BUCKS SUPPORT SERVICES

EATING SUPPORT COLLABORATIVE | LGBTQ CENTER | RECOVERY CENTER | FAMILY CENTER

Clinician / Client Intake Form

General Client Information

Preferred Name: _____ Preferred Pronouns: _____

Legal Name (If different from above): _____

Date of Birth: _ _ /_ _ /_ _ _ _ Age: _____ Race/Ethnicity: _____ Sex/Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone: _____ Preferred Email: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Name of School (If student): _____ Grade: _____

Medical Information

Current Medical Physician: _____ Phone: _____

Current Psychiatrist (If applicable): _____ Phone: _____

Current medications & dosages: _____

Presenting Concerns (What issues or topics would you like to discuss?):

_____

_____

Parent/Guardian Information (If applicable)

Name: _____ Preferred Pronouns: _____

Date of Birth: _ _ /_ _ /_ _ _ _ Age: _____ Race/Ethnicity: _____ Sex/Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone: _____ Preferred Email: _____

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HIPAA Privacy Policy Notice

NOTICE OF MENTAL HEALTHCARE POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR 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.

1. **Uses and Disclosures for Treatment, Payment, and Health Care Operations:**
    a. I may use or disclose your protected healthcare information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:
        i. "PHI" refers to information in your health record that could identify you.
        ii. "Treatment, Payment, and Healthcare Operations" - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist. - Payment is when I am paid for your healthcare services. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care and/or to determine eligibility or coverage. - Healthcare Operations are activities that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
        iii. "Use" applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
        iv. "Disclosure" applies to activities outside of my practice such as releasing, transferring, or providing access to information about you to other parties.
2. **Uses and Disclosures Requiring Authorization**
    a. I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosure. In those instances when I am asked for information for purposes outside of treatment, payment and 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 clinical notes. "Clinical notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have 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 clinical notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.
3. **Uses and Disclosures with Neither Consent and Authorization**
    a. I may use or disclose PHI without your consent or authorization in the following circumstances:
        i. *Child Abuse*: If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Pennsylvania Department of Child and Family Services.
        ii. *Adult and Domestic Abuse*: If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required

by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

iii. *Health Oversight*: If a complaint is filed against me with the Pennsylvania Department of Health, the Department of Health Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

iv. *Judicial or Administrative Proceedings:* If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and We will not release information without the written authorization or you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance in this case.

v. *Serious Threat to Health or Safety*: When you present a clear and immediate probability or physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

vi. *Worker's Compensation*: If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

4. **Patient's Rights and Healthcare Provider Duties**

a. *Patient's Rights:*

i. Right to Request Restrictions – You have the right to restrictions on certain uses and Disclosures or protected health information about you. However, I am not required to agree to a restriction you requested.

ii. Right to Receive Confidential Communications by Alternative Means and at 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 a therapist/healthcare provider. Upon your request, I shall send any mailings to another address).

iii. Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the request process.

iv. Right to Amend – You have the right to request an Amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I shall discuss with you the details of the amendment process.

v. Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I shall discuss with you the details of the accounting process.

vi. 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.

b. *Healthcare Provider Duties:*

i. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

ii. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently I effect.

iii. If I revise my policies and procedures, I shall provide individuals with a revised notice during their session or by mail within 60 days, and subsequent to any request made by you when you are no longer in treatment with me pertaining to the release of any information or consultation with an outside person or agency.

5. **Business Associates**
   a. I may rely, depending on the circumstances, on certain persons or entities, who are not my employees, to provide services on my behalf. These persons might include lawyers, billing services, collection agencies and credit card companies. Where these persons or entities perform services, which require the disclosure of individually identifiable health information, they are considered under the Privacy Rule to be my business associates. I enter into a written agreement with each of my business associates to obtain satisfactory assurance that the business associate will safeguard the privacy of the PHI of my patients I rely on my business associates to abide by the contract, but will take reasonable steps to remedy any breach of the agreement that I become aware of. If my attempt to remedy the breach is not successful, then I will terminate the contract, or if termination is not feasible, I will report the problem to the Department of Health and Human Services.
6. **Complaints**
   a. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me (as above). You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed at the outset can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.
7. **Effective Date Restrictions and Changes to Privacy Policy**
   a. I will limit, i.e., deny, the disclosures that I make when your request to access copies of either your or your child's psychotherapy notes may, in my professional opinion, pose harm to you or your child's mental health. Such denials to access may be considered final and not reviewable by another licensed health care professional typically designated as a reviewing official with respect to other conditions (see below). I may also deny access to records when information is compiled in reasonable anticipation of, or for use, in a legal or administration action of proceeding, and when someone other than a health provider provides information about you or your child under a promise of confidentiality and the access to the requested information would be reasonably likely to reveal the source of the information. However, you may request and are entitled to a review of my denial by another licensed health care professional for access to other information contained in your medical records when I deny access if: 1) in the exercise of my professional judgment I determine that access to the record is "reasonably likely to endanger the life or physical safety" of you, the patient, or another person; 2) the requested information makes reference to another person (other than another health care provider) and in the exercise of professional judgment I determine that access is "reasonably likely to cause substantial harm" to this person; or 3) a personal representative for you or the patent has requested access to the record and in the exercise of professional judgment I determine that such access is "reasonably likely to cause substantial harm" to the you, the patient or another person. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. We will provide you with a revised notice by face-to-face verbal explanation and written notice in person or via mail within 60 days.

I have read, reviewed, and understand the Bucks Support Services HIPAA Privacy Policy.

Signature: _____ **Date:** _ _ /_ _ /_ _ _ _

BUCKS SUPPORT SERVICES

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Informed Consent

OUTPATIENT SERVICES CONTRACT

Welcome to Bucks Support Services. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the concerns you hope to address. There are many different methods I may use to deal with those concerns. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. For the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, We will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy. You should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 1 to 4 sessions. During this time, we can both decide if I am the best person to provide the services to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one 50-minute session per week, at a time we agree on, although some sessions may be longer or more frequent. Once an appointment is scheduled, you will be expected to pay for it unless you provide *24 hours* advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My session fee is $____. If we meet more than the usual time (45-53 minutes), I will charge accordingly. In addition to weekly appointments, I charge this same rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other

professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $400 per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of $1 per page for records requests.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have mutually agreed upon coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, I may be allowed to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information We will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

To set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. **I only provide services as an out-of-network provider and I make no representation that I am in-network with any provider.** We will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services and out-of-network benefits. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If necessary, I am willing to call the insurance company on your behalf to obtain clarification.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end and may not provide out-of-network benefits at all. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.

Be aware that most insurance companies require that I provide a clinical diagnosis. At times, I must provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire

record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any records I submit if you request it.

You understand that, by using your insurance, you authorize me to release such information to your insurance company. We will try to keep that information limited to the minimum necessary. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by your insurance contract.

EMAIL AND TEXT MESSAGING

In order to communicate with you by email or text message, I need to make sure you are aware of the confidentiality and other issues that arise when we communicate this way and to document that you are aware of these and agree to them.

I understand that all e-mail messages are sent over the Internet and are not encrypted, are not secure, and may be read by others. I understand that my email communications with my therapist will NOT be encrypted and, therefore, my therapist can NOT guarantee the confidentiality and security of any information I send to him or that he sends to me via email.

- I understand that text messages are even less secure than e-mail, and the same conditions apply.
- I understand that for this reason my therapist has advised me not to send sensitive information via email or text message. This includes information about current or past symptoms, conditions, or treatment, as well as identifying information such as social security numbers or insurance identification information.
- I give permission for my therapist to reply to my messages via email, including any information deemed appropriate, that would otherwise be considered confidential. I agree that my therapist shall not be liable for any breach of confidentiality that may result from this use of email via the Internet.
- I understand that my therapist will limit text messages to brief inquiries or responses regarding scheduling.
- I understand that my therapist may at times e-mail me information about resources that I can use as part of my treatment. I hereby consent to receive such information via email.
- I understand that email and text communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. I understand that if I use email or text to make or request scheduling changes it is my responsibility to confirm that my therapist has received my communication more than 24 hours before the appointment time being changed. If I believe I need a response within 48 hours, I will not use email but will call my therapist. If I do not receive an answer to a routine email or text message within two working days, I understand that I should call my therapist.
- I understand that all email and text communications may be made part of my permanent medical record and would be accessible anyone given access to those records. I also understand that I may withdraw permission for my therapist to communicate with me via e-mail or text by notifying my therapist in writing.

CONTACTING ME

I am often not immediately available by telephone or text. Though I am usually in my office between 9:00am and 5:00pm, We will not answer the phone or return texts when I am with a client. When I am unavailable, my telephone is answered by voicemail. We will make every effort to return your call on the same day you make it, except for weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. In emergencies, if you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If We will be unavailable for an extended time, WIwill provide you with the name of a colleague to contact, if necessary.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I must reveal some information about a patient's treatment. For example, if I believe that a child [or elderly person or person with a disability] is being abused or has been abused, I must, or may be required to, make a report to the appropriate state agency. If I believe that a patient is threatening serious bodily harm to another, I am, or may be, required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult with my Clinical Supervisors or other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice, I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney. If you request, I will provide you with relevant portions of the state laws regarding these issues.

Whether attending Individual Counseling, Couples Counseling or Family Therapy of any kind, each party should review the above and by your signature below, you are indicating that you have read the information in this document and agree to abide by its terms during our professional relationship. (All parties sign as applicable)

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Further, by signing below, you are indicating that you consent to and authorize your chosen clinician at Bucks Support Services to release and exchange both General and Alcohol and Drug Information, pertaining to either your or your child's evaluation and therapy sessions to all other parties who have signed below as well as affiliates of Bucks Support Services. I understand that authorization shall remain valid from the date of my signature below and for 12 months thereafter. I have been informed that I may revoke this authorization by written or email communication to Bucks Support Services. I certify that this form has been fully explained to me and that I understand the content.

I have read, reviewed, and understand the Bucks Support Services Informed Consent Outpatient Services Contract.

Signature: _____ **Date:** _ _ /_ _ /_ _ _ _

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Collaborative Care Agreement

Bucks Support Services and its independent contractors and collaborating clinicians, physicians, and dieticians, strive to work together is a way that allows us to best serve or clients while adhering to clinical best practices. Bucks Support Services has developed a Collaborative Care Agreement. This agreement is based on best practice guidelines.

1. Purpose:
    a. To provide optimal care for our clients
    b. To provide a framework for better communication between behavioral health care providers and other key treatment professionals
2. Principles:
    a. Safe and effective client care is our central goal
    b. Effective communication between behavioral health care, medical and adjunctive providers is key to providing optimal patient care and to eliminate the waste and excess costs of health care.
    c. Collaborating Parties:
        i. Behavioral Health Clinicians contracted to work with Bucks Support Services which includes psychologist, social worker, professional counselor, family therapist
        ii. Any and all clinical, financial and other management, support staff contracted with Bucks Support Services
        iii. Clinical Referral Sources (Including but not limited to psychiatrist, psychiatric nurse practitioner, primary care physician, dieticians)
        iv. Other as directed by client (This may include schools, case managers, adjunctive providers, other dieticians)
            1. Indicate here: _____
3. Reasons:
    a. Pre-consultation exchange – communication between referral sources including between providers referring clients for other types of therapy (e.g., EMDR, family therapy, nutrition, referral to higher level of care)
    b. Answer clinical questions and/or determine the necessity of a formal consultation
    c. Formal Consultation (Advice) – a request for an opinion and/or advice on a question regarding a patient's diagnosis, diagnostic results, procedure, treatment or prognosis with the intention of enhancing quality of care
    d. Complete transfer of care for entirety of care
    e. Collaboration of care (Co-management) – where providers actively contribute to the patient care for a condition and define their responsibilities including first contact for the patient, patient education, care teams, patient follow-up, monitoring, etc.

I understand that my treatment provider will work collaboratively with the clinicians in the roles listed above in order to enhance quality of care. Clients may opt out of this agreement for a single provider or specialty as indicted below. Please note that patient opt out may result in referral to another provider as this may interfere with the clinical treatment plan.

____ ***I wish to opt out (if selected, cease signing and contact for referral out)***

____ ***I do not wish to opt out, and wish to continue with Bucks Support Services***

I have read, reviewed, and understand the Collaborative Care Agreement.

Signature: _____ **Date:** _ _ /_ _ /_ _ _ _

BUCKS SUPPORT SERVICES

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Informed Consent

FOR TELETHERAPY AND IN-PERSON SERVICES DURING AND AFTER THE COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services considering the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, We will respect that decision, if it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

<u>If there is a resurgence of the pandemic or if other health concerns arise</u>: To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, BSS clinicians and other patients) safer from exposure, sickness, and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. By signing below, you indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free.
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.
- You will wait in your car or outside until no earlier than 5 minutes before our appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.
- You will wear a mask in all areas of the office (I, and BSS staff will too).
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me or BSS staff.
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.

- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID.
- If you have a job that exposes you to other people who are infected, you will immediately let me know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know.
- If a resident of your home tests positive for the infection, you will immediately let me know, and we will then resume treatment via telehealth.

I may change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, Bucks Support Services staff and all of our families safe from the spread of this virus. If you show up for an appointment and I or Bucks Support Services staff believe that you have a fever or other symptoms, or believe you have been exposed, We will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I or BSS staff test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I must report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at present and/or at the start of our work together.

Benefits and Risks of Teletherapy

Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing (Zoom, Facetime, etc.) or telephone. One of the benefits of teletherapy is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client moves to a location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Teletherapy, however, requires technical competence on both our parts to be helpful. Although there are benefits to teletherapy, there are some differences between in-person sessions, as well as some risks. For example:

- Risks to Confidentiality – Because teletherapy sessions take place outside of the therapist's office, there is potential for other people to overhear sessions if you are not in a private place during the

session. On my end We will take reasonable steps to ensure your privacy. It is important for you to find a private place for our session where you will not be interrupted.

- Issues to Technology - There are many ways that technology issues might impact teletherapy. For example, technology may stop working during a session, other people might be able to get access to our private conversations, or stored data could be accessed by unauthorized people or companies.
- Crisis Management and Intervention - Usually, We will not engage in teletherapy with clients who are currently in a crisis requiring high levels of support and intervention. Before engaging in teletherapy, we will develop an emergency response plan to address potential crisis situations that may arise during our teletherapy work.
- Efficacy – Most research shows that teletherapy can be about as effective as in-person psychotherapy. However, some therapists and clients believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non- verbal information when working remotely.

Electronic Communication

We will decide together what kind of teletherapy service to use. You are solely responsible for any cost to you to obtain any necessary equipment to take part in teletherapy. For communication between sessions, We will use email and text messaging only with your permission and only for administrative purposes unless we have made another agreement. This includes things like setting appointments, billing matters, and other related issues. I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and ask that you do not either. I do not regularly check email and texts, so these methods should not be used in an emergency. If an urgent need arises while not in session, you should feel free to attempt to contact me. If you are unable to reach me contact your family physician or nearest emergency room for the psychologist or psychiatrist on call.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are part of our teletherapy. However, the nature of electronic communications such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. There is a risk that our communication could be compromised, unsecured, or accessed by others. No party is allowed to record, in any way, communications during teletherapy, office visits or any other communication between therapist and client unless written permission is obtained and signed by both parties.

I have read, reviewed, agreed to, and received a copy of the Bucks Support Services Informed Consent for Teletherapy and In-Person Services During and After the COVID-19 Public Health Crisis.

Signature: _____ **Date:** _ _ /_ _ /_ _ _ _

BUCKS SUPPORT SERVICES

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Good Faith Estimate Explanation

We truly appreciate you choosing to come to Bucks Support Services for therapy.

As part of providing high-quality services, we need to be clear about our financial arrangements. We do not accept insurance plans (please discuss this prior to scheduling). Cash, check or credit card payments are the only acceptable forms of payment. Payment is due at the time of service.

A valid credit card is required to be always kept on file. Your credit card can be used to pay for services, or you can provide a different form of payment at the time of service. The credit card on file will be charged for the full amount of your session if you fail to cancel your session 24 hours before your session and/or you no-show for your scheduled appointment. Your therapist will wait for you to arrive up to 15 minutes after the scheduled start time of your session. If you fail to contact your therapist within the 15-minute window, your session will be considered a late cancel/no-show.

If you have an insurance plan that offers out-of-network reimbursement, we can provide you with a superbill so that you can submit a claim for reimbursement. It is your responsibility, not that of our providers, to know and understand your insurance plan and benefits. Your therapist does not verify insurance plans or benefits on behalf of you, the client. We do not guarantee that you will receive any reimbursement from your insurance provider.

Most therapy sessions are 45-53 minutes (Counseling/Psychotherapy) for an individual, couples, family, or group:

We recognize that every client's therapy experience is unique. How long you will need to engage in therapy and how often you attend sessions will be influenced by many factors.

- Your schedule and life circumstances
- Therapist availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them

You and your therapist will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs. This estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. The information provided in the good faith estimate are estimates and not the final overall total charges. Additionally, the good faith estimate is not a contract and does not require the uninsured (or self- pay) individual to obtain the items and services from any of the providers or facilities identified on the good faith estimate.

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Provider Name	Bucks Support Services
Provider Address	4936 York Rd., Suite 2300 Buckingham, PA 18902 17 Barclay St., Suite B-3 Newtown, PA 18940 Teletherapy

Each clinical session carries a charge of $_____. Both service codes and diagnosis codes can change throughout the arc of your individualized therapy; however, those changes generally do not affect individual pricing. These are some common diagnosis and service codes for 45–53-minute sessions:

Service Codes:

90791	Intake Assessment
90837	53 minutes of individual psychotherapy
90846	50 minutes of family psychotherapy without the client present
90847	50 minutes of family psychotherapy with the client present
90949	Multiple-family group psychotherapy
90853	Group psychotherapy

Diagnosis Codes:

F00-F09	Codes for organic, including symptomatic, mental disorders
F10-F19	Codes for mental and behavioral disorders due to psychoactive substance abuse
F20-F29	Codes for schizophrenia, schizotypal, and delusional disorders
F30-F39	Codes for mood disorders, depression, and bipolar disorders
F40-F49	Codes for neurotic, anxiety, stress-related, and somatoform disorders
F50-F59	Codes for behavioral syndromes associated with physiological disturbances and physical factors
F60-F69	Codes for disorders of adult personality and behaviors
F70-F79	Codes for intellectual disabilities
F80-F89	Codes for pervasive and specific developmental disorders
F90-98	Codes for behavioral & emotional disorders with onset usually occurring in childhood & adolescence
F99	Unspecified mental disorder

If you feel you have been billed for more than you think you should have been billed (and that amount is greater than $400 above the good faith estimate provided to you), you have the right to dispute the bill.

You may contact the healthcare provider at Bucks Support Services to let them know the billed charges are higher than the good faith estimate, you have the right to ask to negotiate the bill or ask whether financial assistance is available.

You may also start a dispute resolution process with the US Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date of the original bill. For questions or more information, visit www.cms.gov/nosurprises or call 1-800-985-3059.

I have read, reviewed, and understood the Bucks Support Services Good Faith Estimate.

Signature: _____ **Date:** _ _ /_ _ /_ _ _ _

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Financial Agreement

I have agreed to pay privately for my mental health services. **The agreed upon charge is $____ per session**. The initial intake session is approximately 50 minutes. All subsequent sessions are approximately 50 minutes long for adults, and 45 minutes for children and adolescents, unless another arrangement is made.

Testing, paperwork, and other requests will be a separate cost according to the current Fee Schedule.

Payment is due at the time of service. I acknowledge that Bucks Support Services will not bill my insurance company but will provide me with a receipt for service. Additionally, I acknowledge that my insurance company may not reimburse me for services at the Bucks Support Services.

There is a 24-hour cancellation policy which requires that you cancel or reschedule your appointment 24 hours in advance. Missed appointments or same-day cancellations will be charged the full fee. By signing below, I am also acknowledging that any communication about payment may be conducted with the individual providing said payment. This communication may be about scheduling, fees, receipt, and information included on any receipts.

Payments may be made by Cash, Check or Credit Card. Complete below to pay for services by Credit Card/HSA. Bucks Support Services will charge this card for Group or Individual Sessions.

Card Information

Name of Client: _____ Name on Card: _____

Card Number: _____

Expiration Date: _____ CVC Code: _____ Zip Code: _____

Reminder:

Cost Per Session: $____
Sessions must be cancelled or rescheduled 24 hours in advance.
Sessions not changed or cancelled with 24-hour's notice will result in full charge for that session.

I have read, reviewed, and understood the Bucks Support Services Financial Agreement.

Signature: _____ **Date:** _ _ /_ _ /_ _ _ _