Client/Therapy Service Agreement
With Madora D. Howell LISW-CP
Bay Laurel Center, Inc.
110 Manly Street, Greenville, SC 29601

Confidentiality:

A cornerstone of therapy is respect for confidentiality. All therapists are bound by the same confidentiality laws and by the ethical standards of their respective professions. Therapists are permitted to disclose information in the following situations:

1. Client requests therapist to disclose.
2. Therapist determines client may be in danger to self or others.
3. Therapist is ordered by court or some legal proceedings.
4. Therapist suspects child or elder abuse or neglect.
5. In order to defend self against accusations of wrongful conduct.
6. For Worker's Compensation and similar benefit programs.

Appointments:

The office staff of Bay Laurel Center will be your contact for making appointments, leaving messages as well as for billing questions and insurance filing. The office staff are bound by confidentiality for the protection of your private health care information.

Contact Information:

Office hours are 9:00 AM – 5:00 PM, Monday through Friday. Clients are seen by appointment only. Telephone hours to schedule or change appointment are 9:00 AM to 12:00 and 2:00 PM to 5:00 PM. For emergency after call hours, call 864-298-8026 and the Answering Service personnel will contact whoever is "on call."

Payment/Insurance Information:

Payment is expected at the conclusion of each session. The fee for a 50-minute therapy session is $100. If I am a provider with your insurance company, you will be required to pay the contracted fee, which may involve meeting a deductible and/or paying a co-payment for therapy. You will be charged for any scheduled appointments you fail to keep unless you give 24 hours notice of cancellation. If you wish to file for reimbursement on your own, the receipt you receive, with a clinical diagnosis, may be attached to a completed claim form and mailed to your claims office.

It is your responsibility to determine: if your insurance policy provides mental health benefits; to call for pre-certification; amount of deductible, if any, and whether it has been met; co-payment amount and limitation of services. If pre-certification is required, you must ensure it is in place prior to your session.

A diagnosis is usually requested from the insurance company as a condition of payment. You will be informed of the diagnosis prior to the claims being filed. Any diagnosis will become a part of your permanent insurance record.

Professional Qualifications:

- B.S. Psychology, Trinity College, Hartford, Connecticut
- M.S.W. University of North Carolina, Chapel Hill, North Carolina 1980
- Licensed Independent Social Worker – Clinical Practice (SC # 4304)
- 24 years in public and private practice

Clinical Services:

- Individual, marital/relational and family therapy for adults.
- Areas of expertise: depression, anxiety, marital/couples issues, grief issues, obsessive compulsive disorders, substance abuse issues, trauma/abuse issues, workplace issues.

Ethics:

South Carolina provides the client the opportunity to file an inquiry/complaint with the Board of Social Work Examiners and/or the SC Department of Labor, Licensing and Regulation. You may file a complaint by sending a letter directly to the Board:

SC Board of Social Work Examiners
PO Box 11329
Columbia, SC 29211-1329

I have read the Service Agreement. I fully understand and agree with its provisions. I have been sufficiently advised and give my informed consent to engage in psychotherapy with Madora D. Howell, LISW-CP.

Signature: _____

Client Name (Please Print): _____

Date: _____

In my capacity as Personal Representative, I have been sufficiently advised and give my informed consent to participate in psychotherapy of the above-named client.

Signature: _____

Date: _____

Bay Laurel Center Services Application
Madora D. Howell, MSW, LISW-CP

[Please be as complete as possible with this information as it may help us serve you better.]

Client Name: _____

Address: _____
[Please give both "street" & "mailing" addresses, if different.]

_____ _____ _____
City State Zip Code

Telephone Numbers: _____ _____ _____
Home Work [Extension] Other [Specify]

E-mail Address: _____

Birthdate: _____ **Social Security #:** _____

Sex: ___Male ___Female **Marital Status:** _____

Education: 0 PS K 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19+
[Circle highest grade or year completed]

Degrees(s): _____ **Current School** [if enrolled]: _____

Employer [if any]: _____

Primary Care Physician: _____

Current Health Issues [if any]: _____

Current Household Members: [For all persons in home, list name, age, & relationship to client, if any]:

_____ _____

_____ _____

_____ _____

_____ _____

Emergency Contact Name _____ **Phone** _____

Responsible Party's Name [if other than Client]: _____

Birthdate: _____ **Social Security#:** _____

Address: _____

_____ _____ _____
City State Zip Code

Prior Mental Health Services Experience(s):_____ Yes; _____No. If "Yes," please give a brief description of the reason(s) service was sought, when/where service was received, who provided the service, and whether it was helpful or not helpful in reaching your goal(s).

_____

_____

_____

Who referred you to this office? [Please specify]: _____

Please describe the concern(s) that brings you here. _____

_____

_____

_____

What has prompted you to seek assistance <u>now</u>? _____

_____

What change(s) do you want to see as a result of this service?_____

_____

_____

List all currently prescribed/over-the-counter medications/allergic reactions to medication: [Please give the name, amount (mg), dosage frequency, length of time taken and details concerning allergic reactions if any.]

_____

_____

_____

_____

Health Insurance Company: _____ **ID#**_____

Subscriber Name:_____ **Social Security#:** _____

Subscriber DOB:_____ **Employer:**_____

_____ _____

Date **Signature of Client or Parent or Legal Guardian**

_____ _____

Date **Signature of Additional Client [e.g. Partner if entering Couple's Treatment]**

Bay Laurel Center Services & Fee Agreement

Thank you for choosing a professional* at Bay Laurel Center, Inc. to assist you. We hope that the ensuing relationship will help you attain your goals. To that end, **please read and sign the following agreement:**

- Only through a frank and open relationship between the client and service provider can the outcome be effective. The best service is based on friendly, honest and mutual understanding. You are encouraged to speak freely and to ask about any concerns that you might have with the individual with whom you consult.
- Your services will be offered through private, confidential sessions tailored to meet your particular needs. These sessions will be scheduled by appointment to insure you time with your provider. You are responsible for attending and compensating your provider for any and all such appointments made on your behalf. If you cannot attend a scheduled appointment for any reason, you are required to give **clear notice of cancellation at least twenty-four (24) business hours in advance** to avoid being charged the appropriate fee for the scheduled service. If the scheduled appointment is for service to more than one client (e.g., couples or family therapy), please make certain that all parties involved are canceling to avoid the fee charge. Refer to your provider's *Fee Schedule* or talk with your provider for an understanding of the appropriate fees for your services.

[*Note: Our fees are established to reflect both our costs in providing services to our clientele and the fair market value of such services in our geographic area. While we strive to hold our fees constant, factors sometimes make it necessary to alter our fee schedule. We will provide our clients with as much advance notice as possible in the event of any fee increase.*]

- **You are expected to pay all fees in full at the time service is given unless you make other acceptable arrangements in advance**. Failure to comply with responsible fee payment could jeopardize continued services from your provider as well as your credit rating.
- It is the policy of the professionals at Bay Laurel Center, Inc. **not** to accept direct assignment of insurance/managed care payments for services provided unless required to do so by an existing contract with such company. Under that arrangement, it is the client's responsibility to pay all deductibles, co-insurance, co-pays or other balances not paid by insurance.
- If Bay Laurel Center files your claim, we will allow forty-five (45) days from the filing date for the carrier to process your claim and make payment. If a claim is not received within this timeframe, we will notify you to clear your account. **Insurance filing by Bay Laurel Center, Inc. does not dismiss you from your responsibility to pay for services.** Insurance misquotes and/or other errors in stating your fee responsibility do **not** relieve you from the actual financial obligation for time/services rendered.

I thoroughly understand the above *Service & Fee Agreement* and that I am financially responsible for all charges incurred whether or not paid by an insurance carrier or managed care company, unless released from such by contract. I hereby authorize release of all information necessary to secure payment. This applies to all charges outstanding as of the date of signature and shall remain in effect for all current and future charges until revoked in writing. A photocopy of this release is to be considered as valid as the original. Should my account be referred to a collections agent, I, the undersigned, agree to pay all reasonable attorney fees and other costs incurred for said collections services.

Client's Signature: _____ Date: _____

Co-Client's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

*All professionals at Bay Laurel Center, Inc. are in independent practice from one another.

Revised 9/16/2008

Bay Laurel Center, Inc.
Fee Schedule & Billing Policy
for
Madora D Howell, MSW, LISW-CP

Service Description	Length of Time	Charge
Diagnostic Evaluation, Initial	60 minutes	$125.00
Individual Psychotherapy	50 minutes	$125.00
Couples/Marital Therapy	50 minutes	$125.00
Clinical Consultations by Telephone	1-15 minutes	$40.00
	16-30 minutes	$75.00
	31-50 minutes	$125.00

Note: Clients who are receiving services under an insurance plan may have fees that have been negotiated by that plan's contractors. If so, your fees may be different. Please check with our staff or your therapist if you have any concerns about your fees.

Reminder: If you are unable to keep your appointment, you must give us at least 24 hours notice or you will be charged the designated fee.

I have read and understand the above Fee Schedule and Billing Policy.

_____
Signature of Client or Legal Representative

_____
Signature of Additional Client [e.g. partner, if entering couple's treatment]

3.2017

Bay Laurel Center, Inc.
Waiver Regarding Missed Appointments

I, _____, agree to be responsible for any missed appointments for which I have not given the agreed upon advanced, twenty-four (24) business hours notice of cancellation at a rate commensurate with the time allotted to me for the appointed service. Such a charge incurred cannot and will not be billed to my insurance company.

_____ _____

Client's Signature Date

BAY LAUREL CENTER NOTICE OF PRIVACY PRACTICES

This *Notice* describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this *Notice* about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI" under the Health Insurance Portability and Accountability Act of 1996, "HIPAA"). We will follow the privacy practices that are described in this *Notice.*

SECTION I - USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures ***WITHOUT*** Your Written Authorization

- Uses or disclosures required by law, such as mandatory reporting of child abuse or neglect.
- Uses or disclosures required by Court Order.
- Uses or disclosures necessary to prevent or lessen a serious or imminent threat to the safety of yourself or others (duty to warn). If the information is disclosed to prevent or lessen a serious threat, it will be disclosed to the person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- Uses or disclosures for judicial or administrative hearings, such as a case where you are claiming malpractice or breach of ethics.
- Uses and disclosures for health and oversight activities, such as correcting records or correcting records already disclosed.

B. Uses and Disclosures ***REQUIRING*** Your Written Authorization

- Psychotherapy notes recorded by the clinician documenting the contents of a therapy session as well as your medical record will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.
- Uses and disclosures other than those described in Section 1A above will only be made with your written authorization. You may revoke any such authorization at any time.

SECTION II – YOUR INDIVIDUAL RIGHTS

A. Right To Inspect and Copy: You may request access to your medical record in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a reasonable fee for the costs of copying and sending you the requested records. Psychotherapy notes are afforded special privacy protection under the regulations and are excluded from this right.

B. Right To Alternative Communication: You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right To Request Restrictions: You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing. We are not required to agree to any such restriction you may request.

D. Right To Accounting of Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI made by us after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures authorized by you, and is subject to restrictions and limitations.

E. Right To Request Amendment: You have the right to request that we amend your health information. Your request must be in writing. We may deny your request under certain circumstances.

F. Right To Obtain Notice: You have the right to request a paper copy of this *Notice*.

G. Questions and Complaints: If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, please let your particular therapist know. If you are concerned that we

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have violated your privacy rights, you may also file a complaint with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or ourselves.

III. EFFECTIVE DATE AND CHANGES TO THIS *NOTICE*

A. Effective Date: This *Notice* is effective April 14, 2003.

B. Changes To This *Notice*: We may change the terms of this *Notice* at any time. If we change this *Notice*, we may make the new *Notice* terms effective for all PHI we maintain, including any information created or received prior to issuing the new *Notice*. If we change this *Notice*, we will post the revised *Notice* in the waiting area of our office. You may also obtain any revised *Notice* by request.

❖❖❖ALL THERAPISTS AT BAY LAUREL CENTER, INC. ARE IN INDEPENDENT, SOLO PRIVATE PRACTICE❖❖❖

I acknowledge that I have been given this document - BLC ***Notice of Privacy Practice*** - and that I have read this document. My signature below confirms that I understand and accept all the information contained in the ***Notice of Privacy Practices***.

_____ _____

Signature of Client Date

If this acknowledgement is signed by a personal representative on behalf of the client, please complete the following:

Personal Representative's Name: _____

Please Print Clearly

Relationship To Client: _____

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of this ***Notice of Privacy Practices*** from this client or client's personal representative, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented obtaining the acknowledgement
- ☐ Other (Please specify): _____

_____

_____

_____

_____ _____

Authorized BLC Signature Date

This form will be maintained in your medical record.