

Oaktree Counseling

Counseling Agreement for Clients of

Nicole Schwartz, LPC, NCC

(Professional Disclosure Statement/Client Agreement/Consent for Treatment/HIPAA Notice and General Information)

INSTRUCTIONS: Please read this document and complete the forms found on page 6. Please keep pages 1-5 for your records and bring your completed form (page 6) to your first session.

Counselor Qualifications and Areas of Practice

I am a Licensed Professional Counselor. I hold a Master's Degree in Community Counseling from Regent University and a Bachelor's Degree in Psychology from Radford University. My experience includes work with adolescents, children and families involved in Therapeutic Foster Care, and Residential Care. My background includes counseling individuals experiencing anxiety, mood, and attention deficit disorders, adjustment, grief and loss, family and relationship issues, developmental and cognitive delays, including Autism, especially in children and adolescents. My work at Oaktree Counseling incorporates the use of Neurofeedback Training along with other counseling techniques and theories.

Theoretical Orientation

My primary theoretical orientation is Integrative. This theoretical orientation allows the counselor/therapist to apply components of several major counseling and psychological theories including Neurofeedback Training, Cognitive-Behavioral, Existential, Family Systems, Hypnotherapy, and other disciplines within the field of psychology and counseling to allow for maximal results based upon the specific needs of the client. Each of these approaches is well established, researched and respected therapies.

Counselor and Client Responsibilities and Expectations

I have found that counseling and Neurofeedback Training is most effective when it is a collaborative process. Within the next few sessions we will establish goals for your counseling and therapy. I will use these goals to develop a treatment plan that seems likely to assist you in meeting them. We will make adjustments to treatment plans, goals, and methods as needed. We will also agree that I reserve the right to refer you to another mental health or medical professional if, in my professional judgment, there is a need for medical or other interventions that I cannot provide.

You can expect that I will provide compassionate, empathic, and sensitive counseling that is specific to you and your experience of your life problem or transition. I expect you to come to sessions on time, to complete tasks we agree upon, and to do your best to talk about those concerns, behaviors, thoughts, and feelings that are bothersome. If anything about what occurs in our sessions troubles or disappoints you, I strongly encourage you to talk about that in our sessions, so we can address your concerns.

You may be asked to work both in and outside the sessions. This may include writing in a journal, writing letters, making drawings, performing tasks, or completing other assignments between or during sessions. Most likely, you will find that our sessions provide a safe place to share thoughts and feelings, act out behaviors, and plan for the future. You may find that therapy provides rapid relief, or that the work is arduous and painful. At times, you may feel that progress has been made, and then later feel that nothing has been resolved. Similarly, Neurofeedback Training often provides quick results and then proceeds more slowly. This is normal. My goal is that your counseling and neurofeedback experiences provide you with opportunity for growth and healing.

Complaint Procedures

If you have a complaint, we believe in professional responsibility. If you think you have been treated unethically and cannot resolve this problem with us, we encourage you to contact the National Board of Certified Counselors (336-547-0607) and/or the Virginia Board of Health Professions (800-533-1560) to lodge a complaint.

Role of Diagnosis

As your counselor, I use the Diagnostic and Statistical Manual (5th Edition) published by the American Psychological Association (2014) to assist in coding any diagnosis I may determine to be appropriate to your situation. This coding serves the purpose of providing a framework upon which I can view your situation and plan treatment. In the event a diagnosis is appropriate, I will I inform you of the diagnosis I render.

Scheduling, Cancellation, Communication Policies, and General Information

Scheduling, Length of Sessions, Cancellations

I am able to provide services at a reduced fee to clients, their families, children, and spouses. We will schedule your sessions for the mutual agreement of both of us. Sessions are 45-60 minutes in length unless otherwise agreed upon. Payment is expected at the time of service. If you are unable to keep an appointment, **please call to cancel or reschedule at least 24 hours in advance, in order to avoid a missed appointment fee.**

Oaktree Counseling

No Show/Cancellation Policy

Our goal is to manage our time wisely to serve our clients better. When timely (24 hours or more notice) cancellations occur, it is possible to offer open appointment times to clients on the appointment waiting list. We sincerely appreciate your cooperation and understanding of the following policy, which is in effect to encourage timely notice of cancellations.

POLICY: Clients are responsible for a \$50 charge for the first No Show/No Call or late cancellation (less than 24 hours notice) event, and full session fee for subsequent no show/no call or late cancellation events (cancelled with less than 24 hours prior notice). The client agrees to having these charges made to their registered credit/debit card at the time of the missed appointment or thereafter. These charges may be appealed if extenuating circumstances exist that prevent timely notification of cancellation.

Voice Mail Messages

Messages may be left on our voice mail or texted to our phone at any time. Voice mail is checked regularly between 8am and 7pm, seven days a week. We return calls within 24 hours, Monday Through Friday. We respond to texts as soon as possible after they are received. Please indicate your preferred method of communication on your **New Client Form** or in your message.

Emails and Text Messages

Email and text messages are not useful methods of communication for counseling purposes. Please do not send private or personal information to us via email or text. We cannot guarantee the confidentiality of any communication sent to us in these ways, nor can we guarantee that emails and texts will be received or read. Likewise, we can't respond to questions or counseling needs described in emails or texts (ethical concerns and severe limitations created by security issues, time lapses, and potential technological problems make this problematic).

We do use both phone calls and text messages for scheduling and cancellation purposes. But, email is checked infrequently and is not a method for communicating needs. You may elect to text requests for appointments and cancellation notices (please understand that cancellations must be received by our office at least 24 hours before your appointment time, and that message delivery times can be affected by many factors). Please do not include personal information about your status or case in these emails/texts.

Please, never use email or texting to communicate an emergency or crisis.

Why Oaktree Counseling doesn't bill insurance

Many professionals do not work directly with insurance companies. This ensures that your therapist makes treatment decisions that are purely based on professional expertise and not on health insurance policies. Likewise, many professionals prefer to allow the client/patient decide what information they will share with their insurer. **Your privacy is respected and protected here.**

Oaktree Counseling is a private, secure, and highly personalized counseling practice. Your privacy, sense of safety, and individual needs are of paramount importance. Clients routinely comment on the personalized and private experience they receive in this practice. Part of what makes this experience work is that we do not file insurance claims for the services I provide. Therefore, **clients pay their full session fee at the beginning of each session.** Payments may be made by cash, check, or credit card. (Please see the fee schedule included in this document). We will provide you a **Superbill** if you have health insurance and wish to attempt to have them reimburse you for the costs of the services you receive. **Superbills** are provided, **upon request**, at the end of your session. A superbill **does not guarantee** that an insurance provider will pay for the services provided. Nor can Oaktree Counseling guarantee that you will be reimbursed for the services you receive here. Each insurance plan is different, **and it is your responsibility to contact your insurance provider and find out exactly what will be covered and what procedures you must follow to submit your superbill(s).**

Emergencies

An emergency is **a life threatening event or need that may qualify for immediate hospitalization. An urgent request for services is prompted by events or circumstance that leads a client to believe that the counselor's services are needed in the short term.**

If you have an emergency, please call 911 and have an emergency services unit respond to your location. If possible, call your counselor afterwards to advise of the circumstances and that the unit is on the way, or is on scene. In these circumstances, immediate medical intervention must be accessed to resolve the crisis. Afterward, a follow up appointment should be made with your counselor to address needs. If you have an urgent need for services, please call to request your counselor's next available appointment. Please be advised that this appointment may require you to be available during your work or school hours if there are no available appointments times that fit your schedule. If you desire to speak with your counselor via telephone or online, please see the Fee Schedule section regarding fees for telephone and internet based services.

Phone and Online Consultations/Appointments

Counseling and Coaching services via telephone and internet are available if there is a pre-arranged appointment. I am unable to provide emergency or urgent care services via telephone or internet. If you are in need of immediate services, please call 627-LIFE or 911 or your local emergency services.

Clients are responsible for all charges for services provided via phone or internet. To engage in phone or internet based communications about your case, you must supply a valid credit card to your counselor at the beginning of the each session. This card will be used to process your payment for the services provided during your session. Please see our fee schedule to determine the associated costs for these services. If you opt to schedule your counselor's next available appointment instead of requesting a phone consultation, we will strive to set this appointment within as brief a period of time as possible.

If you are located outside the State of Virginia, I may not legally or ethically be able to provide counseling services, which include but are not limited to, diagnosis and in-depth counseling for severe mental health disorders. Depending on your situation, I may still be able to provide coaching services and therapeutic support through a HIPAA compliant video conferencing platform. We will determine together if your situation is appropriate for distance counseling or coaching services, if not, I will attempt to help you locate appropriate local services. However, it is your responsibility to follow-up on these local referrals.

Inability to Pay at Time of Service

We are a small practice with limited staff and are unable to dedicate resources to billing, client account management, and debt collection. Therefore, payment is required in full at the time services are provided (unless other arrangements have been made in advance). However, we understand that there may be instances when a client is not able to pay at the time of service. Therefore, we have developed a simple means of helping clients receive services without incurring mounting debt or requiring debt collection protocols. Our policy is as follows:

In the event that you cannot make your payment at the time of your session, we offer you two options:

- (1) Be seen at your scheduled appointment time **after you agree to all of the following:**
 - a) Provide a valid credit card before or during your first appointment. (Please complete the authorization form your will find below)
 - b) Agree to deliver to our office the full payment of the amount due within 7 days of your appointment date,
 - c) Authorize us to charge the unpaid fee to your card if payment is not received within 7 days of any appointment
 - d) Authorize us to charge missed appointment fees to your card to avoid disruption of your counseling services.
- OR**
- (2) Reschedule your appointment (at least 24 hours in advance of your appointment date and time) to a date when you can have your payment available at the time services are provided.

Defaulted Payments

We believe in the fairness and honesty of our clients and expect that we will be paid outstanding balances in timely ways. However, those few clients who default on payment of fees for services rendered are responsible for all legal and administrative fees related to collection on defaulted accounts. Your signature on this document signifies your agreement to this policy.

Release Authorization Statement

Be aware that by submitting a superbill, you are releasing medical information that is protected by law. This means you are waiving some of your rights to privacy and confidentiality. Your insurance company will have and keep a record of your diagnosis as part of your permanent medical file. These files can be used by insurance companies to set your rates and to allow or disallow further treatment. This policy is no different than when a doctor bills insurance for you. When sending in the paperwork for your reimbursement, be sure to include the following:

1. The superbill
2. A photocopy of your insurance ID card, front and back
3. Release Authorization Statement (in bold, above)

Oaktree Counseling

Fee Schedule at Oaktree Counseling (November 2015)

Counseling and Psychotherapy (50-60 minutes)	\$95
Couples Therapy (50-60 minutes)	\$95
Family Therapy (50-60 minutes)	\$95
Scheduled Phone/Internet Based Sessions (50-60 minutes)*	\$95
Email/text based consultations (per hour of therapist's time)	\$95
Each Additional 1 to 30 Minutes	\$50
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Off Site/In Home Counseling Services (50-60 minutes)	\$250
Each Additional 1 to 30 Minutes Off site/In-home	\$100
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Unscheduled Phone Consultations (1-30 minutes)*	\$50
Each Additional 1 to 30 Minutes*	\$50
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Emergency On-Site (Scheduled less than 24 hours in advance) (50-60 minutes)	\$150
Sessions Scheduled Outside of Regular Office Hours** (50-60 minutes)	\$150
Saturday or Sunday Sessions (50-60 minutes)	\$150
Each Additional 1 to 30 Minutes	\$50

Subpoena for Court Appearance when the case for continued or dismissed or therapist is excused from appearing with less than 72 hours prior notice: \$1000 each occurrence - billed to the client.

Court Appearance with or without testimony: \$1000 a day for any part of a day, each day - billed to the client

*Your credit card will be automatically charged for all phone, video-conference, email, and other telecommunications based appointments/ consultations and for cancellations without 24 hours notice. Please make sure that the credit card you have on file is valid/up to date.

**Regular office hours are Tuesday, Wednesday, and Thursday 9:00 am to 5:00 pm.

Document Requests (Letters, Work, School, or FMLA Forms, Recommendations, etc.)

In the event that we cannot complete any needed documentation during your scheduled appointment time, I will be required to do so outside of your regular session. Your credit/Debit card will be charged \$50 per hour for all documentation completed outside of your sessions. If you need me to complete documentation for you to assist you (letters to the court or to an employer, FMLA paperwork, documents required by your employer, etc.) PLEASE request it at the beginning of your session so that we can attempt to complete the paperwork during your session time.

Notice of Privacy Practices for Protected Health Information (HIPAA)

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.

As a Licensed Professional Counselor in the State of Virginia, I create and maintain treatment records that contain individually identifiable health information about you. This notice, among other things, concerns the privacy and confidentiality of those records and the information they contain.

Uses and Disclosures of Information without Your Authorization

Federal privacy rules and regulations allow me to use or disclose your personal health information (without your written authorization) to enable me to provide treatment to you, for billing and related business purposes, to conduct health care operations, and to disclose your protected health information to any health care provider to facilitate their treatment activities, This may include consultations or referrals with other licensed health care providers or a third party, and oversight organizations that work to ensure that services are provided in a manner that complies with applicable laws, regulations and professional ethics.

I may be required or permitted to disclose your personal health information without your written authorization in other circumstances including, but not limited to the following:

- When compelled by a court, board, commission, administrative agency, arbitration panel, or search warrant as long as the request is lawful and follows the guidelines established by law and the regulations of the requesting entity.
- For the purpose of Reporting Child or Elder Abuse, Neglect or Domestic Violence to appropriate authorities.
- To report the need for additional services if I believe you have become a danger to your own safety or the safety of other persons.
- To Contact you to provide appointment reminders or information about alternatives or other health related benefits and services that may be of interest to you.

*Uses or disclosures of your personal health information (without your authorization) will be limited to the minimum necessary to accomplish the intended purpose of the use or disclosure.

Other Uses and Disclosures Requiring Your Authorization

In those instances when I am asked for information for purposes outside of the situations described above, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each revocation is in writing. Any revocation applies to only that information for which an authorization is required, and is not retroactive to any time prior to the date of the revocation.

Client's Rights and Therapist's Duties

You Have The Right To:

- Request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request. We will discuss this issue if this occurs.
- Request and receive confidential communications of your private health information by alternative means, including by email, and at alternative locations.
- Inspect and/or obtain a copy of protected health information and billing records used to make decisions about you for as long as the protected health information is maintained in the record. I may deny your access to protected health information under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Request an amendment of protected health information for as long as the protected health information is maintained in the record. If requested, I will discuss with you the details of the amendment process. Please understand, however, that I am not required to amend the information in the record.
- Generally, to receive an accounting of any disclosures of your protected health information. On your request, I will discuss with you the details of the accounting process.
- Obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

My Duties

I am required by law to maintain the privacy of your Personal Health Information and to provide you with a notice of my legal duties and privacy practices with respect to Personal Health Information. 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 in effect. If I revise my policies and procedures, I will provide you a copy of these revisions at the next appointment.

Complaints

If you have a concern about the privacy of your records or any other element of this policy, you may complain to myself, or to the Secretary of the U.S. Department of Health and Human Services. Please submit complaints in writing, to myself at the office, or to the Secretary of the U.S. Department of Health and Human Services at the following address:

U.S. Department of Health & Human Services
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441; (215) 861-4440 (TDD)
(215) 861-4431 FAX

Credit Card Registration Form (required to receive services)

Please complete the attached form to acknowledge the payment policies described herein and update your credit card information. Please bring this form to your next appointment or email it to Nikki@OaktreeCounselor.com.

Client Credit/Debit Card Registration Form/ Acknowledgment of Payment Policies

This is a small practice with no additional staff. Unfortunately, we are unable to dedicate resources to billing, client account management, and debt collection. Therefore, payment is expected in full at the time services are provided (unless other arrangements have been **made in advance**).

Each client is required to submit a completed credit card registration form before services can be provided. In the event that you request a telephone or internet based service, or if you have missed an appointment without giving the required 24 hours notice of cancellation, the associated fees will be charged to your card. If you made prior arrangements regarding payment, but payment has not been received by the agreed upon date, your card will be charged for the balance owed.

Charges are processed using the Square credit card processing service. To facilitate credit card processing, Ms. Schwartz will mark the letter "S" on the signature line on the square payment page in lieu of your signature when processing credit/debit card payments. You agree to maintain an up to date, valid card in your file. Updates to your credit card information communicated by the client or client's representative are automatically entered onto your existing credit card sheet. Your original authorization for use of your "on file" card immediately transfers to the new card information. Charges will be processed by Square Payment Processing and receipts will be sent via Square to your preferred email address, unless otherwise indicated in writing. Your signature below authorizes all actions described herein and signifies your agreement with the policies described in this and related documents. Clients agree to maintain a current, up to date, valid card on file at all times.

Oaktree Counseling

Credit Card Information and Permission

Directions: Please complete this form and submit it to Nikki Schwartz, LPC, NCC.

Client(s) Name(s): _____

Cardholder's Name as listed on card: _____

Credit/Debit Card #: _____ **Expiration: Month** _____ **Year** _____

CVV Code: _____ **Your Zip Code:** _____ **Type of Card:** _____

(3-4#code/back of card)

(Visa, MasterCard, etc.)

Your Email Address: _____ **Your Phone:** _____

Payment Authorization/Acknowledgements

By my signature below, I certify that I have read, understand, and agree to abide by the payment policies of Oaktree Counseling and authorize Nikki Schwartz, LPC, NCC or her agent **to charge outstanding fees as they occur** (in accordance with the payment policies described herein) to the credit or debit card provided by me in this document. **I authorize** Nikki Schwartz, LPC, NCC to mark the letter "S" in the signature line of the Square payment processing screen in lieu of my signature to facilitate payment of charges. **I agree** that Nikki Schwartz LPC, NCC will provide the email address indicated on this form to Square, in order to facilitate a copy of my receipt to be sent by Square via email. **I certify** that the information I have provided herein is accurate and complete. Further, **I agree** to provide a second credit or debit card or other form of payment and give my permission for representative of Oaktree Counseling to charge my outstanding fees/balances to that second or subsequent card, in the event that the listed card expires or otherwise becomes invalid. **I agree** to provide new card or payment option information within 5 days of the deactivation or expiration of the form of payment listed on this form.

Client Signature: _____ Date: _____

Client/ Guarantor/ Parent / Guardian: _____ Date: _____

Client Options, Permissions, Acknowledgements

INSTRUCTIONS: Please review and then sign this document. Afterward, **please separate this page** from this packet and **turn it in to your Counselor** at the beginning of your first session.

Attestation: I understand that I am responsible for all fees for services provided to me at this practice. I have read, understand, and agree to comply with the Oaktree Counseling fee policies, and the No Show/Cancellation Policy, and the policy regarding maintaining a payment source on file with this practice. I also acknowledge receipt of a copy of the Oaktree Counseling *Notice of Privacy Practices for Protected Health Information (HIPAA Notice)*.

Your Acknowledgement of Policies and Signatures

By signing below, I certify that I:

- (1) Have reviewed, understand, and agree to comply with the policies found on Pages 1, 2, 3, 4, 5, and 6 of this disclosure statement/ agreement,
- (2) Have reviewed the practice Payment Policies and have completed the associated card registration form and signature sheet (Page 6 of this document). I am submitting my completed Page 6 at or before my first session.
- (3) Have reviewed the Oaktree Counseling Fee Schedule (Page 4). I agree to pay fees as stated in this document at the time services are rendered.
- (4) Acknowledge Receipt of a copy of the Oaktree Counseling HIPAA Notice (pages 4 and 5), and consent to treatment for myself or my minor child.

Client Signature: _____ Date: _____

Guarantor/ Parent / Guardian: _____ Date: _____