Client Name _____ **Date** _____

Client Information
Policies and Procedures
Betsy Deeter, LCSW

The following information is provided to you to assist you in understanding policies and procedures at this office. I wish to provide you care that is both comfortable and has the highest professional quality.

Appointments

Appointments are made and reserved for you. **Please give 24 hours notice if you must cancel your appointment.** Sometimes illness and/or emergencies occur which prevent you from keeping your reserved time. I will not charge for this infrequent occurrence. However, a $50 fee will be charged for repeated late cancellations or missed appointments with no notification. You are fully responsible for these charges.

Emergencies and Telephone Calls

While you will be seen at a scheduled time there may be times when you need to speak with me between appointment times. I handle phone calls and urgent situations in a manner sensitive to the needs of any given client. I will discuss this matter with you at the beginning of your care. Should you need to talk to me during normal business hours I will return your call as promptly as I can. If you must leave a voice mail after hours please know that I will return the call during the next business day. If it is an emergency please leave a detailed message and your call will be returned as soon as possible. If it is a life threatening emergency please go to the nearest ER.

Fees and Payments

My fees will be discussed at the initial appointment. Office staff will file third party insurance payments if you so choose. **Co-payments and deductibles are due at the time of service.** You are responsible to know your insurance coverage plan and co-pay information.

Insurance Usage and Issues of Confidentiality and Privileged Communications

Many clients elect to file insurance coverage, including Medicare, for services rendered. We will fine insurance claims for you, provided you authorize us to do so and provide us with the necessary information to file such claims.
Many plans require an initial certification of care before you can use your policy. IT is your responsibility to make sure you meet such pre-certification requirements if you elect to use your insurance policy.
If filing an insurance claim for you, it is understood that you are granting my permission to reveal confidential information, such as the dates you were seen, length of the appointments and your diagnosis. Your carrier requires this information if your want insurance to pay for your claim. Most carriers also require further utilization reviews and participation with outcome and quality measures. Unless your care is very brief, it is

likely that your therapist will be required to submit a more extensive report documenting the clinical necessity for your care, if further sessions are to be authorized.
Most carriers require auditing and review of records for every visit. Nearly all companies require participation in outcome and quality care studies such as client satisfaction surveys. If your carrier requires such activities in order for you to use your insurance, I will comply with those requirements. It is my responsibility to inform you about the compromising of confidentiality and privacy when complying with such requirements. This is standard in today's marketplace whenever one elects to use third party insurance coverage for services.

Fortunately, the HIPAA regulations do provide you're a degree of privacy and confidentiality regarding your protected health information. Instead of releasing the entire record of your treatment I will be able to limit the information to only your designated mental health notes and not my psychotherapy notes of our sessions. The designated mental health record is limited to the following: billing information, paperwork you complete today, your treatment plan, progress notes, clinical summaries, correspondence with outside parties your authorize me to release, and any utilization review reports which have occurred regarding your care.

LCSW's in this state have a strong client/therapist confidentiality status. What you talk with me about in our sessions is protected by privilege communications laws and confidentiality principles, with the exception of the following issues: clear and imminent danger to self and/or others, suspected child abuse, worker's compensation related cases, if your psychiatric or psychological health becomes an issue in a lawsuit, information shared in the utilization review reports for authorization of care, compliance with audits by your insurance carrier. Unless you give written permission for me to release information to another party, all communication here is kept private, confidential and privileged.

Your Informed Consent to Care

I have provided this information to you in the hope of fully informing you about he policies of our office. Like other things in life, psychotherapeutic services offer no absolute guarantee of success and there are limitations to any form of care offered a patient. Your treatment will be tailored to your individual needs and I invite you to discuss your treatment plan with me so that you have a sense of direction regarding the care you are receiving.

Please feel free to discuss any of these issues with me in more detail. By signing below, you acknowledge that you have read, understood and agree to these policies. Your signature acknowledges your informed consent for care with your provider.

_____ _____

Signature of adult client or guardian of minor Date

_____ _____

Witness Date