Four Elements Integrative Counseling, LLC

The Park Center II
3681 South Green Road, Suite 406 Beachwood, Ohio 44122

OUTPATIENT SERVICES CONTRACT
Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and write down any questions that you may have so that we can discuss them at our next meeting. Once you sign this, it will constitute a binding agreement between us.
In addition to this Outpatient Services Contract, please see the HIPAA: Notice of Privacy Practices attached.

FOUR ELEMENTS INTEGRATIVE COUNSELING SERVICES, LLC
As part of your integrative counseling evaluation, I will start with a full evaluation that will last approximately one to two fifty-minute sessions, but may require an additional session or two to complete if there is a lot of information to gather. In the following session, we will discuss treatment plan options. It may include suggestions for complementary modalities including various breathing techniques, yoga, mindfulness, hypnotherapy, EMDR (eye movement desensitization reprocessing) as well as other modalities. This is a collaborative effort that requires your participation. It is your responsibility to evaluate this information along with your own assessment about whether you feel comfortable working with me. 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 secure an appropriate consultation with another mental health professional.

SELF-ASSESSMENT FORM
Before your evaluation, it is important that you complete the Self-Assessment Form in as much detail as possible. The information will not only be useful during your assessment, but it will also help organize your thinking about your psychiatric history and reason for the present visit. It will help me to better understand you and your

needs. If there is a question on the form that you do not wish to answer or cannot answer, then leave it blank.

PROFESSIONAL FEES

The fee for each fifty-minute session is $120. Ninety-minute sessions are $160. If you have an appointment scheduled and choose to only stay for part of the scheduled time that is your choice, but the fifty-minute fee will still be charged as that time was set aside for you. How you choose to use it is up to you. In addition to appointments, it is my practice to charge this amount on a prorated basis for other professional services you may require such as report writing, telephone conversations which last longer than 5 minutes, consultations with other professionals which you have authorized, preparation of records or treatment summaries or the time required to perform any other service which you may request of me.

FEE STRUCTURE

My practice is fee-for-service although I do accept Medical Mutual Insurance. Payment is expected at the time of service, unless we agree otherwise. I accept check, cash, and credit card. A fee of $30 will be charged for any returned checks. If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, l have the option of using legal means to secure payment, including collection agencies or small claims court. (If such legal action is necessary, the costs of bringing that proceeding will be included in the claim.)

INSURANCE REIMBURSEMENT: *Working with your Insurance Company*

Health services may be covered in full or in part by your health insurance or employee benefit plan. Although I am considered out-of-network for most insurance carriers, some of my patients are able to obtain reimbursements from their insurance carriers. Most PPO policies will reimburse between 60-80% after your deductible is met; however, out-of-network benefits vary among carriers. Clients will receive a Super Bill with all the information needed to seek reimbursement from traditional insurers or from health care spending accounts. Figuring out what else might be required of the

insurance companies is up to you. These statements are typically sufficient to obtain reimbursement. You should also be aware that most insurance agreements require you to authorize me to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or, in some cases, a copy of the entire record. This information then becomes part of the insurance company's files, and I have no control over what is done with the information.

CONTACTING ME

I am often not immediately available by telephone. While I am usually available between 9 AM and 3 PM, I will not answer the phone when I am with a client. When I am unavailable, please leave a message on my voicemail, and I will get back to you as soon as possible. If it is a quick question regarding a time of appointment, feel free to text me and I will be able to respond more quickly. I will make every effort to return your call or text within 24 hours with the exception of weekends, holidays, and calls made after office hours. If you are difficult to reach, please leave some times when you will be available.

In the case of an emergency, if you cannot reach me, or you feel that you cannot wait for me to return your call, you should go to the emergency room at the nearest hospital and ask for the psychiatrist on call.

CANCELLATION POLICY

I understand that events arise and appointments cannot always be kept and must be rescheduled. I request, however, that you **call 24 hours in advance**, so that time may be rescheduled for another client. **The policy is to charge in full for late cancellations and missed appointments**. These charges must be paid before the next scheduled appointment. Obviously, there are situations that cannot be anticipated and these may be discussed at the next visit.

DISCHARGE POLICY

If three or more appointments are missed without cancelling in advance, my policy is to discharge you from the practice. Please make every effort to either keep your appointment or call 24 hours in advance to cancel to avoid this.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead, unless to do so would cause emotional damage, upset, etc. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

PATIENT RIGHTS

The Health Insurance Portability and Accountability Act provides patients with several expanded rights regarding their protected health information. These rights include the right to receive a notice of privacy practices, the right to access a copy of medical records, the right to request an amendment of medical records, the right to request special privacy protection for protected health information, and the right to an accounting of disclosures. For more information, please see the HIPAA: Notice of Privacy Practices attached. I would be happy to discuss any of these rights with you.

CONFIDENTIALITY

In general, the law protects the confidentiality of all communications between a client and practitioner, and information can only be released to others with your written permission.

However, there are a number of exceptions to confidentiality. In the following situations, I am legally required to take action to protect you or others from harm:

1. If I believe that a child, elderly person, or disabled person is being abused, I must file with the appropriate state agency.
2. If I believe that a client is threatening bodily harm to self or another, I am required to take protective actions, which may include notifying the potential victim, notifying the police, seeking hospitalization for the client, or contacting family members or others who can provide protection.
3. If a judge thinks I have evidence about a client's ability to provide care or custody in a child custody or adoption case as well as in court proceedings involving the care and protection of children or to dispense with the need for parental consent to adoption.
4. If a court orders access to my records in a sexual assault or other criminal case.
5. If you bring an action against me as a therapist and disclosure is necessary or relevant to defense.
6. If it is necessary to use a collection agency or other process to collect amounts owed for services.
7. You authorize me to consult professional colleagues if needed to enhance the clinical services you receive.

These situations rarely occur, but if they should, I will make every effort to fully discuss it with you before taking any action.
Should you have questions about these policies, please discuss them at your first session.

I have read and understand the service contract above. Once you sign this, it will constitute a binding agreement between us.

Signature of Patient:______________________________________

Date: ____