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**WELCOME!** This form has a number of purposes. It tells you little of what to expect out of therapy. It also tells you about my professional services and business practices. Lastly, it explains your privacy rights outlined by HIPAA. The Health Insurance Portability and Accountability Act regulates the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information. Please let me know if you have concerns about any of these policies.

**ABOUT THERAPY**: Your first visit will help me get a general understanding of your situation in order to determine how I might best help you. Psychotherapy is a way of talking through your problems in order to begin resolving them. You will need to take an active part in psychotherapy by working on and thinking about the things you talk with me about. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems and feeling much less distressed. Many times, you will feel more at peace and having a sense of calm and control over your situation.

However, the process of therapy can take many turns. Since therapy often involves discussing difficult experiences and feelings, there may be times after a session that emotions like sadness, guilt, anger, frustration arise. There may be times you may think you do not want to continue to come in. These feelings are very normal and understandable. Please don’t think this signals that therapy is not working and perhaps you should stop coming. Instead, let me know what you are feeling so we can discuss these issues. Since therapy involves a large commitment of time, energy and money, it is important that you feel comfortable addressing your concerns with me so that we can work through these issues and feelings. Not every therapist can meet the needs of every client. If you feel uncomfortable or feel like you are not making progress, we need to discuss this and I won’t take it personally. I may not be the right therapist for you and will be happy to help you with referrals to another mental health professional who might meet your needs.

APPOINTMENTS: Individual and family sessions last usually 55-60 minutes. *If you cancel an appointment, notify me at least 24 hours before the session, or you will be charged the full hourly fee for the time you reserved for the appointment. Insurance does not pay charges for reserved time; you will personally be responsible for any such charges.* However, in case of an emergency, if you call in advance to cancel an appointment , there will be no charge.

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail, which I monitor frequently. I will make every effort to return your call on the same day you make it, except on weekends and holidays. If you are difficult to reach, please inform me of the times when you will likely be available and I will make every effort to return your call at one of those times.. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

FEES, HEALTH INSURANCE AND MANAGED CARE: My hourly fee for a diagnostic interview (evaluation) is $225 and my hourly fee for individual, marital or family therapy is $175 for a 55-60 minute session. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will pro rate the hourly cost if I work for periods of less than one hour. Other services include possible court report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries and time spent performing any other service you may request of me. With regard to court hearings I will not voluntarily testify on your behalf and if summoned, my hourly rate for legal preparation, personal consultation, transportation and related expenses as well as testifying is $300.

If there is a financial hardship, please let me know so that we may work out your concerns and reach some agreement as to how I will be paid for my services.

Most group health insurance plans cover *part* of my fee. I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payments of my fees. Therefore, you are responsible for contacting your insurance company to obtain authorization before service is provided, if required by your insurance. Please understand that if you do not pre-certify treatment or obtain required referrals, you may cause a reduction in benefits payable and you will be liable for the loss or reduction in benefits.

There may be two kinds of noninsured costs to you: (1) a deductible, which is an amount you must pay before your insurance coverage begins to pay; and (2) many plans also have a co-payment, which is a portion of the fee for each visit that you must pay yourself. **It is the client’s responsibility to pay this co-pay or the established fee to go towards the deductible at the time of service.** I have contracted with some insurance companies to accept less than my standard fee as payment in full. If this is the case, your account balance will be adjusted when I receive payment from the insurance company. However, if the insurance pays less than 100% of the contracted fee, you will owe the balance of the fee up to 100% of the contracted fee. Many insurance plans are managed care plans. Under managed care plans, the insurance company may periodically require that I submit your diagnosis, progress and treatment plan to their reviewer, who then determines if further treatment is medically necessary. If you have a managed care insurance plan, this information will be released to the reviewers. Any diagnosis made by any clinician can be used to determine future eligibility for insurance coverage. This information may become part of the insurance company’s files and is beyond my control of how they keep such information confidential. If you are concerned about the diagnosis, please feel free to discuss this with me.

**For problems involving payments and insurance, please contact JMT Billing Services, Inc., at 815-235-2353 or at www.jmtbilling.com.** If an account is overdue and no provision for payment has been made, I may turn the account over to a collection agency or small claims court, as authorized by state or federal law, and failure to pay will show up on a client’s credit history. The client is responsible for all fees and costs involved in pursuing such action.

**EMERGENCIES:** You are expected to be responsible for your own well-being and be able to function autonomously between sessions. If you are experiencing a crisis, please understand that I will make every effort to return your phone call as soon as possible.

However, if the matter is urgent and an emergency:

Dial 911

Or

Go the local Emergency Room even if you are waiting for a return call from me

If I believe you present an imminent, serious risk of injury or death to yourself or another, I may make disclosures that I believe are necessary to provide protection for the parties involved.

As a therapist in private practice if I feel that I cannot meet your needs that may extend beyond the scope of traditional psychotherapy, I will make an appropriate referral on your behalf after we discuss the issue.

Often Mental Health Clinics or Hospital Programs have more resources and supports available that may help you make the greatest progress. If you are under acute distress and I am worried about your safety, please understand that I would require you to contact your medical doctor or go to a hospital emergency room if a psychiatric emergency would arise.

CONFIDENTIALITY AND FILES

The laws governing confidentiality can be quite complex. You should be aware that, pursuant to HIPAA, I may keep Protected Health Information about you in two sets of professional records. One set constitutes your clinical record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical, social and treatment history, any past treatment records that I receive from other providers, 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 therapy notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of therapy notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations and how they impact your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your clinical record. These therapy notes are kept separate from your clinical record. While insurance companies can request and receive a copy of your clinical record, they cannot receive a copy of your therapy notes without your authorization. Insurance companies cannot require your authorization of therapy notes as a condition of coverage or penalize you in any way for your refusal to release therapy notes.

In summary, only the minimum necessary information will be communicated to your insurance carrier, including diagnosis, the date and length of our appointments and what services were provided. Often the billing statement submitted to your insurance company is sufficient. Sometimes treatment summaries or progress goals are also required. Psychotherapy notes will not be disclosed to your insurance carrier unless explicitly authorized by you.

 You may examine and/or receive a copy of both set of records if you request it in writing. Because these are professional records, they can be misinterpreted. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I charge a fee of $1.00 per page for printing.

You also have the Right to Request Restrictions on certain uses/ disclosures of Protected Health Information. However, I am not required to agree to the request. If you feel that the PHI about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. You then have the right to file a statement of disagreement in your record. You also have the right to receive confidential communication by alternative means and locations. (For example, you may not a want a family member to know that you are seeing me. On your request, I will send your bills to another address without further explanation.

I also want to let you know I employ billing resources. In most cases, I need to share information for purposes such as billing, scheduling and quality assurance. I sometimes use collection agencies; an accountant and technical support services. As required by HIPAA, these businesses will sign contracts with me in which they promise to maintain the confidentiality of protected health information.

Also, I consult with other therapists concerning clients on occasion. I do not disclose any identifying information. Please let me know if you would prefer that other counselors not be consulted about your case. All counselors are bound by the same rules of confidentiality. I will note all consultations in your Clinical Record.

I may find it helpful to share information with your primary care physician or other health and mental health professionals who are currently treating you and will request you sign a Release of Information in order to do so. A record of these disclosures will be kept in your Clinical Record.

There are some situations where I am permitted or required to use or disclose information without either your consent or authorization:

· If a client is clearly likely to seriously harm him/herself, I am required to take action to prevent self-harm.

· If there is a clear risk that a client plans to seriously harm another person, I may have a duty to warn the potential victim; or disclose the risk to appropriate public authorities.

· If I suspect that abuse of a child or senior citizen may have taken place, I am required to report the suspected abuse to the Department of Child and Family Services.

· If the client is a minor under the age of 12, both parents have access to the minor client’s complete Clinical Record, including Psychotherapy Notes, unless there is a court order prohibiting one of the parents from access.

· If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the psychotherapist-client privilege law. I cannot provide any information without your (or your personal or legal representative’s) written authorization. However, if a court orders me to disclose information, I am required to provide it. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

· If a government agency (such as Medicare) is requesting information for health oversight activities, I may be required to provide it for them.

· If a client files a complaint or lawsuit against me, I may disclose relevant information regarding the case in order to defend myself.

· If a client files a worker’s compensation claim, the client must sign an authorization so that I may release the information, records or reports relevant to the claim.

· I may present disguised case material in seminars, classes or scientific writings; in this situation, all identifying information and Protected Health Information is removed, and client confidentiality and anonymity is maintained.

**INFORMED CONSENT REGARDING ELECTRONIC AND TELECOMMUNICATIONS**

In regards to confidentiality it is important to have an understanding of how I may reach you outside of our scheduled appointment times. Please make sure you complete the information on the Intake Form which lets me know how I may best contact you.

It is important for you to understand that I cannot ensure the confidentiality of any form of communication through electronic media, including e-mails; faxes and text messages. You are also advised that any email sent to me via computer in your work-place environment is legally accessible by an employer. We are able to communicate via texting and email messaging for the purposes or scheduling and cancellations as long as you understand the potential limits to privacy it poses.

Texting and Emailing are not totally secure. While my Smart Phone has a privacy lock on it, it is difficult to ensure it is fully protected in regards to texting, emails and voicemails. In addition, I will store your number and identify you only by your first name and last initial in my Contacts which gives limited identity protection. There is also a privacy lock on my computer but that does not full guarantee privacy protection in regards to client e-mails and other data. While I try to return messages in a timely manner, I cannot guarantee an immediate response and request that you do not use electronic methods of communication (texting and e-mails) to discuss therapeutic content or request assistance for crisis/emergencies. Please call my cell phone if you are needing to talk me about an urgent matter.

I am also ethically and legally obligated to maintain records of each time we meet, talk on the phone or correspond via electronic communication such as email, voicemail or text messaging. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting.

**SOCIAL MEDIA/INTERNET SEARCHES/ LOCATION BASED SERVICES/BUSINESS REVIEW SITES**

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Linkedin…). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

While my present or potential clients might conduct online searches about my practice and/or me, I do not search for my clients with Google, Facebook or other search engines, unless there is a clinical need to do so, as in the case of a crisis or to ensure your physical wellbeing. If clients ask me to conduct such searches or review their websites or profiles and I deem that it might be helpful, I will consider it on a case by case basis and only after discussing possible impacts to our relationship and privacy.

If you used location-based services on your mobile phone, you may wish to be to aware of the privacy issues related to using these services. I do not place my practice as a check in location on various sites. However, if you have GPS tracking enabled on your device, it is possible that others may summise that you are therapy client due to regular check in’s at my office. Please be aware of this risk.

You may find my practice on sites such as Healthgrades or other places which list businesses. Many of these sites include forums in which users rate their providers and add reviews. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating or endorsement from you as my client. Of course, you have a right to express yourself on any site you wish. But, due to confidentiality, I cannot respond to any review whether it is positive or negative. You should be aware that if you are using these sites to communicate with me about your feelings about our work, there is a good possibility I will never see it.

If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. Confidentiality means that I cannot tell people we are working together but you are welcome to tell anyone you wish that I am your therapist or how you feel about the treatment I provided to you. If you do choose to write something on a business review site, I hope you keep in mind that you may be sharing personally revealing information in a public forum and it could comprise your privacy.

If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can contact: The US Department of Health and Human Services/Office of Civil Rights/200 Independence Ave./Washington D.C. 20201

**TELEHEALTH INFORMED CONSENT**

Telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

With Telehealth:

1. You have the right to withdraw your consent at any time without it affecting your right to future care, services or programs to which you are entitled.
2. You have the understanding that there are risks, benefits and consequences associate with tele- health, including but not limited to, disruption of transmission by technology failures, interruption sand or breaches of confidentiality by unauthorized persons, and/or limited ability to respond in emergencies. You understand that if your privacy maybe comprised by your location, for example, other family members may enter the room that you are engaged in telehealth sessions from.
3. You have the understanding that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and /or required by law.
4. You have the understanding that privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder; or vulnerable adult abuse; danger to self or others)
5. You understand that if you are having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.
6. You understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, we will end and restart the session. If we are unable to reconnect within 10 minutes, please call me at 815-235-0009 to discuss since we may need to reschedule.
7. You understand that I may need to contact your emergency contact or other appropriate authorities in case of an emergency. Therefore, you agree to provide me your location and a contact person who I may contact in case of a life threatening emergency. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

**MINOR AND PARENTS**: Clients under 12 years of age and their parents should be aware that the law allows parents to examine their child’s treatment records. Parents of children between 12 and 18 cannot examine their child’s treatment records unless the child consents and I find that there are no compelling reasons for denying access. Parents are entitled to information concerning their child’s current physical and mental condition, diagnosis, treatment needs, services provided and services needed. Since parental involvement is often crucial to successful treatment, in most cases, I request clients between 12 and 18 years of age and their parents to enter into an agreement that allows parents access to certain treatment information. If everyone agrees, I will provide parents with general information about the progress of their child’s treatment. Any other communication will require the child’s authorization, unless I believe the child is in danger or is a danger to someone else. Before giving parents any information, I will discuss this matter with the child, if possible and do my best to handle any objections he or she may have.

**TERMINATION AND FOLLOW UP**

Deciding when to stop our work together is meant to be a mutual process. Before we stop, we will discuss how you will know if or when to come back or whether a regularly scheduled “check-in” might work best for you. If it is not possible for you to phase out of therapy, I recommend that we have closure on the therapy process with at least one termination session.

Noncompliance with treatment recommendations may necessitate early termination of services. I will discuss this with you and exercise my judgment about what treatment will be in your best interest. Your responsibility is to make a good faith effort to fulfill the treatment recommendations to which you have agreed. If you have concerns about my recommendations, please express them so that we can resolve any difference or misunderstanding. If during our work together, I assess that I am not effective in helping you reach your goals, I am obliged to discuss this with you and if appropriate, terminate and give you referrals that maybe of better help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help you transition. You have the right to terminate treatment at any time. If there are any threats of violence toward me, my family or my office, I reserve the right to terminate treatment immediately. Failure or refusal to pay for services after a reasonable to time is another condition for termination of services. If you choose to terminate our work together, you will be responsible for paying for all accrued fees.

**YOUR SIGNATURE ON THE *CLIENT INFORMATION FORM* INDICATES THAT YOU HAVE READ THIS CLIENT SERVICES AGREEMENT, AGREE TO ITS TERMS AND UNDERSTAND THAT THERE CAN BE NO ABSOLUTE CURE IN THE PRACTICE OF PSYCHOTHERAPY. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE NOTICE OF HIPAA RIGHTS INCLUDING IN THIS FORM INCLUDING INFORMED CONSENT FOR TELEHEALTH.**