Counseling Center at the Crossing, Inc.

10412 Allisonville Rd. – Suite 105, Fishers, IN 46038

317-578-9200; Fax 578-9201

CENTER INFORMATION AND POLICY STATEMENT

Please read the following important information. If you have questions, you may discuss them with your therapist.

CONFIDENTIALITY Federal HIPAA and Indiana law require that issues discussed with a therapist will be confidential. The information you reveal will not be discussed by the therapist with anyone, except with CCATC staff or a consulting/supervising psychologist, without a signed *Authorization* form from you. If information is requested from your therapist by a third party, e.g. family members, schools, or other mental health professionals, it would be helpful if you would discuss this with your therapist as soon as possible. If at any point the therapist believes it would be useful to confer with other professionals, you will be asked to grant permission and to sign an *Authorization* form.

EXCEPTIONS TO CONFIDENTIALITY The release of confidential materials may be legally required of your therapist in the following situations: 1) Potential harm to you (suicide) or others (homicide);
2) Suspected child or elder abuse or neglect; and 3) Instances where the court or government subpoena records.

TREATMENT Evaluation may include psychological and/or psychosocial evaluations. Treatment may consist of psychotherapy, counseling, and other modes of treatment available and tailored to your needs, including hospitalization, if required. We do not do email exchanges as a part of therapy. Your consent does not waive your civil rights and you may reserve the right to decline treatment against professional advice.

You have the continuing right to an explanation of the therapy plan. Understand that there is no assurance that you will feel better. Because psychotherapy is a cooperative effort between you and your therapist, you must work with your therapist in a cooperative manner to resolve your difficulties. During the course of your treatment, material will be discussed which will be upsetting in nature and this may be necessary to help you resolve your problems.

This office prohibits dangerous weapons, non-prescribed controlled substances, alcohol, and assaultive behavior on the premises. Anyone thought to be in violation of this policy will be requested to: 1) discontinue their assaultiveness and/or, 2) immediately remove any weapons, non-prescribed controlled substances, or alcohol from the premises or to surrender these items. Violation of this policy may result in: 1) a report to law enforcement officials, 2) refusal to further services, and 3) permanent confiscation of the prohibited drugs or weapons.

APPOINTMENTS Appointments usually are scheduled weekly or every other week. Because ongoing therapy is a negotiated process between you and your therapist, it should be assumed that you will not automatically be continuing in therapy. Both you and your therapist need to evaluate the progress of your therapy periodically to determine the need for further appointments. It is your right to discontinue treatment any time you feel it is in your best interest to do so. It is the therapist's ethical responsibility to end therapy when it is reasonably clear that you are no longer benefiting from treatment.

CANCELLATIONS If you find it necessary to cancel a scheduled appointment, <u>24 hours notice is required</u>. With less than 24 hours advance notice, you will be responsible for half of our total regular fee for a 45-minute session ($60 or one-half of $120). Failure to appear with no prior notice will result in a penalty equal to our full charge of $120. These charges must be paid before or at the time of your next appointment. Late cancellations and missed appointments are not covered under any insurance. In case of a serious emergency or illness, if you notify us immediately, we will reschedule your appointment without additional charge.

EMERGENCIES & AFTER HOURS CARE Our general philosophy regarding emergencies is that clients are assumed to be self-responsible (i.e. autonomous, functioning, not in need of day to day supervision). In addition, as private practice clinicians, we cannot assume responsibility for a client's day to day functioning as can institutions, nor can we be available for 24 hour per day crisis care.

If known ahead of time, you must discuss any expectations you have with your therapist and agree to develop and follow a written step-by-step crisis plan. If the need for crisis care arises unexpectedly, you may call and leave your therapist a message. Calls will be returned during your therapist's working hours. If your crisis

needs immediate attention outside of our operation hours, proceed to the nearest hospital or emergency room. You should be aware that you will be charged for after hours care whether it is on the phone or in person.

FEES

- Individual, marital or family therapy is $120.00 for a 45-minute session.
- Group therapy fees vary based on the services provided.
- There will be a $12.00 charge for each "non-sufficient funds" check returned.
- The following professional activities are billed at $120 per 45 minutes (including travel time) and prorated to 15 minute increments ($40): phone consultations, court appearances, consultations or letters / reports on your behalf. These services are not normally billed to insurance and are to be paid by the client.
- Extra administrative services are available upon request, and any copies of records will require a minimum of a $15 fee.

PAYMENTS Payment in cash, check or Visa/MasterCard/Discover is expected at the time of service. If necessary, special payment arrangements can be made with your therapist. Health insurance may pay a portion of fees submitted, and we will submit claims for you. Until we have information from your insurance company that your insurance deductible is met, and that your insurance company will send payments to CCATC, we ask that you pay the full fee at each visit. After your co-insurance payment has been determined, we ask that you pay the amount not covered by your insurance at the time of each session.

In cases of divorced or blended families, we look only to the custodial parent or adult client for full payment regardless of any court ordered arrangements for the non-custodial parent or spouse to provide reimbursement. However, if it is helpful, we will send duplicate statements to a spouse or parent. As a policy, we will not become involved between divorced parties regarding payments.

The billing cycle ends with the last day of each month. Statements are mailed for your payment during the first week of the following month. The account balance on your statement includes the portion owed by your insurance company. The maximum account balance permitted is $500; once this balance is reached, therapy may be suspended until further payment is received.

If monies due from you become delinquent after 60 days, the portion you owe will be charged to your credit card below (not Health Benefit card). We will make every effort to inform you of this charge ahead of time.

Credit Card: (MC, VS, or Disc) Credit card number _____Security Code _____

Exp. Date _____ Zip code _____Signature _____ Date _____

INSURANCE If you have health insurance, part of your therapy expenses may be covered. It is your responsibility to contact your insurance company if pre-certification or a referral is necessary. ***It is important that you understand that the total bill is ultimately your responsibility.*** Any dispute over payments received from the insurance company will be your responsibility to resolve. Any amount disputed by the insurance company will need to be paid by you. If the insurance problem is resolved later and a payment is sent to us, we will return it to you.

PRIVATE PAY It may be to your benefit to not use any insurance benefits, due to the following reasons:
1) PRIVACY and CONTROL. Many insurance companies ask for detailed clinical information about you and this is kept in their computer database. We have no control over how this information is used or who has access to it. Therefore, we cannot guarantee confidentiality on any information released to your insurance company.
2) You receive NO psychological DIAGNOSIS that anyone else is aware of. (When you use insurance, a diagnosis has to be submitted to them.)

Your signature(s) below indicate(s) that: (1) you have read the information in this document and agree to abide by its terms during our professional relationship, and (2) that you have been provided a HIPAA Notice of Privacy Practices.

_____	_____	_____	_____
Date	Client/ Guardian Signature	Client/ Guardian Name (print)	Witness