Informed Consent, Privacy Practices, and Financial Policy

Welcome to my practice! Recent legislative and professional activities have led me to prepare this form which I ask you to read, sign and return to me at the first meeting. You may have a copy if you wish.

The Clinical Relationship

I am licensed by the Indiana Professional Licensing Agency, Behavioral Health and Human Services Licensing Board, and practice in accordance with the professional and ethical guidelines of that Board and appropriate national professional organizations such as the American Counseling Association and American Association of Sex Educators, Counselors and Therapists. I will answer any questions regarding my professional credentials, as well as your diagnosis. If you wish, you may have access to clinical assessment results as provided by legal and professional guidelines. Treatment recommendations with rationale will also be explained, as well as the rationale if no treatment is recommended.

Psychotherapy cannot be easily described in general statements. It varies depending on the presenting issues of the client. There are many different methods I may employ to help address presenting issues. Psychotherapy is not like a medical visit. Instead, it requires a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during and outside our sessions.

Privacy Practices

The confidential relationship and communications between a licensed mental health professional in the State of Indiana and his/her clients are privileged, and communication will not be disclosed except for the following provisions:

(1) If the client requests and agrees in writing to such disclosure;
(2) As professionals we are required to report to state authorities any instances of reported, observed, and/or suspected abuse of children, the elderly, or handicapped adults;
(3) Under provisions of Indiana law (IC 34-30-16-1) a mental health service provider is immune from civil liability to persons other than the patient for failing to:

(1) predict; or

(2) warn or take precautions to protect from; a patient's violent behavior unless the patient has communicated to the provider of mental health services an actual threat of physical violence or other means of harm against a reasonably identifiable victim or victims, or evidences conduct or makes statements indicating an imminent danger that the patient will use physical violence or use other means to cause serious personal injury or death to others. As added by P.L.1-1998, SEC.26. This also applies to incidents of possible harm to self. If such efforts are made, the mental health professional is not liable for any legal action for having broken the privacy or confidentiality of the therapist-client relationship
(4) Should a Court Order require such disclosure;
(5) State regulatory agencies (e.g., Behavioral Health and Human Services Licensing Board) have a legal right of access to client records when and if a question of professional misconduct is raised;
(6) When you agree to have me bill your insurance carrier for services, the insurer or their designated representative does have access to your record for review purposes. Unless you otherwise indicate, you release Donald Cronk, LMHC, CST/DC Counseling Inc. to provide only

billing information to the subscriber of any insurance, if the subscriber is other than yourself unless other arrangements are in place.
(7) If the individual receiving treatment is under eighteen years of age, treatment must be authorized by a parent or guardian (with limited exceptions). It is my preference to undertake treatment only with the consent of both parents. If we determine that it is appropriate or necessary to proceed with therapy with only one parent providing consent, the non-signing parent still has a legal right to a copy of the minor's record if requested, unless his/her parental rights have been terminated or there is a Court Order prohibiting him/her from receiving records. Please be aware that the law also provides parents the right to examine such treatment records. It is my policy to request an agreement from parents that they agree to give up access to the adolescent's records and/or provide them only with general information about our work together, unless we were to believe there is a high risk for serious harm to themselves or another. In this case, we would notify parents of our concern(s). Before giving parents any substantial information, I would discuss the matter with the adolescent, if possible.
(8) If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

(9) Lastly, treatment records of couple's therapy sessions contain information about each person. Both clients should be aware that either person has a right to obtain treatment records unless both persons agree that treatment records will only be released by joint consent. In the event of a disagreement, the records will not be released without a Court's Order. In the case of couple treatment, each person is requested to initial the appropriate box, below, to indicate how they would like this issue handled:

Yes No
___ ____ I wish to have access to treatment records without the joint consent of my partner.
___ ____ I understand and agree that records shall only be released with the joint consent of both partners.

Contacting Me
Due to my work schedule, I am not immediately available by telephone. While I am usually in my office between 8:00 am and 6:00 pm, my telephone is answered by confidential voicemail. I will make every effort to return your call the same day you make it with the exception of weekends, holidays and vacations. I am also available via e-mail and text, but please keep in mind I will likely respond to non-scheduling/clinical issues via telephone call to protect confidentiality.

Emergencies
I do not employ a receptionist or a 24 hour answering service. If you are unable to reach me by phone, and you feel your issue is an emergency, please go to the nearest emergency room.

Privacy Practices and HIPAA
Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) for purposes of treatment, payment, and health care operations. (That is, your case file). HIPAA requires you be provided with this Notice of Privacy Practices for use and disclosure of PHI for such treatment, payment, and health care operations.
Protected Health Information may not be used or disclosed in violation of the HIPAA Privacy Rule (45 CFR parts 160 and 164) (the "Privacy Rule"), or in violation of

state law. As a clinician, I am permitted, but not mandated, under the Privacy Rule to use and disclose PHI without patient consent or authorization in certain circumstances. However, state or federal law may supercede, limit, or prohibit these uses and disclosures Such permitted uses and disclosures of PHI include: Those made to the patient, for treatment, payment, or health care operations purposes, or as authorized by the patient; those related to or made pursuant to reporting on victims of domestic violence or abuse (as required by law), Court orders, Worker's Compensation laws, serious threats to health or safety, government oversight (including disclosures to a public health authority, coroner or medical examiner, military or veterans' affairs agencies, an agency for national security purposes, law enforcement). We use and disclose PHI only as permitted by the Privacy Rule and in accordance with state or federal law.

The law also requires that your signature be obtained, acknowledging that you have been provided with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. You can discuss any questions you have about the procedures upon meeting with me. When you sign this document, it will represent an agreement between yourself and me, your clinician. You may revoke this Agreement in writing at any time. That revocation will be binding unless action has already been taken in reliance on it or if there are obligations imposed on Donald Cronk, LMHC, CST/DC Counseling Incorporated by your health insurer in order to process or substantiate claims made under your policy.

You should be aware that, pursuant to HIPAA, I will keep Protected Health Information about you in two sections of the professional record. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, description of the ways in which your problem impacts your life, diagnosis, goals for treatment, your progress towards these goals, medical and social history, treatment history, any past treatment records that were received from other providers; as well, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist in providing you with quality treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of conversations with me. They also contain particularly sensitive information that you may reveal that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of the Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed Authorization.

HIPAA also provides you with several new or expanded rights with regard to your Clinical records and disclosures of Protected Health Information. These rights include requesting that your clinician amend your record; requesting restrictions on what information from your Clinical Records may be disclosed to others; requesting an accounting of disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about Donald Cronk, LMHC, CST/DC Counseling Incorporated or the my policies and procedures recorded in your records; and the right to a paper copy of the Agreement, the attached Notice form, and Donald Cronk, LMHC, CST/DC Counseling Incorporated privacy policy and procedures. Your clinical record will be confidentially treated and maintained as

required by law. I have established guidelines within my practice for clinical record management should death or disability of the clinician occur.

Further, it is my understanding that insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of both sets of records, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents with such assistance. There is a charge of $15.00 or .50 per page, whichever is greater, for requests to copy records.

Please note that by providing me with your cell phone number you are agreeing to receive session date communications via text from me and from TherapyAppointment.com.
Lastly, Donald Cronk, LMHC, CST/DC Counseling Inc. has contracts with various businesses in order to conduct clinical and business services, such as financial collections services and TherapyAppointment.com for records storage and billing. As required by HIPAA, we have a formal business contract with these businesses in which it is agreed each will maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, the names of these organizations and/or a blank copy of this contract can be provided to you.

Financial Policy
Fees for service depend on a number of factors (types of service, length of session, etc.) but the cost per visit should always be clear between you and me. I request payment at the time of service. Please discuss any other arrangements with me. The cost for an initial assessment is $225.00 and my hourly fee is $210.00.

Donald Cronk, LMHC, CST/DC Counseling Incorporated is an eligible provider for most insurance carriers. As a service to you, I can bill your insurer, but it is your responsibility to verify eligibility. In today's world of managed care, PLEASE verify in advance your outpatient mental health benefits/options including the need for pre-authorization, copayment, limits to sessions, and your deductible. Again, if your insurance company requires you to obtain authorization, those sessions which occur without such authorization will be billed to you and are your financial responsibility. All deductibles and copays are your responsibility. Copayment MUST be paid at the time of service. (Managed care contracts obligate us to collect the copay at time of visit). You, not your insurance company, are responsible for full payment of related fees. You may also elect to pay Donald Cronk, LMHC, CST/DC Counseling Incorporated yourself to avoid any of the problems above, e.g., managed care requirements, possible disclosure of your clinical records to the insurance company.

When scheduling an appointment, you have reserved an hour of time in my schedule. If you are unable to keep a scheduled appointment and do not give me forty-eight (48) hours notice, you will be personally charged for that visit; I cannot bill insurance for missed appointments, and less than 48 hours notice makes it unlikely that I will be able to find a replacement for you. There may be other charges not covered by insurance including (but not limited to) report writing, telephone conversations lasting longer than ten (10) minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, time spend performing any other service you may request. If you become involved in legal proceedings that

require clinical participation, you will be expected to pay for all professional time, including preparation and transportation costs. Because of the difficulty of legal involvement, I charge $225.00 for preparation, transportation and attendance at any legal proceedings, even if I am called to testify by another party.

The methods of payment I accept are cash, check and some credit/health savings cards. Please note that I apply a 4.0% fee to all credit card transactions to cover the cost of processing fees. An account balance ninety (90) days overdue will be considered PAST DUE and I will contact you to develop a payment arrangement. A balance one-hundred twenty (120) days overdue and with no response to the payment arrangement may be sent to a local agency for collection, which will require me to disclose otherwise confidential information, such as your name, nature of services provided, and the amount due. I do not anticipate collections procedures but I have established this policy so that all clients are clear as to my office procedures. Again, please TALK with me first and frankly if you have questions about fees, payments or your balance. While certainly none of the above concerns may ever occur, we must make each client aware of the nature and limits of clinical and business policy procedures. Returning this form to us with your signature will signify that you have been duly informed of and agree to our business and clinical policies, the Mental Health Bill of Rights, and HIPAA requirements and rights as described.

_____	_____	_____
Client Signature(s)	Therapist Signature	Date