Wings of Eagles Counseling Clinic

To nurture a partnership of hope, health and wholeness in all people using solution focused and evidenced bases practices

Therapist Client Agreement
Office Policies/Fees/HIPAA/PRIVACY POLICY

Client Name: _____

Client Date of Birth:_____Insurance ☐ Cash Pay ☐

WELCOME: Welcome to Wings of Eagles Counseling. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA}, a new federal law that provides new privacy protections andnew patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is included in your folder, explains HIPAA and its application to your personal health information in greater detail, and our practice is in general accordance with HIPAA policies. The law requires that I obtain your signature acknowledging that I have provided you with this information.

Although these documents are long and sometimes complex, it is very important that you read them carefully before our session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. Thatrevocation will be binding on me unless we have taken action in reliance on it or if youhave not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES: Therapy is a relationship between people that works in part because of the clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to create change. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to know about. There are also legal limitations to those rights that you should be aware of. We, as therapists, have corresponding responsibilities to you. These respective rights are described in the following section.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of yourlife. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things that we discuss outside ofsessions.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what

your work together may include. At that point. we will discuss your treatment goalsand create a personalized, initial treatment plan, if you decide to continue. You should evaluate this information as well as your own assessment about whether you feel comfortable working with your therapist. Therapy involves a large commitment of time. money, and energy, so you should be very careful about the therapist you select. If youhave questions or concerns about your therapists' procedures. ask to discuss them whenever they arise.

APPOINTMENTS: We normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if your therapist is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy isbegun, we will usually schedule one, 1-hour session per week at a time you both agree on, although some sessions may be longer or more frequent.

CANCELLATION: Psychological services are most effective when meeting times are regular and consistent. The time scheduled for your appointment is assigned to you andyou alone. If you need to cancel or reschedule a session. it is required that you provide more than 24 hours notice. If you miss a session without canceling. or cancel with less than 24 hours notice. you must pay the appropriate fee (usually half of the session cost)for the missed session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. In addition, you are responsible for coming to your session on time and at the time scheduled. If you are late, your appointment may still need to end on time.
Indicate agreement to cancellation policy with your initials here. _____

FEES, BILLING, AND PAYMENT: Psychotherapy sessions are 50 minutes to an hour and billed at $100 per hour session (initial sessions are $120; other fees are dependentupon service provided and will be arranged at the time of service). Session fees or insurance co-pays are payable at time of service. If you are a cash-paying client. you must fill out and sign the appropriate agreement. All payment arrangements must be I writing and signed by both the client and the therapist. Fees will be reevaluated periodically. You will be responsible for paying the entire fee if your insurance fails to cover your services. Moreover. legal fees ($250 per hour of service provided) are not billable to insurance companies and will be charged to the patient directly (e.g. court evaluations, court appearances). Should a balance accrue, and no payment is received,Wings of Eagles Counseling reserves the right to seek remuneration by any means legally possible including. but not limited to, the retention of a collection agency.
You may contact Wings of Eagles Counseling: 920-227-7078 217 N Madison Street ,Green Bay. WI 54301
Indicate agreement to fees, billing, and payment policy by your initials here:_____

INSURANCE: We accept payment directly from insurance companies, and our therapists are participating providers on several managed care preferred provider plans.In the event

that we are not a participating provider in your managed care plane. our services are typically reimbursable. Insurance companies sometimes require a formal diagnosis with their claims. Diagnoses are technical terms that describe the nature of you problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. There is a copy in our office and we will be glad to let you see it to learn more about your diagnosis, if applicable.

PROFESSIONAL RECORDS: We are required to keep appropriate records of the psychological services that we provide. Although psychotherapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here. what was done in session, and a mention of the topics discussed. You have the right to a copy of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request; you will be charged $0.06 per page. Your records are maintained in a secure location in the office. There are occasions where we will share your records interoffice with other practitioners or therapist that make up your "treatment team"; but only within Wings of Eagles Counseling unless you sign a written authorization form thatmeets certain legal requirements imposed by HIPAA.
Indicate agreement to professional records policy with your initials here: _____

CONFIDENTIALITY: The confidentiality of all communications between a client and a psychologist is generally protected by law and Wings of Eagles Counseling, as your therapy center, cannot and will not tell anyone else what you have discussed or even that you are in therapy without your written permission. In most situations, we can onlyrelease information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. With the exception of certain specific situations described below. you have the right to confidentiality of your therapy. You, on the other hand, may request that information is shared with whomeveryou choose, and you may revoke that permission in writing at any time.
There are, however, several exceptions in which we are legally bound to take action even though that requires revealing some information about a patient's treatment. If at all possible. we will make every effort to inform you when these will have to be put into effect legal exceptions to confidentiality include. but are not limited, to the following:

1. If there is good reason to believe you are threatening serious bodily harm to yourself or others. If we believe a client is threatening serious bodily harm to another. we may berequired to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens harm to him/herself or another. we may be required to seek hospitalization for the client, or to contact family members or others who can provide protection.
2. If there is good reason to suspect, or evidence of, abuse and/or neglect toward children, the elderly or disabled persons. In such a situation, we are required by law tofile a report with the appropriate state agency.

3. In response to a court order or where otherwise required by law.
4. To the extent necessary, to make a claim on a delinquent account via a collectionagency.
5. To the extent necessary for emergency medical care to be rendered.

Finally, there are times when your therapist may find it beneficial to consult with colleagues as part of their practice for mutual professional consultation. Your name and unique identifying characteristics will not be disclosed. The consultant is also legally bound to keep the information confidential.

CONTACTING US: Your therapist may not be immediately available by telephone. While we are usually in the office during normal business hours, your therapist may not answer the phone when they are with a client. If you need to reach your therapist between sessions, or in an emergency, you have the right to a timely response. You may leave a message on their confidential voicemail at any time. Your call will be returned as soon as possible or by the next business day under normal circumstances. On weekends, we do not typically check voice mail. But, for any number of unseen reasons, if you do not hear from us or we are unable to reach you, it remains your responsibility to take care of yourself until such time as we can talk. If you feel unable tokeep yourself safe, call the crisis liner or go to your nearest emergency room and ask tospeak to the psychiatrist or psychologist on call. We will make every attempt to inform you in advance of any planned absences and provide you with a name and phone number of the therapist covering the practice.

OTHER RIGHTS: If you are unhappy with what is happening in therapy, we hope thatyou will talk with us so that we can respond to your concerns. Such criticism will be taken seriously and with care and respect. You may also request that we refer you to another therapist and are free to end therapy at any time.
You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or sourceof payment.
You have the right to ask questions about any aspect of the therapy and about our specific training and experience. You have the right to expect that we will not havesocial or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY: Your signature below indicates that you have read this Agreement and agree to its terms. It also serves as an acknowledgment that you have received the HIPAA Notice Form described above.

Print:_____

Sign:_____Date:_____