**Informed Consent Agreement:**

**Financial & Treatment**

SOS: Seeking Out Solutions, Ltd. holds as one of its core values that clients benefit most from a counseling process that promotes the highest standard of care, is ethically sound, and ensures that the clients are fully aware of what to expect. This is often referred to as “Informed Consent.” The following information is divided into two areas: Financial & Treatment. Additional information can also be found under our Frequently Asked Questions or FAQs section of our website.

**Financial**

Fees for Counseling & Related Services

The following Fees are effective January 1st, 2016. Please note that Fees may be subject to change and appropriate notice will be given.

Therapy/Telehealth & Related Services *(These Services have billing codes that may allow for reimbursement by insurance.)*

Psychotherapy Diagnostic Evaluation (53+ Mins) $160.00

Psychotherapy 30 (16-30 Mins) $60.00

Psychotherapy 45 (35-45 Mins) $120.00

Psychotherapy 60 (46-60 Mins) $140.00

Psychotherapy for Crisis (30-74 Mins) $160.00

Each Additional 30 (16-30 Mins) $60.00

Family Therapy w/o Client (53+ Mins) $140.00

Family/Couple Psychotherapy w/Client (53+ Mins) $140.00

Multi-Family Group (53+ Mins) $70.00

Group Psychotherapy (53+ Mins) $70.00

Interpretation/Explanation of Results/Report (53+ Mins) $140.00

Preparation of Tx Progress Report $15.00/pg

Telephone Services (5-10/11-20/21-30 Mins) $40/80/120.00

Team Conference w/o Client (30+ Mins) $140.00

Team Conference w/ Client (30+ Mins) $140.00

Related Fees (*These Services do not have billing codes and cannot be billed to insurance and are thus considered self-pay.)*

Late Cancellation (less than 24 hours notice) $ full appt rate

No Show/Failed Appt $ full appt rate

Collateral Staffing (in-person w/ non-provider) $140.00/hr

Case Consultation (via Telephone) $140.00/hr

Case Consultation (in-person) $140.00/hr

Legal Expert Witness Testimony $200.00/hr

Travel $120.00/hr

Letter Writing/Other Correspondence $ 15.00/pg

Copies of Client Records (Excludes related to Claims) $ 0.50/pg

*\*records will be released to Clients only*

I understand that:

* when the client is assessed or diagnosed, that Protected Health Information will be collected, and that it will be used to arrange for payment of services.
* SOS: Seeking Out Solutions, Ltd. uses a HIPPA compliant telehealth service, Ther-a-Link. Information required to utilize telehealth services include: personal identification information, insurance or third-party payer information.
* SOS: Seeking Out Solutions, Ltd. uses a billing service for the purpose of maintaining all financial and electronic health records (EHR) information required to process and bill the account including: personal identification information, insurance or third-party payer information, etc. Any changes in insurance information or other financial account information are the responsibility of the client and must be provided to the billing service.
* payment is expected at time of service for any non-insurance covered fees due.
* cancellations must occur 24 hours prior to the appointment. Late cancellations and missed appointments are subject to a fee.
* the client or designated financial responsible party is responsible for any payment of fees not covered by insurance or other third-party payer, including: co-payments, deductible, or any other balance due.
* I understand if I become 120 days delinquent in paying my bill, my account will be transferred to a Collection Agency at the choice and discretion of SOS: Seeking Out Solutions, LTD. I will also be responsible for the payment of all collection fees/charges.
* there is a $35.00 fee for insufficient fund checks (NSF)
* there is a $35.00 fee for a copy of my clinical records, that will **only** be released to the client

**Treatment**

I understand that:

* when the client is assessed or diagnosed, that Protected Health Information will be collected, and that it will be used to determine the best course of treatment and to provide that treatment.
* the Notice of Privacy Practices (NPP), also known as HIPAA, was effective 04/13/2003 and is available upon request, and on the SOS: Seeking Out Solutions, Ltd. website. Any changes will result in notification. Treatment may be denied to those who refuse to consent. If there is a concern about any of the client’s information, the right exists to ask, in writing, for some of it not to be used or shared for treatment, payment or administrative purposes, although there is no requirement for SOS: Seeking Out Solutions, Ltd. to agree to such requested limitations. Client consent may be revoked at any time by giving written notification, but will not apply to any previous action taken under the consent prior to the revocation.
* all treatment information is confidential, and that no information may be disclosed to any other person without a completed and signed Consent and Authorization to Release, Use and Disclose Protected Health Information, unless exempted by law.
* there are exceptions to the confidentiality limitation, under which confidentiality may be waived, also referred to as “Mandated Reporter” requirements, including: where a known or suspected incidence of child physical, emotional or sexual abuse or neglect is occurring or has occurred; where a known or suspected incidence of elder abuse or neglect is occurring or has occurred; where the client may be at risk of harming him or herself e.g. suicidal; where there is the risk of the client harming another. If applicable, the emergency contact person and/or the proper authorities would be notified.
* there are benefits of treatment, as well as possible side effects of treatment, and possible consequences of not receiving or participating in treatment.
* the types, or modalities, of treatment may include: Assessment, Individual Psychotherapy, Couples/Marital Psychotherapy, Family Psychotherapy, Group Psychotherapy, Telehealth and referral to a Psychiatrist or to other treatment provider.
* the frequency of the treatment program may include: weekly, twice weekly, monthly, bimonthly, or on an as needed basis as agreed upon between client and therapist.
* the length or duration of treatment is a decision reached between the client and the therapist, usually based upon progress towards the agreed upon goals, except in cases where discharge may occur first.
* there are other alternative treatment methods and services. The therapist reserves the right and discretion to refer a client to another or additional treatment provider should the client’s needs exceed what the therapist can provide or as needed and in the best interest of the client. The therapist also reserves the right to consult with other treatment professionals, subsequent to an appropriate release of information.
* the client has the right to refuse treatment.
* the therapist has the right to refuse or discontinue treatment should the client fail, neglect, or refuse to cooperate with the recommended treatment program. In such cases, the therapist will provide a referral to another treatment provider.
* client has the right to review his/her records (PHI), upon appropriate request and notification. There may be times, where in the best interest of the client, that such records be provided to another treatment provider or professional. Records will only be released to the client. There is a fee for copying such records.
* You will not be discriminated against of any rights, benefits, and privileges guaranteed by the Illinois and Federal Constitutions/ Services will not be denied, reduced, suspended, or terminated if you exercise any of these rights.
* You will not be denied services because of age, gender or sexual orientation, race, religious belief, ethnic origin, marital status, disability, or a criminal record that is unrelated to your current service needs.
* You have a right to be treated in an ethical and professional manner. You have the right to treatment in the least restrictive manner. You have the right to be free from abuse, neglect, and exploitation.
* if I have indicated that I am the SOLE Custodial Parent of the named minor or Guardian of the named dependent that I may be required to provide a copy of the legal document verifying such.
* my participation in and communication about the provided services is invited and expected as may be appropriate or allowed.
* no client will be treated differently or denied access to counseling services based upon race, national origin or ethnicity, gender, age, religion, disability, or sexual orientation.

**VIDEO THERAPY SESSION**

* I understand that I am about to engage in a therapy session via video or phone.
* I understand that the phone or video conferencing technology will not be the same as an in-person session with a therapist due to the fact that I will not be in the same room as my therapist. I also understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions when I start the session.
* I understand the potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the phone or video therapy session if it is felt that the phone or video conferencing connections are not adequate for the situation.
* My therapist agrees to inform me and obtain my consent if another person is present during the consultation, for any reason. I agree to inform my therapist if there is another person present during the session.
* I understand that there are alternatives to a phone or video therapy session available, including the option of finding another provider to see in-person if available in my area.
* I understand that I can direct questions about this phone or video therapy session at any time to my therapist.
* I understand that this consent will last for the duration of the relationship with my therapist, including any additional phone or video therapy sessions I may have; I can withdraw my consent for a phone or video therapy session at any time and, my therapist will work with me to find a suitable alternative.
* I understand that the same confidentiality protections, limits to confidentiality, and rules around my records apply to a phone and video therapy session as they would to an in-person session.
* I agree to work with my therapist to come up with a safety plan, including identifying one or two emergency contacts, in the event of a crisis situation during our sessions.
* I understand that my therapist may decide to terminate phone or video therapy services if they deem it inappropriate for me to continue therapy through phone or video sessions. My therapist will either provide in-person care or work to identify another therapist for in-person care.

**Media and Technology**

I understand that:

* it is strongly recommended I turn my cell phone off during sessions.
* audio or visual recording, taping or other methods are not allowed during sessions.
* no social media is utilized with clients.
* each therapist will use their own discretion and best standards of practice in regard to the utilization of electronic forms of communication, e.g. email, texting, etc.
* texting is for appointment changes only. No clinical information should be sent via text.
* if I chose to communicate via email, unless my email is encrypted, email is not HIPAA compliant.
* messages are returned within 24 hours by therapists Mondays through Thursdays. Messages left Fridays through Sundays will be returned until Mondays. In cases of emergencies, clients should call 911 or go to the nearest ER.
* a receptionist is available Mondays through Fridays from 9:00am to 5:00 pm CST.
* Telehealth Services are conducted through Ther-A-Link, which complies to all applicable federal confidentiality regulations and HIPAA guidelines.
* Clients’ Private Health Information (PHI) and Electronic Health Records (EHR) are maintained by KASA Practice Solutions/Therapy Brand on behalf of SOS: Seeking Out Solutions, Ltd.

*Dev 03/2019*

*Rev 04/2024*