidentiality. However, there are platforms that your Provider may use that are confidential and made specifically for this reason. While you are always free to express yourself in the manner you choose, please be aware of the potential impact on your confidentiality prior to leaving a review. It is often impossible to remove reviews later, and some sites aggregate reviews from several platforms leading to your review appearing other places without your knowledge.

FEES AND PAYMENT FOR SERVICES

You may be required to pay for services and other fees. You will be provided with these costs prior to beginning therapy, and should confirm with your insurance if part or all of these fees may be covered. You should also know about the following:

No-Show and Late Cancellation Fees

• If you are unable to attend therapy, you must contact your EBT and your Provider 24 hours before your session. Otherwise, you may subject to fees outlined in your fee agreement. Insurance does not cover these fees.

Balance Accrual

• Full payment is due at the time of your session. If you are unable to pay, tell your Provider. Your Provider may offer payment options or a sliding scale. If not, your Provider may refer you to other low- or no-cost services. Any balance due will continue to be due until paid in full. If necessary, your balance may be sent to a collections service.

Administrative Fees

• Your Provider may charge administrative fees for writing a letter or report at your request; consulting with another healthcare provider or other professional outside of normal case management practices; or for preparation, travel, and attendance at a court appearance. These fees are listed in the fee agreement. Payment is due in advance.

Insurance Benefits

Before starting therapy, you should confirm with your insurance company if:

• Your benefits cover the type of therapy you will receive;
• Your benefits cover in-person and telehealth sessions;
• You may be responsible for any portion of the payment; and
• Your Provider is in-network or out-of-network.

Sharing Information with Insurance Companies

• If you choose to use insurance benefits to pay for services, you will be required to share personal information with your insurance company. Insurance companies keep personal information confidential unless they must share to act on your behalf, comply with federal or state law, or complete administrative work. If you have questions about how this information is provided, please ask EBT or your Provider

Covered and Non-Covered Services

• When EBT and your Provider is in-network, they have a contract with your insurance company. Your insurance plan may cover all or part of the cost of therapy. You are responsible for any part of this cost not covered by insurance, such as deductibles, copays, or coinsurance. You may also be responsible for any services not covered by your insurance. This does not mean you can be balance billed for the portion your insurance company does not cover.

• When EBT and your Provider is out-of-network, they do not have a contract with your insurance company. You can still choose to see your Provider; however, all fees will be due at the time of your session to EBT. EBT will tell you if they can help you file for reimbursement from your insurance company. If your insurance company decides that they will not reimburse you, you are still responsible for the full amount.

Payment Methods

• EBT requires that you keep a valid credit or debit card on file. This card will be charged for the amount due at the time of service and for any fees you may accrue unless other arrangements have been made with EBT ahead of time. It is your responsibility to keep this information up to date, including providing new information if the card information changes or the account has insufficient funds to cover these charges.

COMPLAINTS

If you feel EBT and your Provider has engaged in improper or unethical behavior, you can talk to them, or you may contact the licensing board that issued your Provider's license, your insurance company (if applicable), or the US Department of Health and Human Services.

CONSENT TO RELEASE INFORMATION TO A PROFESSIONAL EXECUTOR IN CASE OF THERAPIST'S DEMISE OR INCAPACITATION

I understand that there is always a risk of death or incapacitation. Each agency must have specific information in order to provide services and benefits. By signing this form, you are allowing a Professional Executor to access your records and exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits. These services or benefits include, but limited to, billing and insurance information, forwarding your information to a new mental health professional if you so wish, etc. This information will be released to/from EBT and your Provider for the purpose of continuity of care. This consent is subject to your revocation in writing at any time except to the extent that action has been taken in reliance thereon, and unless earlier revocation shall expire, without express revocation, upon date, event or condition specified above. You agree to allow designated agencies to accept a copy of this form as a valid consent to share information.

LEGAL AND HUMAN RIGHTS

• You have the right to impartial access to treatment regardless of race, religion, gender, sexual orientation, age, disability, etc.
• You have the right to the provision of professional and humane service, regardless of the source of financial support.
• You have the right to dignity, decency, and respect: as an individual with personal needs, feelings, preferences, and requirements.
• You have the right to privacy in your treatment, in your care, and in the fulfillment of your personal needs.
• You have the right to be fully informed of all services available to you and any associated charges to you with this organization.
• You have the right to receive any information necessary to give your informed consent prior to the start of any treatment.
• You have the right to continuity of care.

- You have the right to voice your opinions, recommendations, and grievances regardless of policies and services offered by this organization, without fear of reprisal, restraint, coercion, or discrimination.
- You have the right to confidential treatment of your records. Information of these sources will not be released without your prior written consent, with the following exceptions:

1. Threat of immediate or imminent danger to self or others, such as suicide, homicide, other physical abuse, neglect, or mal-service;
2. Any incidence of suspected elder, child, or other vulnerable person abuse, neglect, or mal-service;
3. In legal cases, the court may subpoena clinicians or clinical records.
4. I also understand that in the event of a medical emergency, information necessary to provide appropriate service may be disclosed. For HIPAA and privacy information please visit my website

CONSENT TO TELEHEALTH (When applicable)

- Purpose: The purpose of this form is to obtain your consent to participate in a telehealth visit in connection with the following service(s) and/or procedure(s): Psychotherapy
- Scope and Limitations: Telehealth visits are not appropriate for all medical services and procedures. Your Provider has the right to determine which telehealth service(s) and/or procedure(s) are appropriate for you.
- Confidentiality and Security: All information given at your telehealth visit will be kept and protected in full compliance with federal and state privacy laws. Efforts, including training of staff, using of secured platforms, updating/patching of software, and encryption of data, etc., have been made to keep your information confidential. No system is flawless. You agree that technological failures may occur. Some or all of your information may be electronically lost or breached. The telehealth visit may also be interrupted or cancelled due to technical failure(s).

• Medical Records: All federal and state laws about access to your medical records apply to telehealth. You may request access to your medical records.

- Rights: You may opt out of the telehealth visit at any time. This will not change your right to future care or health benefits. In the event the provider cannot accommodate continuity of care, referrals will be made.
- Risks and Consequences: You have been advised of the potential risks and benefits of telehealth visits. You have had a chance to ask questions about the telehealth visit. You have received satisfactory answers to your questions.

BILATERAL STIMULATION THERAPY (BLS) (when applicable)

Bilateral Stimulation methodology is a form of adaptive information processing which may help the brain unlock maladaptive material. It also appears that BLS may avoid some of the long and difficult abreacted work often involved in the treatment of anxiety, panic attack, post-traumatic stress symptoms (such as intrusive thoughts, nightmares, and flashbacks), dissociative disorders, depression, phobias, identity crisis, and other traumatic experiences.

• You understand that distressing unresolved memories may surface through the use of BLS procedure.

- You understand that some clients experience reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including, but not limited to high levels of emotional or physical sensations and/or memories.
- You further understand that some memories may seem to disappear, while others may become clearer. Therefore, if there are legal proceedings pending, you understand it is your duty to check with your attorney if you need to recall events for a legal procedure. You agree to inform the therapist of such a procedure if applicable.
- You are aware that subsequent to the treatment session, the processing of the incidents and/or material may continue and dreams, memories, flashbacks, feelings, etc., may surface. For some people, this method may result in sharper memories, for others, it may result in fuzzier memories following the treatment.
- You further confirm that you do not have any special medical conditions and will/have consult(ed) with your medical professionals prior participating in BLS treatment. Before commencing BLS treatment, you considered all of the above and obtained whatever additional input and/or professional advice deemed necessary or appropriate. You understand that you may stop treatment at any time before or during any BLS session and that more than one BLS session may be necessary in the treatment. You hereby consent to receive BLS treatment. Your signature on the acknowledgement and consent is free from pressure or influence from any person or entity. You have thoroughly read the material explaining BLS and understand it.

ACKNOWLEDGEMENT OF THIS DOCUMENT

By signing/eSigning, You agree that you have received, read, and accept the information given in this document.

_____ _____

Client or Legal Authority or Client Date