

## INFORMED CONSENT

Thank you for choosing Compass Behavioral Health, LLC. We look forward to working with you. Today's appointment with Emmalee Stoll, LPC will take approximately 45-50 minutes. We realize that starting therapy is a major decision and that you might have significant questions. This document is intended to inform you of our policies, State and Federal Laws, and your personal rights. If you should have questions or concerns, please feel free to contact anyone within our agency and we will do our best to provide you with the necessary information. Emmalee holds a Master's Degree in Mental Health Counseling at Heidelberg University. Her areas of interest include Adjustment Disorders, Anxiety, Bi-polar Disorder, Depression, Eating Disorders, Mindfulness Techniques, Post Traumatic Relaxation, Stress Disorder, Stress Reduction, Personality Disorders, and Trauma. Treatment practices, philosophy, and plan limitations and risks will be discussed with you today. **Emmalee works under the direct Supervision of Karen L. Raber, MA/LPCC-S (license #: E.4064-SUPV)** for all Diagnostic Assessments and Treatment Practices. The limits of confidentiality will be discussed with you today as your case will be discussed in 1 to 1 Clinical Supervision to ensure our clients' continuity of care. Your signature under "Consent to Treatment" indicates your understanding and acceptance of these clinical practices.

## CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for: i) information (diagnosis and dates of service) shared with your insurance company to process your claims; ii) information you and/or your child or children report regarding physical and/or sexual abuse (at which point, by Ohio State Law, we are obligated to report to the Department of Children and Family Services); iii) were you to sign a Release of Information to have specific information shared regarding treatment; iv) if you provide information that informs any designee of Compass Behavioral Health, LLC that you are in danger of harming yourself or others; v) information necessary for case supervision or consultation; vi) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary and I am unable to return your call within 15 minutes, the client or guardian understands that they are to contact their local emergency room or call 911 for emergency services.

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT TO TREATMENT

Your signature below indicates that you have read all of the information within and agree to treatment at Compass Behavioral Health, LLC and to abide by our policies during the course of treatment in counseling.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS

I/We consent that \_\_\_\_\_ (minor child) may be treated as a client at Compass Behavioral Health, LLC. It is mandatory for treatment of children that we have proof of custody even if shared parenting is ordered. Failure to provide legal documentation may result in the rescheduling of your appointment.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## FINANCIAL/INSURANCE ISSUES

As a courtesy, we will bill your insurance company, HMO, responsible party or third-party payer for you. **The co-pay established by your insurance company is due at each session.** In the event you have not met your deductible, the full fee is due at each session until your deductible is satisfied. If your insurance company denies payment or does not cover mental health counseling services, you will be responsible for payment of all services rendered. If a client's unpaid balance exceeds \$150.00 or greater, services will be suspended until such time as the account is paid. Any client who has an unpaid balance to Compass Behavioral Health, LLC and does not make satisfactory payment arrangements will be placed with an external collection agency. The client will be responsible for reimbursement of any fees from the collection agency, including any and all costs and expenses incurred during collection efforts.

Compass Behavioral Health, LLC fees and services include:

Initial Assessment and Diagnosis - \$150

45-50 minute therapy session - \$120

45-50 minute telehealth therapy session - \$120

Telephone consultation/paperwork beyond clinician's therapy notes - \$25 per half hour (billed in 15 minute increments)

Court appearance and/or testimony - \$200 per hour

**No Show/Late Cancel (same day) appointments will be billed to the client at \$25.00 per appointment. Following the 3rd No Show/Late Cancel appointment, the client will be referred to another agency for treatment.**

Signature(s)\_\_\_\_\_ Date\_\_\_\_\_

## HIPAA Notice of Privacy Practices

Compass Behavioral Health is committed to maintaining client confidentiality. Information regarding your care and treatment will only be released in accordance with state and federal laws and professional ethical guidelines. Providing treatment services, collecting payment, and conducting healthcare operations are necessary activities for quality care. State and federal laws allow the use and disclosure of your healthcare information for these purposes.

**Treatment** - We may need to use or disclose health information about you to provide, manage, or coordinate your care or related services. This could include consultants and potential referral sources. **Payment** - Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the individual who holds your insurance coverage.

**Healthcare Operations** - We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance, licensing activities, and supervision/consultation/collaboration or treatment services. Other uses or disclosures of your information which does not require your consent include but are not limited to: i) information you and/or your child or children report regarding physical or sexual abuse. According to Ohio State Law, we are obligated to report this information to the Department of Child and Family Services; ii) if you provide information that informs any agency personnel that you are in danger of harming yourself or others; iii) information to remind you of or to reschedule appointments; iv) information regarding treatment services or alternatives; v) information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law.



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## CLIENT RIGHTS

### Right to request how we contact you

It is our normal practice to communicate with you at your home address, daytime phone number and/or cell phone number, and email address. You may be contacted in one or more of these methods in order to schedule future appointments, discuss treatment, and coordinate services. You have the right to request that our office communicate with you in an alternate format.

### Right to release your medical records

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

### Right to inspect and copy your medical and billing records

You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact our office manager. Under limited circumstances we may deny your request to inspect and copy information. A fee will be charged for costs of copying, mailing, and supplies.

### Right to add information or amend your medical records

If you feel that information contained in your medical record is incorrect or incomplete, you may ask to add information to amend the record. Amendment of records will be completed within 90 days. Under certain circumstances, we may deny your request to add or amend information. You have the right to file a statement of disagreement. Your statement and agency response will be added to your clinical record. You will be required to submit your request in writing, provide an explanation concerning the reason for your request, and submit to the office manager.

### Right to an accounting of disclosures

You may request an accounting of any disclosures Compass Behavioral Health has made related to your medical information used for treatment, payment, or healthcare operational purposes. You may request information shared with you, your designees, or information given under a Release of Information.

### Right to complain

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the US Department of Health and Human Services at 233 N. Michigan Ave., Suite, 240, Chicago, Illinois 60601. Phone: 312-886-2359.

I/We have read and understand Privacy Practices and Client Rights

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## CLIENT REGISTRATION FORM

### Demographic Information

Legal Name:	Home Phone:
Preferred Name:	Cell Phone:
Address:	Work Phone:
City, State, Zip:	Email Address:
Date of Birth:	Emergency Contact Name:
Legal Gender:	Emergency Contact Phone:
Gender Identity/Pronouns:	Relationship to Contact:
Racial Identity:	Marital Status:

### Responsible Party

Responsible Party is the person who will be paying for counseling services.

Responsible Party:	Home Phone:
Street Address:	Work Phone:
City, State, Zip Code:	Cell Phone:
Relationship to Client:	Responsible Party DOB:



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## Insurance Information

Primary Insurance:	Policy Holder:
Company Address:	Policy Holder DOB:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:
Secondary Insurance:	Policy Holder:
Company Address:	Policy Holder DOB:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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## Client Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications and Dosage:

Current Medical Conditions Diagnosed by a Physician:

Briefly describe why you are currently seeking counseling:

• For clients under the age of 18, is counseling being sought as part of a custody case? Yes \_\_\_\_\_ NO \_\_\_\_\_  
Please explain: \_\_\_\_\_

- IF Marked Yes above, "Dual Parental Informed Consent" form MUST be completed and included.
- Unless Compass Behavioral health has custody paperwork on file, we will proceed as if both parents have parental rights.

Does anyone in your immediate family have a history of alcohol or drug abuse?:

Please explain: \_\_\_\_\_

Do you currently smoke or use tobacco products? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you currently use alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Minimal \_\_\_\_\_ Moderate \_\_\_\_\_ Heavy

Do you currently use any form of illegal drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you been convicted of a crime within the past 10 years?

Please explain: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



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