Drea Richards Counseling, Inc
Drea Richards, MA, LCPC
119 Stephen Street
Lemont, IL 60439

Phone: (708)586-9545
FAX: (708) 277-1722
Website:drearichardscounseling.com
Email: drea@drearichards.com

OUTPATIENT SERVICES CONTRACT

Welcome to my counseling practice! Since this is your first visit to my office, I hope what is written here can answer some of your questions about my services. Please let me 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.

COUNSELING SERVICES

The terms "counseling," and "psychotherapy" are often used interchangeably. Given that I am a Licensed Clinical Professional Counselor, I am most comfortable with the term, "counseling," to describe my services.

I provide counseling services for adolescents, adults, couples and families. The first few appointments serve as assessment and consultation. For individual adults, that assessment may take one to two sessions. For couples, families and adolescents, this assessment takes about 3 to 4 sessions *(I require some level of parental/guardian involvement for any minor in the assessment/consultation process)*. I will want to hear about the difficulties which led to you to make an appointment, goals for counseling, and general information about yourself and your current life situation. By the end of the assessment process, I will give you some initial recommendations on what I think will help. If I do not think I am able to best assist you, I will give you names of other professionals who I believe would work well with your particular issues. If you do not agree with my treatment recommendations, or do not think our personality styles will be a good match, let me know and, if you wish, I will help you find a different clinician who may be a better fit.

If we decide to work together in counseling, we will collaborate on a treatment plan which incorporates effective strategies to help with whatever difficulties you wish to address. Individual, couples, and family counseling sessions last 50 -- 60 minutes, unless otherwise arranged. Sessions are commonly set for once each week, but this varies based on what seems most appropriate for your particular situation.

Counseling 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 improve psychological health, and/or family dynamics. There are benefits and risks to counseling. Potential benefits include increased healthy habits, improved communication and stability in relationships, and lessening of distress. Some potential risks include increased uncomfortable emotions as you self-explore, and changes in dynamics or communication with significant people in your life. Sometimes couples who come for counseling choose to end their relationships. Although there are many benefits to counseling, there is no guarantee of positive

or intended results.

If, during our work together, noncompliance with treatment recommendations becomes an issue, I will discuss this with you to determine the barriers to treatment compliance. At times, treatment noncompliance may necessitate termination of counseling. I encourage you to discuss with me any concerns you have about our work together, so that we can address them in a timely manner. Other factors which may result in termination of counseling include, but are not limited to, violence or threats toward me, or refusal to pay for services after a reasonable time and attempts to resolve the issue.

Deciding when counseling is complete is meant to be a mutual decision. Sometimes people begin to schedule less frequently to gradually end counseling. Others feel ready to end therapy without a phasing-out period of time.

When necessary, I may seek consultation with other clinicians to ensure I am helping you in the most effective manner. I will give information only to the extent necessary, and I make every effort to avoid revealing the identity of my clients. The consultant is also under a legal and ethical duty to keep the information confidential.

MY AVAILABILITY BETWEEN SESSIONS

If needed, you can leave me a message on my 24-hour voicemail at (708) 586-9545. When you leave a message, include your telephone number, even if you think I already have it, and the best times to reach you. I 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 me within one day, please leave a second message. If I am unavailable for an extended time, I will inform you of the contact information for the clinician on-call during my absence.

If you are in an emergency situation and cannot wait for me to return your call, go to the nearest emergency room or call 911. Do not contact me by email or fax in an emergency, as I may not get the information quickly.

RATES AND INSURANCE

Counseling is a commitment of time, energy and financial resources. If you have health insurance, it is important for you to verify your mental health benefits so you understand your coverage prior to your appointment. Some insurance companies require a pre-certification before the first appointment or they will not cover the cost of services.

My current fees are as follows:

- Initial Intake Appointment (60 minutes): 145.00
- Individual Counseling (60 minutes): $125.00
- Individual Counseling (45 minutes): $115.00
- Couples or Family Counseling (60 minutes): $135.00
- Brief Counseling (30 minutes): $80.00
- Phone Consultation (20 -- 30 minutes): $50.00
- Phone Consultation (30 -- 60 minutes): $90.00

These fees are reviewed annually and may be subject to change. I do not generally provide telephone sessions. In the rare circumstances in which telephone therapy is mutually agreed

upon, please keep in mind that health insurance carriers do not pay for that service.

I am happy to assist you by having my billing company file claims to your insurance company on your behalf. However, you, not your insurance company, are responsible for payment of the fee for therapy. Acceptable forms of payment include cash, check and major credit card, and payment is expected at the time of service. *Cancellations or missed appointments without 24-hour notice will be subject to full fee charge, and insurance companies do not pay charges for missed appointments.* 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.

Most insurance agreements require you to authorize clinicians to provide a clinical diagnosis and sometimes additional clinical information. If you request it, I will provide you with information sent to your insurance company, by my billing company. This information becomes part of the insurance company's files. Insurance companies claim to keep information confidential, but check with your insurance company directly with questions about their confidentiality practices.

SOCIAL MEDIA POLICY

In order to maintain your confidentiality and our respective privacy, I do not interact with current or former clients on social networking websites. I do not accept friend or contact requests from current or former clients on any social networking sites. I will not respond to friend requests or messages through these sites.

I will not solicit testimonials, ratings or grades from clients on websites or through any means. Although it is your decision, I encourage you to avoid writing testimonials about me on any websites, in order to maintain your privacy. I will not respond to testimonials, ratings or grades on websites, whether positive or negative, in order to maintain your confidentiality.

IN THE COMMUNITY

Occasionally, I may run into clients in the community. I have a "you first" policy, when it comes to this issue. This means you are welcome to approach me first, but, in order to protect your confidentiality, I will not approach you in a public setting.

EMAILS AND TEXT MESSAGES

You are welcome to contact me through email and/or text messages, but you should know this is not a secure communication. If you chose to contact me through email or texts, please do so regarding scheduling or changing appointments, but not about personal information, as text messages and emails are not completely secure and confidential modes of communication. If there is information that you believe needs to be shared prior to our next appointment, call me and we can arrange a time to speak by telephone. I do keep all emails sent to and received from my clients as part of the counseling record.

PROFESSIONAL RECORDS

Both law and the standards of our profession require that I keep appropriate treatment records. In general, if I receive a request for information about you, you must authorize in writing that you want the requested information released before I can release information. However, key

exceptions to this are listed below and in your HIPAA statement.

CONFIDENTIALITY

In general, the confidentiality of all communications between a client and a clinician, such as an LCPC, is protected by law, and I can only release information to others with your written permission. However, there are a number of exceptions, which I have indicated below. More information is provided about this in your HIPAA statement.

In judicial proceedings, if a judge orders the records released, I have to release the records. In addition, I am ethically and legally required to take action to protect others from harm even if taking this action means I reveal information about you. For example, if I believe a child, elderly person or disabled person is being abused or neglected, I am mandated to report this to the appropriate state agency. If I believe a client is threatening serious harm to another person or property, I must take protective action (through notifying the potential victim, the police, and/or facilitating hospitalization of my client). If I believe a client is a serious threat to harming him/herself, I must take protective action (arranging hospitalization, contacting family/significant others for notification, and/ or contacting the police).

I would make reasonable effort to discuss any need to disclose confidential information about you, and am happy to answer any questions you have about the exceptions to confidentiality.

COURT RELATED SERVICES

I do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that I cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings.

If I am contacted by an attorney regarding your treatment (either at your behest or related to a legal matter you are involved in) please note the following:

• I charge $400/hour to prepare for and/or attend any legal proceeding and for all court related services.

• Charges for court related services are not covered by insurance.

• Court related services include: talking with attorneys, preparing documents, traveling to court, depositions and court appearances.

• If my fee is not paid by the court or attorneys, you will be charged for the time I spend responding to legal matters.

• You will also be charged for any costs I incur responding to attorneys in your case, including but not limited to fees I am charged for legal consultation and representation by my attorneys.

COMPLAINTS

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

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REGISTRATION FORM

Name____ Birthdate____/_____/_____

Parent/Guardian (if applicable) ____

Address____ SSN______-______-_______

City/State/Zip____ Marital Status_____________

Employer_________________________________ Referred By____

Emergency Contact ______________________________________

Phone______________________________________

Reason for
appointment____

Home Phone_______-________-___________ May I Leave a Message? Y N

Cell Phone _______-________-___________ May I Leave a Message? Y N

Work Phone________-________-___________ May I Leave a Message? Y N

Email:____ May I Email? Y N

Insurance Company: __________________________________ Phone: ______________________________________

Group #____ ID # ____

Insurance Policy Holder’s Information (if different from client):

Name____ DOB: _____________________________

SSN________-_______-_______

Although many health insurance carriers provide coverage for outpatient mental health services, insurance benefits vary

greatly and do not always pay for all charges. You are responsible for payment of all fees for services rendered.

Cancellation or Failure to Keep Appointments: Please be aware that you will be charged the usual session fee for any appointment missed unless you provide notification 24 hours before the appointment by leaving a message at (708)586-9545. Insurance does not pay for missed appointments.

Agreement to Terms of Service

- I understand that a diagnosis will be submitted to my insurance company if I choose to file a claim and reports about my treatment and progress toward goals may be required by the company.
- If the person who referred me was a professional (psychologist, medical professional, attorney), I may request a release of information, so I can contact, and consult with, that professional.
- I have received a copy of the Outpatient Service Contract.
- I have read the information above and agree to the terms of service.

Signature of Client: ____ Date: _____________________

Parent/Guardian Signature: ____ Date: ______________________

Clinician Signature: ____ Date: _______________________
(Drea Richards, MA, LCPC)

DSM-5 Dx Code: ________________________

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ACKNOWLEDGEMENT OF NOTIFICATIONS

Before signing below, please let me know if you have any questions about counseling or billing issues.

Your signature indicates that you have read my Outpatient Services Contract and agree to enter counseling under these conditions. Your signature below indicates that you are making an informed choice to consent to counseling and understand and accept the terms of this Outpatient Services Contract.

____ _______________
Client Signature Date

____ _______________
Parent/Guardian Signature Date

____ _______________
Witness Date

I also acknowledge the receipt of the HIPAA Notice of Privacy Practices for my review.

____ _______________
Client Signature Date

____ _______________
Parent/Guardian Signature Date

____ _______________
Witness Date

Drea Richards Counseling, Inc.

Information about Privacy and Client Rights

The Federal Health Insurance Portability and Accountability Act (HIPAA) requires mental health professionals to issue this official Notice of Privacy Practices.

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures for Treatment, Payment, and Healthcare Operations

I may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes with your written authorization. The following should help clarify these terms:

1. "PHI" refers to information in your health record that could identify you.
2. "Treatment" is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your physician or your psychiatrist.
3. "Payment" is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care, determine eligibility for coverage, or to my billing service, so they are able to bill your insurer.
4. "Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and and care coordination.
5. "Use" applies only to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
6. "Disclosure" applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.
7. "Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific, legally required form.

Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or healthcare operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our discussions during a private, group, joint or family therapy session, which

I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI. I will also obtain authorization from you before using or disclosing PHI in a way that is not described by this Notice.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization, or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer to right to contest the claim under the policy.

Uses and Disclosures Without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

1. Child Abuse – If I have reasonable cause to believe a child known to me in my professional capacity may be an abused child or a neglected child, I must report this belief to the appropriate authorities.

2. Adult and Domestic Abuse – If I have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, I must report this belief to the appropriate authorities.

3. Health Oversight Activities – I may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

4. Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and I must not release such information without a court order. I can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

5. Serious Threat to Health or Safety – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that person from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may makes disclosures I consider necessary to protect you from harm.

6. Worker's Compensation – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for

work-related injuries or illness without regard to fault.

7. When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility of VA benefits, and national security and intelligence.

Client's Rights and Clinician's Duties

Client's Rights:

1. Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
2. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, if you do not want a family member with whom you live to know that you are in therapy with me, on your request I will send your bills to another address.
3. Right to Inspect and Copy – You have the right to inspect and/or obtain a copy of PHI in my mental health and billing records used to make decision about you for as long as the PHI is maintained in the record and psychotherapy notes. On your request, I will discuss with you the details of the request and the inspection/copying process.
4. Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
5. Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
6. Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
7. Right to restrict disclosures when you have paid for your care out-of-pocket: You have a right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
8. Right to be notified if there is a breach of unsecured PHI: You have a right to be notified if: a) there is a breach (a use of disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; b) that PHI has not been encrypted to government standards; and c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Clinician's Duties:

1. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
2. I reserve the right to change the privacy policies and practice described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
3. If I revise my policies and procedures, I provide you with written notice at the time of service, or by mail in response to an inquiry.

Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please discuss this with me directly.

You may also file a written complaint to the Secretary of the U.S. Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

If you have any questions about this Notice, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

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AUTHORIZATION TO RELEASE MENTAL HEALTH INFORMATION

FROM YOUR CLINICAL RECORD TO THE PERSON/ORGANIZATION YOU DESIGNATE

I, ____, DOB______________________,
Authorize Drea Richards, MA, LCPC, to exchange information with:

Name/Organization:______________________________________, Ph:______________________

Address:____

Fax Number:__________________________________

Specific nature of information to be released:

_____any or all of the following
_____attendance/scheduling/transportation
_____information related to payment
_____presenting complaints/issues
_____diagnosis and/or assessment results
information_____initial
_____treatment plan and goals
_____other:_____________________________
_____summary of treatment
_____response to treatment/progress
_____prognosis
_____recommendations/suggestions
_____substance use/abuse

The information above is being released for the purpose of:

_____facilitating consultation and/or collaboration
_____facilitating continuity of treatment
_____facilitating scheduling/transportation
_____facilitating payment
_____facilitating family involvement in treatment
_____other:_____________________________

I understand that:

1. This consent will automatically expire one year from signing unless a different date of expiration is specified here:_____________________________________
2. I have the right to copy and inspect the information being disclosed.
3. I have the right to revoke this authorization, in writing, at any time by sending such written notification to my provider's office. However, my revocation will not be effective to the extent that my provider has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. The statutes that govern this authorization include but are not limited to: Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), 735 ILCS 5/8/2001 (inspection and copying of hospital records), and any relevant confidentiality code of any state, and the Employee Personnel Records Act (820 ILCS 40/0.01).
5. If I refuse to consent to the release of information specified above, the following are the consequences:

____

My counselor generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

____ _________________

Client (Adult or Minor over age 12) Date

____ __________________

Parent/Guardian of minor or legally disabled client/patient (if applicable) Date

____ _________________

Witness Date

If the signature is not the client's, indicate the legal relationship of the signer to the client and the legal basis on which the consent is given for the client:____

Notice to Receiving Agency/Facility/Person: Under the provision of the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et.seq.) you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. Under Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records, may be further disclosed without the client's specific authorization for such disclosure.

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CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent to the treatment of ___________________________________ as a client of Drea Richards, MA, LCPC. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. This consent to treat expires at the end of treatment or if revoked in writing.

____ Date__________________
Signature(s) of parent(s) or guardian(s)

____ Date: _________________
Signature of Client

____ Date: _________________
Drea Richards, MA, LCPC