**E. BROOKE BARNARD, M.S., LPC #7909**

**Licensed Professional Counselor**



**Family Matters Counseling of Winston-Salem, Inc.**

**3504 Vest Mill Road #20**

**Winston-Salem, NC 27103**

**336-745-1373**

**CLINICAL COUNSELOR-PATIENT SERVICES/INFORMED CONSENT AGREEMENT**

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and 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 I 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 enclosed, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information prior to or at the end of the first session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our first/next session. We can discuss any questions you have about the procedures by telephone or at the time of our first contact. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; or there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

**PRACTICE INFORMATION**

Ms. Barnard holds a Masters of Science degree in Counseling and Human Development from Radford University, the degree having been awarded in 1993. She has been a professional clinical counselor since 1994, and worked professionally for four years before taking time off to raise her children. She has been a Licensed Professional Counselor (#7909) in North Carolina since 2010. Ms. Barnard opened a private practice, Family Matters Counseling of Winston Salem, Inc., in March of 2013.

Ms. Barnard’s services include individual, couples, family, and group counseling for children and adolescents and their parents and/or guardians. She has training in grief and loss, Autism Spectrum Disorder, parent education, victimization issues (i.e., physical, emotional and sexual abuse, neglect), developmental transitions, depression, anxiety, adjustment issues, ADHD, and behavioral modification. Her therapeutic approach is strength- and solution-based and reflects eclectic influences derived from her training in play therapy, art therapy, behavioral modification, family systems, social learning, Motivational Interviewing, and cognitive behavioral theories of psychotherapy.

**PSYCHOLOGICAL SERVICES**

Counseling (therapy) is not easily described in general statements. It varies depending on the personalities of the counselor and client, the treatment approaches used, and the particular problems that are areas of concern to you. There are different methods I may use to deal with the problems that you wish to address. Counseling calls for a very active effort on your part, whether you be the client, and in the case of a minor, the client’s parent or guardian. In order for therapy to be most successful, you will need to work on the issues and strategies that we talk about, both during our sessions and at home.

Counseling can have benefits and risks. Because therapy often involves discussing unpleasant aspects of life, you may experience uncomfortable feelings like sadness, guilt, anger, anxiety, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have benefits for people who are actively involved in such treatment. Therapy often leads to better relationships, resolution of specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience. Sometimes change is swift and easy, but most often it is slow and deliberate with efforts having to be repeated.

Our first few sessions will involve an evaluation of your needs. By the end of that evaluation, I will be able to offer you some first impressions of what our work will include and an overview of what the treatment plan will be if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so 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 or for further treatment.

**EXPLANATION OF DUAL RELATIONSHIPS**

Although sessions are psychologically intimate, the therapeutic relationship is professional, not social. It is critical that the professional relationship is based on respect, safety, and trust. Therefore, it is in your best interests that contact with me is limited to counseling sessions or telephone conversations necessary to your therapy. It is not appropriate to extend social invitations or gifts to me or to ask me to relate to you in any other way that is outside of the professional context of your therapy.

**LENGTH OF SESSIONS/MISSED APPOINTMENTS/CANCELLATIONS**

Services will be rendered in a professional manner consistent with accepted ethical standards. Sessions are fifty (50) minutes in duration and will be scheduled at mutually agreed upon times. If you must cancel your appointment, please do so promptly. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide twenty-four (24) hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control. **FOR A MISSED APPOINTMENT THAT IS NOT CANCELLED, A FULL CHARGE IS MADE.** If no one is available to take your call, please leave a message at (336)745-1373.

**PROFESSIONAL FEES**

The fee for professional services is due when the service is rendered. My fee is $100.00 for the standard fifty- minute session, although that charge can be altered if your mental health services are covered by a Managed Care Organization (MCO) or by another insurer with which I have a contractual arrangement. Cash, personal checks, or credit cards (Visa, Mastercard, or Discover) are acceptable for payment. There will be a $35.00 charge for returned checks. In addition to our scheduled appointments, I charge this amount for other professional services you may need, services that are unlikely to be covered by your insurer and will be your responsibility. I will break down the hourly cost if I work for periods of less than one hour. Such services can include report writing, telephone conversations that last more than 15 minutes, attendance at meetings with other professionals that you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. For services that require my attendance at meetings that are outside of the Winston-Salem geographical area, I will include travel time in the fee charged. My preference is not to become part of court situations. However, if you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulties involved in legal involvement, I charge $200 per hour for preparation before the event. I charge $300 per hour for my attendance and/or participation at any legal proceeding, including depositions, even if I am not called to testify.

**CONTACTING ME**

While I am usually in my office during my scheduled office hours, I am most likely in session and do not answer the phone. All of my calls are forwarded to my voice mail to prevent any interruption to treatment of another patient. This is a confidential voice mail system. I will check for messages several times a day and on the weekends. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some definite times you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or go to the nearest emergency room and ask for the psychiatrist or other mental health specialist on call.

**USE OF MIND-ALTERING DRUGS OR ALCOHOL**

Please do not appear for a session under the influence of any mind-altering drug, including alcohol. If this situation occurs, the therapy session will not take place and you will be charged in full for the session. Such an occurrence may be considered grounds for the termination of therapy. Third party payers, e.g. insurance companies, should not be expected to pay for these events.

**LIMITS ON CONFIDENTIALITY**

In general, law protects the privacy of all communications between a patient and a counselor, and I can only release information about our work to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

I may occasionally find it helpful to consult with other health and mental health professions about a case as a way of clarifying issues and determining other useful interventions. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals also are legally bound to keep the information confidential. If you do not object, I will not notify you about these consultations unless I feel that is important to our work together. I will note all consultations in your Clinical Record (which is called “PHI” in my Notice of Counselor’s Policies and Practices to Protect the Privacy of Your Health Information). I will not reveal your identity in colleague consultations without your written consent.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

If I believe that a patient presents an imminent danger to his/her health or safety, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

Please note that I cannot guarantee the security of electronic correspondence (e-mails, faxes, etc.) from unauthorized persons (hackers).

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

* If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you, such information is protected by the counselor-patient privilege law. I cannot provide any information without your written authorization or a court order. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody or visitation issues and those in which your emotional condition is considered to be an important issue, a judge may order my testimony if he/she determines that the situation demands it. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
* If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
* If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
* If a patient files a worker’s compensation claim, and my services are being compensated through worker’s compensation benefits, I must, upon appropriate request, provide a copy of the patient’s record to the patient’s employer or the North Carolina Industrial Commission.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient’s treatment. These situations are very unusual in my practice:

* If I believe a patient presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning potential victims, if identifiable, and/or calling police.
* If I have cause to suspect that a child under 18 is abused or neglected, or if I have a reasonable cause to believe that a disabled adult is in need of protective services, the law requires that I file a report with the County Director of Social Services. In such situations, I will make every effort, without use of names or other identifying information, to review the circumstances with an agent of that state agency in order to determine whether a more detailed report is mandated. Once such a report is filed, I may be required to provide additional information.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentially should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. In situations where specific advice is required, formal legal consultation may be needed.

**PROFESSIONAL RECORDS**

You should be aware that, pursuant to HIPAA, I keep Protected Health Information (PHI) about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problems impact on your life, the diagnosis, the goals that we set for treatment, progress made toward those goals, medical and social history, treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, billing records, any reports that have been sent to anyone, including reports to your insurance carrier, and test information if testing was accomplished. Except in unusual circumstances that involve danger to yourself, and/or others or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. I typically am willing to conduct this review meeting without charge. In most circumstances, I am allowed to charge a copying fee of $1 per page. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

In some circumstances, I may keep a set of Counseling Notes for patients. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Counseling Notes vary from patient to patient, they can include the contents of conversations during our contacts, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record and information that is revealed to me confidentially by others. These Counseling Notes are kept separate from your Clinical Record. These Counseling Notes are not available to you and cannot be sent to anyone else, including insurance companies, without your written, signed Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

**PATIENT RIGHTS**

HIPAA provides you with expanded rights with regard to your Clinical Records and disclosures of protected information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss these rights with you.

**MINORS & PARENTS**

For individuals under 18 years of age, the law may provide your parents the right to examine your treatment records. While privacy in counseling is very important, especially with teenagers, parental involvement is also essential to successful treatment, and this requires that some private information be shared with parents.

**BILLING AND PAYMENTS**

If you are paying out-of-pocket for each individual psychotherapy session, I would appreciate receiving that payment at the time the session is provided. If you have insurance coverage, which requires meeting a deductible and/or providing a co-pay amount, please pay that amount at the time of service. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I am willing to discuss and negotiate a fee adjustment or payment installment plan for psychotherapy services.

If your account has not been paid for more than 60 days after the date of my bill and arrangements have not been agreed upon, that action on your part will render our contract null and void. I will not be able to provide any services after that point, and 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, which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient’s treatment is your name, the nature of the services provided (as required), and the amount due. If such legal action is necessary, those costs will be included in the claim.

**INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment, although most insurers, especially managed care organizations, do not include coverage for long term psychotherapy. I am willing to 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 insurer covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. Your insurance card also should provide the name of the agency that manages mental health benefits and a telephone number you would need to call if my services must be preauthorized. It is your responsibility to contact the managed care company and seek appropriate authorization; failure to do so would result in you assuming responsibility for all charges. If you have questions about the coverage provided, call your plan administrator. Of course, I will provide you with whatever information I can and will try to assist you in understanding the information you receive from your insurance company.

Due to the rising cost 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, such as HMO’s and PPO’s, often require authorization before they provide reimbursement for mental health services. These plans typically are limited to short-term treatment approaches designed to work on and resolve specific problems that interfere with an individual’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some individuals feel that more services are needed after insurance benefits end. Should that be true in your situation, I am willing to negotiate a reduced fee for which you would be solely responsible. If your managed-care plan will not allow me to provide further services to you once your benefits end, I will do my best to find another provider who will help you continue treatment.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis, which would be stated on an insurance claim form and, if required, on a treatment plan. Sometimes I am required to provide additional clinical information such as treatment plans or summaries or, in rare cases, copies of the entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. It is important that you understand that this information will become part of the insurance company files and will probably be stored in a computer. 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. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your insurance carrier.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. 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 a contract I have with your insurance company.

**COMPLAINT PROCEDURES**

If you are dissatisfied with any aspect of your counseling with me, please let me know. If you think that you have been treated unfairly or unethically and have been unable to resolve the problem, you can contact the North Carolina Board of Licensed Professional Counselors at PO Box 77819, Greensboro, NC  27417, (844) 622-3572 for clarification of your rights or to lodge a complaint.

**SUMMARY OF OUR RELATIONSHIP AND CONTRACTUAL OBLIGATIONS**

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND

AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGMENT THAT YOU HAVE

RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE. YOUR SIGNATURE ALSO

ALLOWS ME TO FILE INSURANCE CLAIM FORMS, TO PROVIDE INSURERS WITH

INFORMATION IF NEEDED FOR CLAIMS PAYMENT, AND TO PROVIDE TREATMENT PLANS

NEEDED TO SECURE PAYMENT OR FURTHER SESSIONS. YOUR SIGNATURE ALSO

AUTHORIZES YOUR INSURER TO PAY ME DIRECTLY.

**Please return this signed copy to me and I will provide you with a copy for your records.**

**I have read all of the information provided in this document and agree to abide by its terms during our professional relationship.**

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Signature of Client Date

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E. Brooke Barnard, M.S., LPC Date