Clear Life Counseling, LLC
1686 Farmington Ave Suite 201
Unionville, CT 06085

Jackie@Clearlifect.com
(860) 414-4245
www.clearlifect.com

Welcome!

My Name is Jacqueline Banasiewicz, and I am the owner of Clear Life Counseling, LLC. I am a licensed professional counselor (LPC) in CT. and have experience working with individuals, couples, families, and groups throughout the developmental lifespan. The goal at Clear Life Counseling, LLC is to engage and inspire others to engage and inspire themselves, and to gain greater clarity and meaningfulness in their lives. The decision to pursue counseling and engage in the therapeutic process is a difficult one, as it sometimes challenges you to move beyond your comfort zone. It also makes a commitment to your emotional well-being and strives to improve the relationships in your life. Please review the following information and ask questions if there is anything that needs clarification.

Safety, Communication and Emergencies

The therapeutic relationship is a collaborative and voluntary partnership. If at any time you feel treatment lacks direction or is not meeting your expectations, I would ask that you begin a dialogue, so we can address your concerns together. If it is determined that I am not the best fit to accommodate your counseling needs, I will make every reasonable effort to refer you to a more suitable provider. You have the right to be treated without regard to race, religion, sex, age, national origin, marital status, sexual orientation, and mental or physical disability. Additionally, I ask that you do not attend sessions under the influence of drugs or alcohol, or your session will need to be rescheduled. Furthermore, abusive language or physical aggression will not be permitted during session. All expectations noted above reflect my highest regard for mutual respect, safety and personal dignity.

- Clinical topics and issues will not be discussed through text messaging or email as such means of correspondence is not guaranteed to be secure/confidential. If you have clinical needs or concerns, please call my office at (860) 414-4245 or email Jackie@clearlifect.com to schedule an appointment.
- In the event of a psychiatric emergency, call **911** or go to the nearest hospital **emergency room,** as my office does not offer on-call or after-hours services.
- You will be required to provide an emergency contact name and number during intake. If during our session I believe that there is a clear and immediate probability of self-harm by the client, I may be required to take protective action and call your emergency contact(s) and/or 911 or mobile crisis services to have you transported to the hospital. (See **Notice of Confidentiality**)

Potential Benefits and Risks of Counseling

Research has shown that individuals entering therapy achieve favorable results when they have a clear understanding of what to expect. Counseling may assist you with improving your ability to handle or cope with marital, family, and other interpersonal concerns, and may enhance your awareness of personal needs, feelings, goals, and other individual concerns. While no one can guarantee or promise a specific outcome, there are several positive outcomes that can result from both short-term and long-term counseling. Additional benefits of counseling may include, but are not limited to, improved general mood, self-esteem and confidence; increased ability to set realistic goals and accomplish them; increased ability to manage strong negative emotional reactions and stressful life circumstances, along with increased ability to communicate your feelings, thoughts, and needs more openly to others; and/or increased ability to stop behaviors that are not serving you well and start engaging in healthier behaviors. Counseling will require you to make efforts to change, and you may experience a variety of emotions, including negative ones, as we work towards meeting your treatment goals.

Cancelation Policy

Please be diligent in keeping your scheduled sessions as I have reserved this time for you. If it is imperative to reschedule an appointment, **48-hours' notice is required by calling (860) 414-4245 or emailing Jackie@clearlifect.com**. Although texting is common today, a call or email is better suited for us to collaborate for scheduling purposes. Appointments canceled with less than 48-hours' notice will result in a missed appointment charge equal to the full cost of the missed session that is due prior to your next scheduled appointment. **Insurance cannot be billed for missed or canceled sessions**. Should two or more appointments be missed without 48-hours' notice in a 60-day period due to non-emergencies, this may result in discharging you from services, at which time I will make every reasonable effort to refer you to a provider more suitable to your scheduling needs. **Thank you in advance for your consideration and attention to this policy!**

_____
(Please Initial)

Payment Policy, Fees and Insurance

- It is important for sessions to start and end on time to allow for session documentation, review of records and/or completion of collateral phone calls on your behalf as well as to meet insurance company protocols. If you arrive late to the session, I cannot extend it beyond our normal session time. The frequency of sessions depends on clinical need and can be discussed.
- If you choose to use your insurance provider, I will make appropriate efforts to obtain payment directly from the insurance companies with whom I am contracted according to your benefit coverage. However, you as the client are ultimately responsible for any outstanding charges not covered by insurance. Unpaid balances over 90 days will be handled by a collections agency.
- Co-payments and Session fees are due at the beginning of each session. Personal checks and Cash are preferred forms of payment. **Use of credit/debit/HSA cards may incur standard processing fees.**
- Customary Fees for Initial Intake Assessment/Evaluation appointments are $140.00 and $100.00 per 50-minute session thereafter. If you choose to utilize insurance, contracted fees are determined by the insurance provider and the insured's policy.
- The rate for Case management services (i.e., writing letters, completing any requested documents/forms) is $140.00 per hour and is not covered by insurance. The rate for other services (Court appearances by subpoena, travel time, court related calls and or documents) is $375.00 per hour and is not covered by insurance. Fee increases may occur at discretion of LLC. In addition, you will be responsible for reimbursement of income lost by Clear Life Counseling, LLC in the case of such court appearances.

Please bring a copy of your insurance card to your first appointment as it identifies your policy information, and insurance company phone number and billing address. Please call your insurance company before your first visit (member services phone number on the back of your insurance card), and **verify** behavioral health coverage and the following details:

- **Do I have in-network AND out-of-network behavioral/mental health benefits coverage?**
- **Do I have a deductible related to Behavioral Health – Out Patient/In Office visits? If yes, has it been met?**
- **Do I owe a copay amount or coinsurance percentage during my visit?**
- **Do I need to obtain pre-authorization before seeing this out-patient provider for services?**
- **Are number of sessions limited or unlimited per calendar year?**

Notice of Confidentiality

The confidentiality of your records is highly valued. The law protects the privacy of communications between a client and therapist, although some situations are excluded by law. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Limits to preserving confidentiality include the following:

- If you have a health insurance policy, it will usually provide some coverage for mental health treatment or assessment. If you choose to use this mental health coverage, your insurance company, external gatekeeper, and quality assurance committee may review your records for quality and/or appropriateness of care. Required information regarding the state of care may also be released to your insurance company to facilitate payment.
- If I know or have reason to suspect that a child under 18 years of age is being or has been abused, abandoned or neglected by a parent, legal custodian, caregiver or any other person responsible for the child's welfare, the law mandates that I file a verbal and written report with the Department of Children and Families. Once a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the client, other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim(s), and/or appropriate family member(s), and/or the police.
- If such a situation arises, I will make a reasonable effort to discuss it with you before taking any action and I will limit my disclosure to what is necessary.

Notice of Privacy Practices - HIPAA

The privacy practices of Clear Life Counseling, LLC are based upon HIPAA (the Health Insurance Portability and Accountability Act of 1996), a federal law that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. The notice of Privacy Practices can be emailed to you upon request and explains HIPAA and its application to your personal health information. For more information, you may go to http://www.hhs.gov/. The law requires that I obtain your signature acknowledging that I have offered you this information by the end of the first session.

_____
(Please Initial)

New Client Service Agreement

In signing below, I consent that I have reviewed, understand and agree to the following policies, notices and information.

- ✓ **Safety, Communication and Emergencies**
- ✓ **Potential Benefits and Risks of Counseling**
- ✓ **Cancelation Policy**
- ✓ **Payment Policy, Fees and Insurance**
- ✓ **Notice of Confidentiality**
- ✓ **Notice of Privacy Practices - HIPAA**

_____ _____

Printed Name of Client (or Responsible Party if Client is under 18 y.o) Relationship to Client

_____ _____

Signature of Client (or Responsible Party if Client is under 18 y.o) Date

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Demographic Information / Permission to Contact / Release to Insurance

The Health Insurance Portability and Accountability Act (HIPAA) requires consent to leave voice messages and send written materials to clients or guardians. Please list contact information (phone/cell, email, address) where confidential voice messages may be left, electronic emails may be sent, and written materials may be mailed. To have sessions authorized and bill the insurance company for reimbursement of services, providers must share relevant information with insurance and billing companies, and in some cases with primary care physicians when a referral is required. Information that may be requested for billing, assessment, treatment planning, and coordination of care may include: psychiatric history, drug/alcohol history, diagnosis, treatment plan, progress notes.

(Complete the below section for the <u>CLIENT</u> receiving services)

Client Name: _____ Client Age: _____ Client DOB: _____

Client Primary Address: (street/city/state/zip)_____

Phone/Cell Number(s): _____ Email: _____
(**Note:** If Client is under 18 y.o the phone/email information can be of his/her primary guardians)

Emergency Contact(s):_____ Relation to Client: _____ Phone: _____

(Complete below section **<u>ONLY</u>** if Insurance is being used) Insured = Person who carries insurance coverage

Insurance Company: _____ Insured ID #: _____

Insured Name (Self / Other)_____ Insured DOB: _____

Plan Effective Date: _____ Provider Services Phone (back of Card): _____

Do you have Behavioral Benefits Coverage? (In-Network): Yes ____ No ____ (Out of Network): Yes ____ No ____

Deductible Amount/(Met?): _____ Copay Amt per Visit: _____ Coinsurance Amt/% per Visit: _____

Counseling Sessions allowed per Calendar Year (i.e., Unlimited or Specified Number): _____

Authorization Required: Yes ____ No ____ Auth Reference Number: _____ Auth Date:_____

In signing below, I authorize Clear Life Counseling, LLC to share demographic information (for billing purposes) as well as diagnostic and treatment information with my insurance company as requested to have sessions authorized and to receive reimbursement. I also authorize my Emergency contact to be called during session if there is a crisis situation.

_____ _____

Signature of Client (or Responsible Party if Client is under 18 y.o) Date

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Adolescent Counseling Information & Consent

What to expect from therapy: You can expect that I will do my best to understand your concerns. I will listen nonjudgmentally and provide an opportunity for you to learn more about yourself and hopefully together we will find better solutions to the challenges in your life. What we discuss will be kept confidential.

What to expect about my communications with your parent or guardian: Generally speaking, I will keep the specifics of what you share with me private.

There are a several exceptions to keeping things confidential, and here they are:
1. You tell me that you plan to hurt yourself or someone else.
2. You tell me that you are being abused physically, sexually, or emotionally, or that you have been abused in the past.
3. You are involved in a court case and a judge demands information about your counseling or your therapy.
4. You tell me that you are or have engaged in a sexual relationship with someone who is significantly older than you. In most cases I would be required by law to report this to Child Protective Services.
5. If I do hear that you are involved in risk-taking behavior that becomes serious, then I will need to use my professional judgment to decide whether I must inform your parent/guardian, or we will discuss how to share this with your parent(s) together.
6. Even though I am committed to keeping your information confidential, I may believe that it is important for your parent/guardian to know what is going on in your life. In these situations, we will work together to find the best way to discuss these things with your parent(s).
7. When meeting with your parents I will discuss challenges and progress that you have made in counseling. I will talk about themes rather than specifics. The purpose of meeting with your parent(s) is to support our work together and to facilitate improved family relationships.

What I expect from you:
1. You agree to attend therapy sessions as scheduled and participate to the best of your ability.
2. You agree to participate in goal setting and take an active role in making positive life changes.
3. You agree to talk with me or your parent/guardian if you have thoughts or feelings about harming yourself and agree to a Safety Plan.

What I expect from your Parent/Guardian:
1. You agree to support your child's treatment by doing your best to arrange for regular attendance.
2. You agree to make yourself available for parenting consultations/family meetings as requested by your child me.
3. You agree to be supportive of the counseling process.

In signing below, I consent that I have reviewed, understand and agree to the above information and exceptions.

Minor Client's Signature _____ Date: _____

Parent/Guardian's Signature _____ Date: _____