Informed Consent for Services

Welcome to Insight Therapy Group! This document contains important information about our 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 about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you acknowledge your review of this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

THERAPY SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should understand. Your therapist has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things discussed outside of sessions.

The first 1-2 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, your provider will be able to offer you some initial impressions of what therapeutic work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with your therapist. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we are happy to help you set up a meeting with another mental health professional for a second opinion.

MEDICATION MANAGEMENT SERVICES

As a client requesting medication management for mental health symptoms, it is important that you understand the need for consent. Informed consent requirements are designed to encourage meaningful participation for the client in the treatment process and to increase the communication and trust between provider and client. Informed consent means that a client has knowingly and intelligently, without duress or coercion, clearly and explicitly given consent to the proposed medication.

As the client, you have the right to accept or refuse the proposed treatment, and that if you consent, you have the right to revoke consent for any reason, at any time. Your provider may urge the proposed medication as the best treatment possible, but may not use any reward or threat (express or implied)

nor any other form of inducement or coercion in an effort to gain consent. Your provider may not place you, the client, in a more restrictive setting without your consent.

You have a right to discuss your medications with your provider. If you have a problem with your medications, such as side effects, a wrong dosage, or if you disagree with your provider's choice of medications, let your provider know.

APPOINTMENTS
Therapy appointments will ordinarily be 45-50 minutes in duration. Medication management appointments will ordinarily be scheduled for 10-20 minutes in duration. Appointments will be scheduled to meet your individual needs. You may discontinue treatment at any time. We want our offices to be a safe environment for all, to that end no weapons are allowed at any time.

Your appointment time is reserved solely for you. If you no-show or cancel an appointment without adequate notice, we are unable to offer that spot to other clients in need. Therefore, you will be billed a no-show fee of $50 for any session that you cancel with less than 24-hours' notice. Mitigating circumstances may be considered.

If there are two instances of no shows you will be removed from your provider's schedule and referred out to other providers.

TELEHEALTH
I understand that "telehealth" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that appointments taking place by means of telehealth also involve the communication of medical/mental information, both orally and visually. Insight Therapy Group offers both in-office and telehealth appointments with all of our providers.

If I choose to participate in telehealth appointments, I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider at Insight Therapy Group PC that: the transmission of information could be disrupted or distorted by technical failures; the transmission of information could be interrupted by unauthorized persons; and/or the electronic storage of medical information could be accessed by unauthorized persons.

In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my/my child/my dependent's provider at Insight Therapy Group PC believes I/my child/my dependent would be better served by another form of mental health services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy or psychiatric medication management, and that despite my efforts and the efforts of my provider, my/my child/my dependent's condition may not be improved, and in some cases may even get worse.

I understand that I/my child/my dependent may benefit from telehealth, but that results cannot be guaranteed or assured. I accept that telehealth does not provide emergency services. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my telehealth appointments, (2) the information security on my computer, (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth appointment, and (4) ensuring that there is no one else in the room during my/my child/my dependent's telehealth appointment. If anyone else will be in the room during the telehealth appointment, they would be required to sign informed consent paperwork in addition to other paperwork required by the provider at Insight Therapy Group PC.

USING INSURANCE FOR YOUR APPOINTMENTS

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, we will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting us know if/when your coverage changes.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-5. We have copies of this book available at our offices and we will be glad to let you see it to learn more about your diagnosis, if applicable.) Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). We will release only the minimum information necessary for the required purpose. 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, we 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. We will provide you with a copy of any reports we are required to submit, if you request it. By acknowledging this Agreement, you agree that we can provide requested information to your carrier if you plan to pay with insurance. It is important to remember that you always have the right to pay for our services yourself to avoid submitting information to the insurance company.

INSURANCE - IN NETWORK

If you are choosing to see a provider **who is in network** with your insurance plan, you will be responsible for the cost share amount that your specific insurance plan has assigned. In accordance with federal law, we can provide you with a Good Faith Estimate of what your cost share amount should be based on the information that is furnished to us by your insurance company. Please be aware that when we receive an estimate of benefits from your insurance, they do not guarantee the estimate they provide us, and that although we do our best to give you the most accurate estimate possible, it is not guaranteed.

If you are working with a provider who is in network with your insurance company, our office will file your insurance claim for you. You are responsible for deductibles, co-insurance, and co-payments. **It is your responsibility to familiarize yourself with your insurance benefits.**

INSURANCE - OUT OF NETWORK

If you have health insurance, but are choosing to see a provider who is **out of network** with your insurance plan we will ask you to sign additional documentation stating that you are aware your provider of choice is out of network, and that you will accept responsibility for additional costs that may incur by choosing an out of network provider vs. an in network provider. This additional documentation will include a Good Faith Estimate on the costs of receiving treatment from a provider who is out of network with your insurance. Please note that not all insurance companies reimburse for out-of-network providers, and that while we can attempt to check your insurance benefits, any estimates we are provided may not be accurate. If you prefer to use an in-network participating provider, we will provide you with a referral. In accordance with federal law, we can provide you with a Good Faith Estimate of what your financial responsibility may be should you choose to see an out of network provider through Insight Therapy Group or if you don't have insurance or are choosing not to use insurance. It should be understood that any Good Faith Estimate we provide is just that - an estimate provided in good faith, and that as with all other estimates it is subject to change based on diagnostic need, clinical evaluation, and changes in circumstance

If you are working with a provider who is out of network with your insurance company, or if you don't have insurance or are choosing not to use insurance, our office may not be able to file your insurance claim for you. If we are unable to do so, we will provide you with the documentation necessary for you to file the claim with your insurance on your own. Working with an out of network provider subjects you to the professional fees listed below.

PROFESSIONAL FEES

Payment is due at the time of the appointment, unless other arrangements have been made. Payments can be made via cash, check, or credit card. Any returned checks are subject to an additional fee of up to $50 to cover the bank fees we incur. In the event of an overdue account, you are responsible for all collection costs, and interest charges may be added to your account.

If you choose to make payments with a credit card, HSA, or flexible benefits account, please be aware that we may need to contact your method of payment if any problems arise. We reserve the right to do so as needed and assure you that we will only communicate information with your payment company that is necessary for them to access your account to answer questions and provide solutions to problems utilizing your form of payment.

Listed below are our cash rates for the services we provide. Please understand that you will likely not be seen for all of these services, and that this is an exhaustive list being provided to you in the interest of full transparency. The services provided to you will be at the discretion of your provider, and will be done so based on your specific clinical needs.

THERAPY FEES:

- 90791 (Therapy intake) $300
- 90832 (Therapy 16-37 mins) $140
- 90834 (Therapy 38-52 mins) $190
- 90837 (Therapy 53-60 mins) $280
- 90839 (add on therapy, additional 60-mins) $280

- 90840 (add on therapy, additional 30-mins) $140
- 90846 (Family therapy without client) $230
- 90847 (Family therapy with client) $240

MEDICATION MANAGEMENT FEES:
- 90792 (Medication intake) $320
- 99213 (Medication low complexity) $175
- 99214 (Medication moderate complexity) $240
- 99215 (Medication high complexity/crisis) $300
- 99417 (add on medication, additional 15-mins) $250
- 90833 (add on therapy, additional 16-37 mins) $200
- 90836 (add on therapy, additional 38-52 mins) $225
- 90838 (add on therapy, additional 53+ mins) $250

OTHER POSSIBLE FEES:
- No Show/Late Cancel fees $50 per incident
- Court Testimony fees $500 per hour, 4 hour minimum
- Administrative fees** $50 per hour, 1 hour minimum

**Administrative fees may be charged for a provider to attend meetings for clients (such as IEP or 504 meetings)

CONFIDENTIALITY

Issues discussed in therapy are generally legally protected as both confidential and "privileged." However, **there are limits to the privileges of confidentiality**. These situations include:

· Suspected abuse or neglect of a child, elderly person, or disabled person.

· When your provider believes that you are in danger or harming yourself or another person, or you are unable to care for yourself.

· If you report that you intend to physically injure someone, the law requires your provider to inform that person as well as the legal authorities.

· If your provider is ordered by the courts to release information.

· When your insurance company is involved (e.g. in filing a claim, insurance audits, or in the case of review or appeals), or when attempting to collect overdue accounts.

· In natural disasters whereby protected records may become exposed.

· When otherwise required by law.

ELECTRONIC COMMUNICATION

Insight Therapy Group sends out automated appointment reminders 24-48 hours before your scheduled appointment as a courtesy. These reminders can be sent via email and/or text. It is important to understand that Insight Therapy Group has no control over who might see any messages once they are sent, even though they are sent to the phone number or email you provide.

Communicating with a provider electronically or online (email or text) has limitations. Insight Therapy Group maintains HIPAA compliant email and electronic health records, and makes every effort to maintain your confidentiality. However, electronic communication comes with inherent limitations,

including possible breach of privacy or confidentiality, difficulty in validating the identity of the parties, and possible delays in response.

PROFESSIONAL RECORDS

A clinical chart is maintained at our offices, as well as through an Electronic Health Record, describing your condition, treatment and progress, dates and fees for sessions, and notes describing each appointment. Electronic communications including text messages and emails are also included in your health record. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

Except in unusual circumstances that involve danger to yourself/others, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them with your provider or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right to have our decision reviewed by another mental health professional, which we will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONTACTING US

We are often not immediately available by telephone. We do not answer our phones while we are with clients or otherwise unavailable. At these times, you may send an email to your provider or leave a confidential voice-mail message and we will get back to you as soon as possible, but it may take a day or two for non-urgent matters. Please be aware that although our email is secure, there are confidentiality risks associated with communicating through text messages and email. Although we will follow your instructions regarding electronic communication, it is possible for your devices to be accessed by others that you may not want having access to your communications with your provider. Please use caution in what you choose to communicate with your therapist electronically. If, for any number of unseen reasons, you do not hear from us or we are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe:

- Contact a 24-hour Crisis Line:
    - Foundation 2:
        - 1-800-332-4224
        - 319-362-2174
        - foundation2crisischat.org
    - Crisis Text Line:
        - Text “start” or “go” to 741741
    - National Suicide Prevention Lifeline
        - 1-800-273-8255
- Call 911 or go directly to the emergency room.

We will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering our practice.

Insight Therapy Group

SOCIAL MEDIA POLICY

We will not friend/follow you on social media platforms. We also will not accept any friend/follow requests from clients or client's family members in order to protect confidentiality and ensure appropriate boundaries are maintained. You are welcome to "like" the Insight Therapy Group page on social media, but do so at your own risk with the understanding that this makes others aware that you have some sort of affiliation/interest in Insight Therapy Group. Please do not use social media messaging to contact your provider. Please note that all electronic communication is included in your health record.

OTHER RIGHTS

If you are unhappy with what is happening in the mental health services we are providing at Insight Therapy Group, we hope you will talk with your provider so that they can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that we refer you to another provider and are free to end services at any time. We provide gender affirming counseling to our clients. As directed by law, we do not provide gender affirming medical treatment, such as hormones or surgery. If you are the parent of a minor child seeking treatment with us and do not want your child to receive gender affirming counseling, please inform your provider so your child's care needs can be thoroughly assessed. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, gender identity, sexual orientation, age, religion, national origin, immigration status, socioeconomic status, marital status, or source of payment. You have the right to ask questions about any aspect of your care and about our provider's specific training and experience. You have the right to expect that we will not have social or sexual relationships with clients or former clients.

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Name of Client

____ _______________________

Signature of Identified Client | Date

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If signature is not that of the client's, indicate relationship to the client