OUTPATIENT SERVICES CONTRACT

Welcome to Transform Youth and Family Counseling. Since this is your first visit, we hope what is written here can answer some of your questions. Please let us know if you want clarification on any of the topics discussed in this Outpatient Services Contract, or if you have any questions that are not addressed here. When you sign this document, you are stating that you understand and will adhere to the information in this Outpatient Services Contract.

THERAPY SERVICES

We provide individual, group, and family therapy services for youth ages 10-24 and their families. The first appointment serves as an intake appointment. We will want to hear about the difficulties that led to you making an appointment, goals for therapy, and general information about your current life situation. By the end of this first appointment, we will give you some initial recommendations on what we think will help. If we do not think we are able to best assist you, we will give you names of other professionals who we believe may be better able to assist you. If you do not agree with our treatment recommendations or do not think our personality styles will be a good match for you, let us know and we will do our best to suggest a different therapist who may be a better fit.

If you and your therapist decide to work together in therapy, you will collaborate on a treatment plan that incorporates effective strategies to help you reach the goals you want to accomplish. Sometimes more than one approach is helpful. The standard individual, group, or family session length is 55-minutes. We also offer 30-minute individual appointments as this works best for some youth. Oftentimes, sessions are set for at least once each week in the beginning phases of therapy, but this varies based on what seems most appropriate for your particular situation.

Therapy can be extremely helpful and fulfilling, and it takes work both in and out of sessions to be most effective. It requires active involvement, honesty, and openness in order to reach your treatment goals. We encourage you to discuss any concerns you have about our work together directly so that we can address it in a timely manner. Factors that may result in termination of therapy services include, but are not limited to: violence or threats towards therapists or staff, refusal to pay for services after a reasonable time and attempts to resolve the issue, or repeated no shows or late cancellations of scheduled appointments.

We may at times seek consultation with other therapists at Transform Youth and Family Counseling to ensure we are helping you in the most effective manner. We will give information only to the extent necessary, and we make every effort to avoid revealing the identity of clients.

AVAILABILITY BETWEEN SESSIONS

If needed, you can leave your therapist a message on our 24-hour voicemail box at 541-507-6400, and their extension. When you leave a message, include your telephone number, even if you think we already have it, and best times to reach you. We make every effort to return calls in a timely manner. In the rare occurrence that a message is missed or accidentally deleted, if you do not hear back from us within 48 business hours, please leave a second message. If we are unavailable for an extended time, such as on vacation, we will inform you of whom you can contact during our absence.

Transform Youth and Family Counseling is not a crisis facility. We may not get your information quickly if you call, email, or fax us in the event of a crisis or emergency. If you are in an emergency situation, such as being in immediate danger of harming yourself or someone else, please go to the nearest emergency room or call 911. If you are in crisis and cannot wait for your therapist to return your call, please contact the Josephine County Crisis Line at 541-474-5360.

RATES AND INSURANCE

Good Faith Price Estimate: Our billing office will reach out to you with a good faith price estimate for routine services by secure email (to the email address that you fill in on the billing information form below) or text message within 3 business days of receiving your completed billing information form and a copy of your insurance card(s). If you have not received a good faith estimate within 3 days of sending your completed forms, please contact our billing office directly at info@professional-practice.org or (541) 234-4781. Please note that this is a good faith estimate based on information provided by you and your insurance company, not a guarantee of payment. Final benefit determination will be made by your insurance company after they have received your claim. We encourage you to contact your insurance company verify your benefits and the terms of your plan. The billing office can provide you with a Patient Price Estimate Worksheet for gathering information to verify your benefits. In some cases, a Patient Price Estimate Worksheet completed before services were rendered can support an appeal if your insurance processes claims differently than they said they would.

Carve-Out Plans: Occasionally, insurance plans will carve out mental health benefits to another company. (In other words, you may have medical insurance with one company, but your mental health claims may be processed by another company.) We can find out about situations like this during the price estimate. If your mental health benefits are carved out to a company that your provider is out of network with, you may have a higher than expected out of pocket expense for treatment. Please be sure to return your insurance information form to the billing office at least 10 business days before your first session so that you have the opportunity to review your estimate before services are rendered.

Changes: **Please contact our office immediately if anything reported on the Billing Information form changes.** In some cases, a change of your information will change your out-of-pocket expense for treatment, even if the type of treatment that you are receiving doesn't

change. We may not be able to bill your insurance or warn you of increased out-of-pocket expense if we don't have current information at least 10 days before changes become effective.

Dual Coverage. If you are covered by more than one insurance plan, please attach additional copies of the Billing Information form completed with your other insurance information and a copy of the front and back of all insurance cards for all plans and policies that cover you. **Please include this information even if you don't think that your other insurance will cover the treatment you're seeking.** If your insurance denies your claim because they think that another payer should be billed first (also known as 'Coordination of Benefits' (COB), we will send you a statement for the balance due, noting that your insurance refused to pay, indicating that you have another coverage that should be billed first. In that event, you would need to contact your insurance company and provide the information that they need in order for your claim(s) to be reprocessed and then contact us to follow up so that your claims can be resubmitted. If we don't hear from you within 30 days of your statement to indicate that you provided the information required by your insurance company and we don't receive updated insurance information from you before the deadline established by your primary insurance company for timely filing, you may be liable for the entire balance of the claim, as established in ORS 410-120-1280(5).

If your insurance policy does not pay for services rendered, you will be responsible for the full fee amount. If fees for services are not paid in a reasonable amount of time, and attempts have been made to resolve the financial matter to no avail, a client account may be sent to a collection service. An additional fee will be imposed to the client account if the account is referred to a collection service. If the outstanding balance on a client account is not resolved, we will be unable to schedule any future appointments until the outstanding balance is paid.

We are in network with Regence Blue Cross and Blue Shield, Moda, Aetna, and Oregon Health Plan (Jackson Care Connect and Open Card). We can also bill out of network if we are not in network with your insurance provider. We also provide online (telehealth) therapy sessions. Some health insurance carriers cover telehealth services. If your insurance plan does not cover telehealth services, it is your responsibility to pay our full fees.

Our current fees are as follows:

55-minute Initial Intake Appointment: $195
30-minute Individual Counseling Session: $90
55-minute Individual Counseling Session: $175
55-minute Family Counseling Session: $175
55-minute Group Counseling Session: $65

Sliding Scale: We offer time and space limited sliding scale fees so that cost doesn't have to be a barrier for high-quality mental health treatment. Sliding scale fees are only applicable for clients that are uninsured or whose insurance is not accepted by Transform Youth and Family Counseling. To be eligible to receive the sliding scale fees, the client and/or family must have an income at or below 100 percent of the current U.S. Federal Poverty Guidelines. If you are interested in receiving sliding scale fees, please ask your therapist or provider.

Cancellation Policy: We require at least 24-hours notice if you need to reschedule or cancel your appointment. All no shows or cancellations with less than 24-hours notice will result in a **$100 fee, and insurance companies do not pay for late cancellation fees.** Chronic no shows or late cancellations may result in termination of services at Transform Youth and Family Counseling.

SOCIAL MEDIA AND COMMUNICATION POLICY

Social Media: In order to maintain your confidentiality and our respective privacy, we do not interact with, accept friend requests or contact requests from current or former clients on any of our staff's personal social media sites including Instagram, Twitter, Facebook, LinkedIn, etc. Please follow us on our Transform Youth and Family Counseling social media sites.
We will not solicit testimonials, ratings or grades from clients on websites or through any means. We will not respond to testimonials, ratings or grades on websites, whether positive or negative, in order to maintain your confidentiality. Our hope is that you will bring concerns about our work together to the therapy session so we can address them directly.

Texting: Please do not contact us through text messages regarding clinical issues. Text messages are not a secure communication, and there is a possibility that we will not get the message in a timely manner, or that communication will be misinterpreted. Text messages are only to be used for scheduling, changing or canceling appointments.

Email: Please be aware that if you send us an email with clinical information, we cannot guarantee it will be a form of secure communication. Our therapists and providers are able to send secure emails out to their clients, but we cannot control the security of incoming emails. Please use your discretion when sending us emails with clinical information. We advise that you contact your therapist or provider by phone at 541-507-6400 and their extension number if you would like to discuss clinical matters.

CONFIDENTIALITY

In general, law protects the confidentiality of all communications between a client and a mental health clinician, and we can only release information to others with your written permission. However, there are a number of exceptions, which are indicated in the Notice of Privacy Practices, included below. We make reasonable efforts to discuss any need to disclose confidential information about you, and we are happy to answer any questions you have about the exceptions to confidentiality.

For youth under 18 years of age, please note what we will share with parents/guardians:

- Immediate safety risks including plans for suicide or plans for harming others.
- Reports of abuse or neglect.

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records unless your therapist finds that there are compelling reasons for denying the access to the records. Before giving them any information, your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have.

COURT RELATED SERVICES

Please be advised that should a therapist of Transform Youth and Family Counseling be requested to write a letter or court ordered to testify in court on any court related matter, that they will **not** be stipulating in writing or in person as to an opinion. Therapists may only provide observations and feedback. At no time will any therapist of Transform Youth and Family Counseling make a recommendation in regards to custody or any other court related matter.

If a court order is served and is requesting that a therapist of Transform Youth and Family Counseling release a client's records, the client's and/or parents/guardian's consent will be requested before turning over confidential information. When obtaining this consent, the client and/or parents/guardians will be told exactly what has been requested by the court and there is no guarantee that the information will be kept confidential. The therapist-client relationship does not render the therapist as an advocate for the client and any dual relationships will be avoided.

Court Fees:
Please be advised that should a therapist of Transform Youth and Family Counseling be court ordered to appear in court or at a deposition by phone or in person, the fees are as follows:

- We charge a $1,500 retainer prior to any preparation or attendance of legal proceedings.
- We charge $200/hour to prepare for and/or attend any legal proceedings and for all court related services, including travel to and from court.
- Charges for court related services are not covered by insurance.
- Court related services include: communication with attorneys, preparing/writing documents, traveling to and from court, depositions and court appearances.
- If the court or attorneys do not pay our fee, you will be charged for the time we spend responding to legal matters.
- You will also be charged for any costs we incur responding to attorneys in your case, including but not limited to fees we are charged for legal consultation and representation by our attorneys.

CLIENT RIGHTS AND RESPONSIBILITIES

As a client receiving services from Transform Youth and Family Counseling you have the right to:

- Access treatment regardless of race, color, religion, national origin, age, sex, sexual orientation, gender identity, marital status, familial status, disability, veteran status, or any other legally protected group status.
- Be treated with dignity and respect from all of our staff.
- Obtain an electronic or paper copy of your medical record.
- Request a different therapist or provider.
- Privacy and confidentiality as outlined in the Notice of Privacy Practices.
- Request information about your treatment plan or diagnosis.

- Ask questions and receive prompt, understandable, and appropriate answers.
- Participate fully in all decisions about your treatment and services and request changes to your treatment and services.
- Refuse treatment unless court ordered to participate.
- Understand your financial obligations for treatment and services.
- Submit a complaint to the licensing board if you feel your rights have been violated.
- Request confidential communication according to your communication preferences.

As a client receiving services from Transform Youth and Family Counseling you have the responsibility to:

- Keep appointments or cancel/reschedule at least 24 hours in advance.
- Pay your bill and inform your therapist or provider and/or administrative staff of changes in insurance coverage or contact information.
- Be an active participate in your treatment planning and therapy services.
- Communicate with your therapist or provider about any concerns or needs you have regarding your services.
- Not discontinue services without discussing it with your therapist or provider.

TELEHEALTH CONSENT FOR TREATMENT (If applicable)

- I understand that I am consenting to therapy services to be delivered through telehealth, which includes video and/or phone therapy sessions.
- Video and/or phone conferencing technology will be used for telehealth sessions and will not be the same as a direct client/therapist visit due to the fact that I will not be in the same room as my therapist.
- I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the telehealth session format if it is felt that the video and/or phone conferencing technology is not adequate for my situation or needs.
- I have had the alternatives to telehealth therapy explained to me.
- I have had a conversation with my therapist, during which I had the opportunity to ask questions regarding telehealth therapy sessions and my questions have been answered, including the risks, benefits, and any practical alternatives to telehealth have been discussed with me in a language in which I understand.

NOTICE OF PRIVACY PRACTICES

The privacy of your health information is very important to us. In addition, we have a legal responsibility under Federal and State laws to keep your health information private. Your health information includes information we receive about you or that we create. We are responsible to give you this notice about our privacy practices and to follow the practices in this notice. This notice tells you how we protect and make use of your health information. Please review it carefully and ask for clarification about anything you do not understand. Copies of this notice are always available to you at no charge.
We have the right to change our privacy practices as long as those changes are permitted or required by law. Such changes may affect how we protect the privacy of both the previous and future health information we maintain about you. When such changes are made, we will update this notice and give you a copy.

Your health information will remain confidential with the following exceptions:

- Reported or suspected child abuse or neglect, which by law must be reported to the Oregon Department of Human Services.
- If a client is in imminent danger of harming themselves or others, including client disclosure of intent to commit a crime, which would result in harm to others.
- In the event of an emergency, we may need to disclose information to a family member, a person responsible for the client's care, or the client's personal representative. If the client is present in such a case, we will give the client an opportunity to object to the disclosure. If the client objects, is not present, or is incapable of responding, we will use our professional judgement, in light of the nature of the emergency, and keeping the client's safety and best interest in mind, regarding the use or disclosure of the client's health information. If disclosure is deemed necessary, it will be limited to information necessary to respond to the emergency.
- Situations in which we are required to disclose to a person authorized by federal, state, or local laws to have lawful access to the client's medical record, such as legal proceedings.
- When necessary, to receive payment from a third-party payer for services provided.
- When Transform Youth and Family Counseling is performing agency operations including, but not limited to: evaluating and improving staff and program effectiveness, staff supervision and consultation, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
- When a client completes and signs an Authorization to Use and Disclose Protected Health Information Form for any individual or agency they wish their therapist or provider to exchange information with. Disclosure authorizations can be revoked in writing at any time and will pertain to client's health information from that point on.
- When we are defending claims brought by a client against a therapist or provider of Transform Youth and Family Counseling.

Clients have these additional rights, with respect to their protected health information:

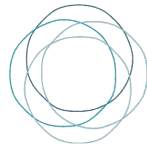
- To have records maintained in locked storage.
- To have any disposable paper correspondence containing client identification or protected health information shredded by Transform Youth and Family Counseling.

- To make a written request to have us communicate with them about their health information by alternative means, at an alternative location. Written requests must specify the alternative means and location. (An example would be if your primary language is not spoken at Transform Youth and Family Counseling.)
- To make a written request that we place other restrictions on the ways we use or disclose their health information. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.
- To make a written request that we amend health information we have created regarding them. If we approve the written request, we will amend our records accordingly. We will also notify anyone else who may have received this information, and anyone else of the client's choosing. If we deny a requested amendment, the client can place a written statement in our records disagreeing with our denial of their request.
- You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or Transform Youth and Family Counseling office's operations. This can go back as far as six years. If you request the accounting more than once in a 12-month period, we may charge you a fee based on our actual costs of tabulating these disclosures.
- We will not use client health information in any Transform Youth and Family Counseling marketing, development, public relations, or related activities without the client's and/or parents/guardian's written authorization.
- If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice, you may send a written complaint:
  - Transform Youth and Family Counseling 1590 SE N St. Suite F Grants Pass, OR 97526
  - Transform Youth and Family Counseling PO Box 503010, White City, OR 97503-0813
- You may also submit a written complaint to the United States Department of Health and Human Services at:
  - Office of Mental Health Services
Alcohol and Mental Health Division
500 Summer St. N.E. E86
Salem, OR 97301-1118

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

COMPLAINTS/QUESTIONS

If you have a concern, question, or complaint about your treatment or about your billing statement, please talk to us about it. We will take your criticism and concerns seriously, openly, and respond respectfully.



Outpatient Services Contract

Please ask before signing below if you have any questions about our treatment services or our office policies. Your signature indicates that you have read our Outpatient Services Contract and agree to enter therapy under these conditions. Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

I have read and agree to the terms in the outpatient services contract (pages 1-6).

Client Name: ____

Client Signature: ____ Date: ____________

Guardian Signature (if minor): _____________________________ Date: ____________

Guardian Signature (if minor): _____________________________ Date: ____________

Notice of Privacy Practices

I have read the notice of privacy practices section (pages 7-8).

Client Name: ____

Client Signature: ____ Date: ____________

Guardian Signature (if minor): _____________________________ Date: ____________

Guardian Signature (if minor): _____________________________ Date: ____________

BILLING INFORMATION

This form is required for all clients regardless of insurance coverage status.

Client Name: ____ DOB: __________________

Legal Gender as listed on insurance and legal documents: □ Male □ Female

Client Address: ____

City:___________________________________ State:_______________Zip: ______________

Phone: ____________________________________ Alternate Phone: ___________________
Preferred method of contact: □ Text (SMS) □ Email (if neither is indicated, we will use secure email)

Email: ____

Do you have coverage with any of the following? (Check all that apply)
*Please attach an additional copy of this page to share information about all other insurance coverage
Medicaid (OHP) □ **Medicare** □ **Other Insurance** □

Insurance Company: ___________________________________ Phone: _________________
This policy is: □ Primary □ Secondary

Name of Primary Insured: _____________________________________ DOB: ____________

Relationship to Client: _________________________ Employer:____________________________

ID#: ______________________________________ Group #: _____________________________

<u>PLEASE ATTACH A CLEAR COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS**</u>**

I have been given an opportunity to read the Notice of Privacy Practices, and I hereby authorize Transform Youth and Family Counseling and appointed billing agent(s) to provide summary of care and assessment information regarding the treatment of the client named above for the purpose of evaluating and processing claims for benefits. I have disclosed all of the payer(s) that cover me. I understand that providing incomplete or incorrect information on this form may result in a higher than expected out of pocket expense for me. I will contact the billing office if any of the information reported on this form changes. If I do not fill out this form, I am attesting to not having insurance or do not want my insurance billed and understand I will be billed the standard fees for services.

Signed: ____________________________________ Printed Name: _______________________________

Relationship to Client: □ Self □ Other: __________________________________ Date: ______________

CREDIT CARD ON FILE

Payments are due at the time of service. Transform Youth and Family Counseling requires a credit, debit, or flex spending/HSA card on file in order to schedule sessions. The credit card on file can be used in order to pay for any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket payments if no other payment method is used at the time of the session or if a late cancellation or no show is incurred (in which case, the credit card on file will be charged for the no show/late cancellation fee). Clients may also pay by cash or check at each session. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Client Name:		
Cardholder Name as it Appears on the Credit Card:		
Credit Card Number:		
Expiration Date:	Billing Zip Code of Credit Card:	Security Code:

I understand that by signing below, I am authorizing Transform Youth and Family Counseling to charge my card at the time of each service for the balance due on my account. Balances may include co-pays, co-insurance amounts, out of pocket payments, deductibles, no show or late cancellation fees.

Cardholder's Signature:	Date:

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I, ____, hereby authorize Transform Youth and Family Counseling
(Client/Parent/Guardian/Power of Attorney)

to exchange/release any and all records of information regarding ____
(Client Name and DOB)

with the following individual or agency ____
(Receiving Individual or Agency)

The following items must be **checked and initialed** to be included in the use and/or disclosure of other health information:

☐ ______ Psychiatric/ Mental health information ☐ ______ Psychotherapy notes

☐ ______ Drug/alcohol diagnosis, treatment/referral

for the purpose of (please check all that apply):

☐ Continuing treatment (health and mental health) or care and continuity of care

☐ Billing, payment and financial matters and arrangements ☐ Consultation, advise and representation

☐ Housing or other arrangements and services ☐ Other ____

This consent is valid until (calendar date)__________________________ or until one year after this form is signed and dated if left blank.

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclose it without my written authorization.

____ __________________
(Client Signature) (Date)

____ __________________
(Parent/Guardian/Power of Attorney Signature) (Date)

____ __________________
(Witness Signature) (Date)

REVOCATION OF AUTHORIZATION

The undersigned hereby revokes the above authorization for disclosure.

____ ____
(Client, parent, guardian) (Witness)

____ ___________________________
(Authorized agent - Power of attorney attached) (Date)