LEGACY
COUNSELING SERVICE

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2022 CONSENT FOR MENTAL HEALTH SERVICES AGREEMENT

This document contains important information about Legacy Counseling Services, PLLC professional services and financial / business policies. While we know this is a lengthy document, it's important that you read this carefully so you can make an educated decision about treatment and understand your rights and responsibilities as a client. You also need to understand the rights, responsibilities, and financial / business policies of Legacy Counseling Services, PLLC, as these will inform the professional services you agree to receive and pay for.

Additionally, please note that April Reeder is a licensed professional counselor and owner of Million Chances Ministries and Counseling Services, PLLC and is an independent contractor at Legacy Counseling Services, PLLC. April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC's financial / business policies are the same as Legacy Counseling Services, PLLC's policies as outlined in this Agreement.

The key factor in successful therapy is a good relationship between the provider and the client, and this document is the first step in building this relationship and understanding the shared venture you and your provider are about to begin. By signing this document, it will represent an agreement between you and employees of Legacy Counseling Services, PLLC for the receipt of mental health services.

1. MENTAL HEALTH SERVICES

The general purpose of individual, couples/marital, or family mental health services is to help alleviate the suffering of an individual or the family through mental health treatment by examining and changing unhelpful thoughts, feelings, and behaviors that are contributing to dissatisfaction.

Group services are where a small number of people meet under the guidance of a professional to help one another to share problems or concerns, to better understand their own situations, to learn from and with each other, and to get educated about skills they can use to cope with various struggles. Groups help people learn about themselves and improve how they cope with stressors in their lives. Groups may address feelings of isolation, loneliness, worry, sadness, or frustration due to life circumstances or

chronic physical and/or mental health challenges. Groups can help people make significant changes, so they feel better about the quality of their lives.

We use a variety of evidence-based modalities, and if Christianity, or another aspect of spirituality, is a part of your perspective on life, we will also incorporate that, if you desire. Receiving mental health services is not like a medical doctor visit. We do not prescribe medications and you will take a very active role in your treatment. The success of receiving mental health services largely depends on your own investment in the process.

Receiving mental health services can have risks and benefits. Mental health services often involve discussing unpleasant aspects of your life and you may experience uncomfortable feelings. Mental health services can also lead to changes in the way you think or behave. These changes may be difficult for people in your life to grow accustomed to and thus some relationships may experience temporary strain. On the other hand, mental health services have been shown to have powerful benefits, such as better relationships, solutions to specific problems of daily living or health, significant reductions in feelings of distress, and an improved sense of well-being. There are no guarantees of what risks and benefits you may experience. The evaluation phase typically lasts 1-3 sessions. During this time, we will gather information about your current and past problems. We will also determine if we are the appropriate group to provide your treatment and how often sessions are appropriate. Treatment may last anywhere from a few months to a few years, depending on your current needs and your history. Sessions are generally 53 minutes in length.

*** Client initials for understanding of the section above:** _____

BLUEPRINT. Blueprint is a HIPAA compliant software program that Legacy Counseling Services, PLLC partners with to help us administer and monitor measures to improve the quality of care you receive. You will be invited to participate in Blueprint but not required to. There are three ways you can send information to your provider using Blueprint: Assessments, Check-Ins (for Worksheets and Symptoms) and Phone Sensor Data. These exist to collect and deliver information related to your treatment from you to your provider. This information helps your provider measure outcomes and results over time so they can make informed treatment decisions. Blueprint is not a tool to use for emergency purposes in the event of suicidal or homicidal thoughts/feelings/urges, as your provider may not see your Blueprint data right away.

Assessments: Assessments are validated symptom rating scales. Your provider will determine which Assessments they'd like you to take, as well as set their frequency for completion. When they are ready to be completed, you'll receive alerts and/or reminders to complete them via the Blueprint Client App, email, or text message based on the communication settings you've decided upon with your provider.

Check-Ins: Check-Ins are a way for you to touch base with your provider by recording thoughts and/or feelings outside of official Assessments and are usually done on a more frequent basis. If your provider assigns you a Check-In, you can set your own preferred frequency to complete them. Even outside of your set frequency, Check-In(s) will always be available for you to complete whenever you would like. Check-Ins are only available within the Blueprint Client App.

Phone Sensor Data: If you choose to enable it, Phone Sensor Data is automatically collected via your phone using the Health app, Motion & Fitness, and Location. This includes data about homestay, travel time, steps, distance. Together, Check-Ins and Phone Sensor Data provide your provider with insight into how certain aspects of your lifestyle correlates with any symptoms you may be experiencing, and how it relates to your care over time. Phone Sensor Data can only be collected if the Blueprint Client App is installed, and appropriate access is given to the app to collect data.

Not all employees or independent contractors may be utilizing Blueprint.

Blueprint is not a tool to use for emergency purposes in the event of suicidal or homicidal thoughts/feelings/urges, as your provider may not see your Blueprint data right away.

*** Client initials for understanding of the section above: _____**

2. VIRTUAL SERVICES (AKA Telehealth or Telehealth):

Virtual mental health services through the computer or by phone) is an option, although insurance may not always pay for these types of appointments. By signing this document at the end, you are also consenting to engage in virtual services with an employee or independent contractor at Legacy Counseling Services, PLLC either as the main mode of treatment OR as a supplementary form of treatment for individual and/or group services.

I understand that virtual services include the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications.

I understand that Legacy Counseling Services, PLLC or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC will verify the address of my physical location at the beginning of each virtual services appointment.

I understand that my insurance plan may not cover mental health services rendered through telehealth.

I understand that my provider is subject to the laws, rules, and regulations of the state in which he/she is licensed under and may not be allowed to provide services for me while I am out of the state of Oklahoma, even temporarily (e.g., business trips, vacation, short-term personal matters) unless the

laws, rules, and regulations of the state that I am visiting allows my provider to offer services in that state. State laws, rules, and regulations regarding virtual services between states are constantly changing and vary between licensed providers (Psychologist, LPC, LMFT, LCSW, licensed candidates).

I understand that I have the following rights with respect to virtual services:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to virtual services. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)
3. I also understand that the dissemination of any personally identifiable images or information from the virtual services interaction to researchers or other entities shall not occur without my written consent.
4. I understand that there are risks and consequences of virtual services. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.
5. In addition, I understand that virtual services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my provider believes I would be better served by another form of psychotherapeutic service (e.g., face-to-face service), I will be referred to a provider in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of mental health services and that despite my efforts and the efforts of my provider, my condition may not improve and in some cases may even get worse.
6. I understand that I may benefit from virtual services, but results cannot be guaranteed or assured. The benefits of virtual services may include but are not limited to finding a greater

ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; there may be a greater opportunity to prepare in advance for therapy sessions.

7. I understand that I have the right to access my medical information and copies of medical records in accordance with Oklahoma law, that these services may not be covered by insurance and that if there is an intentional misrepresentation, therapy will be terminated.

Client expectations for participating in virtual individual or group services:

1. To maintain confidentiality, I will not share my virtual services appointment link with anyone unauthorized to attend the individual or group appointments.
2. I will not record or photograph any part of the individual appointment, group appointment, or the group members or allow anyone into my online or physical room while the appointment is in session.
3. If in a virtual group, I understand that I may learn the full names of group members due to their names being listed on the video. I agree not to seek out any information about group members (e.g., using a search engine or social media), nor contact them outside of the group if this is against the specific group agreements. If I choose not to show my full name, I will ask the group leader how to change my display name, if I do not know how to do it.
4. I understand that I need to be in a location free of disruptions, where I am alone and can speak freely, and where others will not see the screen, or hear the conversations of the group. This may include using headphones if necessary.

*** Client initials for understanding of the section above: _____**

3. PROFESSIONAL FEES AND IN-NETWORK INSURANCE BENEFITS

Professional Fees: Legacy Counseling Services, PLLC “hourly” (53 minutes) private pay fee for mental health services (face-to-face or virtual individual and/or couples/family) service is $160 for employee independently licensed providers, except for Dr. Leedy whose private pay rate is $180. Licensed Candidates “hourly” (53 minutes) private pay fee for mental health services (face-to-face or virtual individual) is $100 for individuals and $130 for couples and/or family services. For clients who are receiving services from a licensed candidate and are alternating individual and couples/family therapy services within or between appointment dates, the client will be charged the rate for the specific service (either the individual rate or the couples/family rate) that is being provided during the majority of a specific appointment.

April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC's "hourly" (53 minutes) private pay fee for mental health services (face-to-face or virtual individual and/or couples/family) service is $160.

The Legacy Counseling Service, PLLC employee and independent contractor rates for in-person or virtual group services vary and will be communicated on our website for specific group services. Some group services require a workbook or curriculum and the cost of these ($25.00) will be in addition to the services rendered. Some services may require all, or some, payment prior to the start of the group service. Detailed information about the financial investment for group services will be based on the specific group and will be communicated on the online registration forms for each group that can be found on the website (www.legacycounselingservices.com).

Phone consultation, emailing or writing letters, preparing reports or treatment summaries, communication with family, friends, other health care providers, legal representatives, and attendance at meetings with other persons you have authorized will be billed to you (not insurance) at quarter-time increments at a hourly rate as noted above based on the provider you are seeing.

In-Network Insurance Benefits: If you use in-network insurance benefits to cover some, or all, of your counseling, you agree to inform Legacy Counseling Services, PLLC or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC of any changes to your insurance plan and benefits as soon as changes occur. You agree to pay any amount that your insurance carrier does not pay for services rendered by Legacy Counseling Services, PLLC or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC. Please note that your insurance benefits, deductible, co-pay, and/or coinsurance amounts are given to us as estimations, not a guarantee, of your cost and are not guaranteed to us from your insurance company.

Legacy Counseling Services, PLLC or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC may collect additional payments from you for a specific date of service if the insurance company changes the rates for that date of service, even after services are rendered.

Insurance may not cover services that are determined by your insurance carrier to be not medically necessary, and/or services not covered by your insurance plan such as telehealth coverage. Coverage cannot be guaranteed prior to your appointment. We do our best to keep you informed of these changes, but ultimately, you are responsible for knowing and understanding your insurance benefits.

When using health insurance to help pay for services rendered, you understand that you are responsible for paying any co-pays, co-insurance, and/or deductibles. Employees of Legacy Counseling Services, PLLC are not allowed to waive co-pays, co-insurance, or deductible payments

per their contract with the insurance company. April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC is not allowed to waive co-pays, co-insurance, or deductible payments per their contract with the insurance company.

Good Faith Estimate / No Surprises Act: Per federal law, Private pay or Out-of-Network clients are offered a Good Faith Estimate that shows the estimated costs of items and services that are reasonably expected for your health care needs for service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include Potential Add-On Services or Business Charges That are Unknown, Unexpected, or Unpredicted at the time of scheduling that may arise during treatment. You could be charged more if complications or special circumstances occur. The estimated costs are valid through the end of the calendar year for the year the Good Faith Estimate was provided.

*** Client initials for understanding of the section above: _____**

4. LATE CANCELLATIONS / NO-SHOW POLICY

The success of receiving mental health services largely depends on your own investment in the process. A late cancellation or no-show appointment negatively affects three people: you, your provider, and another client who may have been able to use your time slot. When a session is canceled without adequate notice, we are unable to fill this time slot by offering it to another client, a client on the waiting list, or a client with a clinical emergency. We send appointment reminders 48 hours in advance, so you have a full day to cancel an appointment if need be. This is different from a medical practice in which a physician may see 35 clients in a day and more easily offer an opening to a patient with an urgent need. Mental health providers can only see 6-8 clients a day, so a late cancellation or a no-show makes it difficult for providers to have a full work schedule.

Late cancellation/no-show policy for Individual, Couples, and/or Family Services: Once an appointment is scheduled, you will be expected to pay the full rate as noted in section 3 (PROFESSIONAL FEES AND IN-NETWORK INSURANCE BENEFITS) for that appointment unless you provide 24-hours advance notice of cancellation, or unless we both agree that you were unable to attend due to circumstances beyond your control.

We will charge the credit, debit, or health savings account card on file for the full private practice rate (see section 3) fee. If you pay by cash or check you must pay the full fee for the missed appointment at your next visit before additional appointments will be scheduled. Insurance does not pay for missed appointments thus you will be charged the full private pay rate (see section 3 for private pay rates) for a no-show or late cancellation even if you are using your health insurance to pay for services.

To cancel an appointment prior to 24-hours, you may leave a voicemail or text us at 918-505-4367 which has a time and date stamp for the message. You may also send an email to intake@legacycounselingservices.com or to your specific provider.

Again, please keep in mind that our late cancellation/no-show policy is not intended as a penalty or a punishment. Scheduling an appointment with Legacy Counseling Services, PLLC or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC is like buying tickets to an event. If you miss the event, it does not matter why you missed it, you cannot turn your tickets in for a refund. Missing appointments may also impact the progress you are making in therapy.

If you have 3 late cancellations or missed appointments within a 3-month period, the therapeutic relationship may be terminated and appropriate referrals to other practices will be offered.

Late cancellation/no-show policy for Group Services (In-person and/or Virtual):

Group services may or may not enforce the late cancellation/no-show policy depending on the purpose and goals of the group. The Legacy Counseling Services, PLLC website will provide information for each group regarding the utilization of the late cancellation/no-show policy.

Overall, when you have a late cancellation or you don't show up for the group it negatively affects you, the professional leading the group, and other clients who are part of the group. All people associated with the group rely on every member being present to fully benefit from the group. Additionally, over time, emotional bonds will form between group members and those bonds help create healing, hope, and confidence for the other group members, and for yourself. Please make a commitment to the group and prioritize the group on your weekly calendar. If you need/want to make your provider aware of not being able to come to a group session, please mail, or leave a voicemail at 918-505-4367 which has a time and date stamp for the message or send an email to intake@legacycounselingservices.com or you can email your provider directly. If you would like to communicate why you can't come to the group meeting, please leave that in your message.

*** Client initials for understanding of the section above: _____**

5. BILLING, PAYMENTS, SERVICE CHARGES FOR DECLINED PAYMENTS

We accept cash, check, credit, debit, and health saving cards from Visa, MC, American Express, and Discover. We use a state-of-the-art practice management software system that securely stores your billing information for all sessions, and you will be billed/payment collected at the beginning of every appointment. Legacy Counseling Services, PLLC and April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC requires that a credit or debit card be on file for services to begin and to be maintained.

Services Charges for Declined Payment: If a check bounces, the associated bank charges ($25) paid by Legacy Counseling Services, PLLC, as well as the time associated with managing the bounced check ($25). If you have two bounced checks or two appointments for which you have not paid for services rendered, services will be discontinued until your account is up to date.

If your credit/debit/HSA/FSA account is declined, a new payment method must be provided within 72 hours after we notify you of the declined payment. Otherwise, a service fee of $25 will be added to your account for delinquent payment at that time and for each month that your account remains in delinquent status.

If your account remains outstanding, Legacy Counseling Services, PLLC, on behalf of its employees and on behalf of April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through a small claims court. If such legal action is necessary, the associated costs will be included in the claim.

Electronic Payment / Storage Authorization: By entering your payment information at the end of this document, on the demographic form, or on the Electronic Payment / Storage Authorization Page, I authorize Legacy Counseling Services, PLLC and/or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC to securely encrypt and store credit, debit, HSA/FSA card information for the purpose of payment for services rendered for varying sessions (individual, couples, family, and/or groups), across multiple dates of service, for payment for late cancellations / no-shows, and/or for any outstanding balances, including balances as a result of declined insurance payments.

If another person is financially responsible for the services the client is receiving, Legacy Counseling Services, PLLC, on behalf of April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC will require that the individual responsible for payment completes an Electronic Payment /Storage Authorization Page and that you, the client and/or Guardian, signs a Release of Information (specifying for the purposes of “billing information for _____”) so that we may communicate with the financial guarantor about issues related to the financial agreement for services rendered.

*** Client initials for understanding of the section above:** _____

6. HEALTH INSURANCE AND CONFIDENTIALITY OF RECORDS

Disclosure of confidential information, including your name, address, date of service, diagnosis, and other personal and confidential information may be required by your health insurance carrier or another third-party payer in order to process your billing claim. Only the necessary information will be

communicated. There may also be instances in which your insurance company requests an audit of your records.

*** Client initials for understanding of the section above: _____**

7. INSURANCE REIMBURSEMENT

Legacy Counseling Services, PLLC and/or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC accepts some select health insurance plans and offers services on a fee-for-service basis for those clients whose health insurance we do not contract with. For clients who wish to use their out-of-network benefits, Legacy Counseling Services, PLLC, on behalf of April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC may be able to electronically file your claims to your insurance company, or we may provide you with a billing invoice that can be submitted to your insurance company if you wish to seek reimbursement. This billing invoice contains confidential information, including your name, date of service, service provided, and diagnosis.

Filing In-Network and Out-of-Network Insurance Claims: We file your in-network and/or out-of-network insurance initially as a courtesy to our clients, but please be aware that you are responsible for payment of services in full (see Section 3) if insurance does not pay for services or if you have not updated us with your insurance information prior to your appointment. If we are out-of-network with your insurance plan we will charge you the full private practice rate for each appointment. We will submit a claim to your insurance company on your behalf. You may be reimbursed directly from your insurance company for a portion of the fee, although this is solely depending on your insurance company and your specific policy.

Refiling Rejected Insurance Claims and Client Responsibility for Outstanding Payment:

If a claim is rejected after we initially file to the insurance company, we will refile an insurance claim two additional times (total filing of 3 times) to get reimbursed from the insurance company. If, after the third attempt, the insurance company continues to deny coverage for a date of service, we will alert you of that and you will be responsible for paying whatever amount the insurance has not paid or the outstanding balance on the account.

Cannot Guarantee Insurance Coverage: Legacy Counseling Services, PLLC cannot guarantee what your insurance will pay, as we are only given estimates from the insurance company regarding your coverage. Also be aware that your deductible, co-pay, or coinsurance amount may change, based on your insurance company, over the course of treatment. We do our best to keep you informed of these changes, but ultimately, you are responsible for knowing and understanding your insurance benefits and any changes to your insurance benefits over the course of treatment.

*** Client initials for understanding of the section above: _____**

8. CONTACTING LEGACY COUNSELING SERVICES, PLLC

Legacy Counseling Services, PLLC administrative staff are available Monday-Thursday between 9 am – 5 pm and Fridays between 9 am-noon and can be reached on the main office line through voice or text services (918-505-4367) or through email (intake@legacycounselingservices.com). Do not leave messages related to your treatment or mental health concerns on voicemail or email as non-clinical staff will have access to these messages. Please keep messages focused on scheduling or billing issues only due to privacy and confidentiality.

If you need to leave a message of a more therapeutic nature you may email your provider through the client portal. Also, be aware that communication through email becomes a part of your clinical/legal documentation.

Phone Numbers to Call If in Crisis: Legacy Counseling Services, PLLC and April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC does not provide mental or medical crisis emergency care. If you are in crisis (e.g., having thoughts of harming yourself or someone else or having such distressing symptoms and believe you need help immediately), you will need to contact the Tulsa area COPES hotline (918-744-4800), the national crisis hotline (1-800-273-TALK (8255), call 911, or go to the nearest emergency room.

*** Client initials for understanding of the section above: _____**

9. PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep treatment records for 7 years. You are entitled to receive a copy of the records unless we believe that seeing them would be emotionally damaging. Due to the professional nature of these records, they can be misinterpreted and/or upsetting to untrained readers. If we do not release records to you, we will be happy to provide you with a treatment summary or will send them to another mental health professional of your choosing. If we provide you with your full records, we recommend that we review them together so that we can discuss the contents. Clients will be charged an appropriate fee for any time spent in preparing information requests and reviewing them with you and/or with others.

*** Client initials for understanding of the section above: _____**

10. CONFIDENTIALITY

In general, the privacy of all communications between a client and a mental health provider is protected by law, and we can only release information to an outside party about our work together with your written permission. If you are in couples or family therapy, we prefer that secrets are not kept between one family member and the provider. We will encourage you to talk about and process things with your partner or family members.

Exceptions to Confidentiality: There are a few exceptions to confidentiality: 1) if a judge court orders or subpoenas our records or testimony, 2) if we believe that a child/minor, elderly person, or disabled person is being abused or neglected, 3) if we believe that you, the client, is threatening serious bodily harm to yourself or another person.

Professional Consultation: To provide optimal care, we may consult with other professionals about your treatment. During a consultation, we make every effort to avoid revealing details that will make you identifiable. Additionally, the consultant is also legally bound to keep the information confidential.

*** Client initials for understanding of the section above: _____**

11. PARTICIPATION IN LITIGATION

Legacy Counseling Services, PLLC or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC will not voluntarily participate in any litigation or custody dispute in which the client and another individual, or entity, are parties. Legacy Counseling Services, PLLC and April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC has a policy of not communicating with the client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter unless agreed upon at the beginning of the therapeutic relationship. Legacy Counseling Services, PLLC and April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC will generally not provide records or testimony unless compelled to do so. Should an employee of Legacy Counseling Services, PLLC or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a client, the client agrees to reimburse the employee for any time spent for preparation, travel, or other time in which the employee has made him/herself available for such an appearance at the usual and customary hourly rate as noted in Section 3.

*** Client initials for understanding of the section above: _____**

12. PUBLIC ENCOUNTERS

There may be instances during which a provider and a client encounter each other outside of the therapy setting (grocery store, bank, gym, movies, etc.). Please note that if we encounter each other in public, we will try not to initiate acknowledgment (e.g., smile, wave, say "hello", etc.). This is an effort to

protect your privacy and confidentiality so that you are not put in a position where you may feel pressure to explain to a person you are with how you know us or the nature of our relationship. If YOU decide to acknowledge your provider, we will acknowledge you in return in a simple manner but will not initiate or encourage conversation. Please keep in mind that it is not appropriate to discuss treatment if we do encounter each other in public.

*** Client initials for understanding the section above: _____**

13. SOCIAL MEDIA POLICY AND ONLINE SEARCHES

We do not accept or solicit “friend” or contact requests from current or former clients on any social networking site. Legacy Counseling Services, PLLC has social media sites as a means of providing the public with general information about mental health and healthy coping strategies and services we offer. The business also maintains a blog and will post practice updates on these sites. You are welcome to view or “like” social media posts. Should you choose to make a comment on a post please be aware that Legacy Counseling Services, PLLC cannot guarantee your anonymity or confidentiality, and Legacy Counseling Services, PLLC will remove your comments if too much personal information has been disclosed.

Do not contact Legacy Counseling Services, PLLC via text, wall posts, @replies, or private messages through any social media platform. These sites are not secure, and we cannot guarantee your confidentiality. Additionally, Legacy Counseling Services, PLLC may not check these platforms regularly. Only under rare and extreme situations would we consider it permissible to search for a client on a social media platform. Such situations include, but are not limited to, if we believe that you may be in danger to yourself or others and are unable to contact you through the typical means of an appointment, phone, or text. Such searches or contacts with those acquainted with you will be documented in your clinical chart.

*** Client initials for understanding of the section above: _____**

14. FOR INDIVIDUALS RECEIVING SERVICES WITH LICENSED CANDIDATES

I understand that a licensed mental health candidate (LPC-C, LMFT-C, LCSW-C, or Psychology Intern), means that they are receiving supervision for their cases from an independently licensed mental health provider. Candidates are required to regularly consult with a trained independently licensed supervisor, with whom they have a supervisee-supervisor agreement, for the purpose of providing clients with the best possible services. The information that Candidates share with their established supervisor is completely confidential.

Occasionally, Candidates will ask me to record a portion of my therapy session to share with the supervisor. Candidates will ALWAYS ask my permission to use an audio recording, and I ALWAYS have the right to say no. Any audio recording will be recorded and stored according to HIPAA regulations. The information in the audio recording will be confidential, and the recordings will be deleted within one week of the session. By signing below, I consent to the use of an audio recording of my sessions under the conditions listed above.

*** Client initials for understanding of the section above:** _____

15. CONSENT TO TREAT MINOR

43A OK Stat § 43A-5-502 (2020) defines "Minor" as any person under eighteen (18) years of age. "Consent" means the voluntary, express, and informed agreement to treatment in a mental health facility by a minor sixteen (16) years of age or older **and** by a parent having custody of the minor.

Signature / Payment Authorization for Personal Representative or Legal Custodian /Guardian: The personal representative or legal custodian/guardian is required to sign this Agreement and to provide authorization for payment.

Signature of Minor Age 16 or Older: 43A OK Stat § 43A-5-502 (2020) defines "Consent" as the voluntary, express, and informed agreement to treatment in a mental health facility by a minor sixteen (16) years of age or older **and** by a parent having custody of the minor. Thus, the minor who is 16 or older must also sign this Agreement.

Copies of Documentation to Make Health Care Decisions for a Minor Individual: A legal custodian/guardian who has been given power of attorney to make medical decisions for the minor (or adult who has a legal guardianship) must provide legal documentation to prove their status as a health care decision maker for the minor before the date of the first visit. In a situation of joint custody or when the minor has a different last name than their personal representative or legal custodian/guardian a birth certificate showing the minor and parents full names, and/or other legal documentation showing that the minor's last name was changed, or the parent's last name was changed is acceptable. This documentation will be kept in the minor's record.

Information For Parents Regarding Child Custody Litigation

When parents have sought the services of a licensed mental health professional for counseling and therapy involving children, special care must be exercised to protect children and their therapy in the event of court involvement.

The codes of ethics of all the counseling professions and Oklahoma law governing the practice of licensed therapists require that therapists define their role clearly, and not mix roles. Therapists must either serve strictly as custody evaluators or as counselors and therapists. Once therapy or counseling has begun, a therapist may not change roles and testify in court about custody recommendations. It is important that children coming to counseling and therapy have a safe place to discuss their thoughts, feelings, and experiences without fear of disclosure or exposure. It is important that parents agree to respect these limits and agree not to attempt to draw the therapist into being on their side against the other parent. If the therapist assures a child that they will keep confidential these discussions, and later a parent seeks to call this therapist to court to testify using things the child has revealed, children may be harmed and children may never again feel safe seeking counseling or therapy.

Therapy may be extremely helpful to children, particularly when parents are divorcing or in a dispute over their custody. Children often need a safe place to think, consider their feelings, and discuss their wishes without disappointing a parent. Children often feel responsible to tell parents what those parents want to hear, and often fear disappointing a parent. There are very limited situations in which a child's disclosures during therapy may occur without a child's permission. Exceptions that may require a therapist to disclose what they have heard in therapy from a child are when a child discloses that they have been the victim of physical or sexual abuse, or if the child discloses they have intent to harm themselves or someone else.

Agreement Between Provider and Parent: I have read the above information, and I agree to protect my child's therapy experience by not authorizing the violation of my child's right to confidentiality, except those stated above. I will not demand to know the details of what my child might disclose during counseling. I will not authorize anyone else to see my child's therapy notes. I will only seek the release of records to another health or mental health professional for the further care of my child. I will not authorize my attorney to seek records of my child's therapy to be used in custody litigation or subpoena my child's therapist to testify in court proceedings regarding child custody. If these services are required, I will seek a qualified child custody evaluator to perform a complete child custody forensic evaluation.

*** Client initials for understanding of the section above: _____**

16. INSURANCE AUTHORIZATION: PLEASE CHOOSE ONE OPTION BELOW

Option 1: IN-NETWORK INSURANCE AUTHORIZATION:

I am authorizing the release of any information by Legacy Counseling Services, PLLC to my insurance company that Legacy Counseling Services, PLLC and April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC is contracted with. By signing, I am stating that I understand that release of this information is necessary to process all 3rd party claims insurance payments to be sent to Legacy Counseling Services, PLLC.

When using health insurance to help pay for services rendered, I understand that I am responsible for paying any co-pays, co-insurance, and/or deductibles, or the full rate for any claims denied by the insurance company, for whatever reason. I understand that those employees, or independent contractors, of Legacy Counseling Services, PLLC are not allowed to waive co-pays, co-insurance, or deductible payments per their contract with the insurance company.

I understand that Legacy Counseling Services, PLLC, on behalf of its employees and April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC, may collect additional payments from me for a specific date of service if the insurance company changes my rates for that date of service, even after services are rendered. I understand that insurance coverage cannot be guaranteed by Legacy Counseling Services, PLLC and that it is my responsibility for knowing and understanding my insurance benefits.

*** Client initials to select In-Network Insurance Authorization: _____**

Option 2: PRIVATE PAY and OUT OF NETWORK AUTHORIZATION:

I am authorizing the release of any information by Legacy Counseling Services, PLLC, on behalf of its employees and April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC, to my insurance company for the purposes of submitting billing claim information for out-of-network insurance reimbursement. This will include the date and location of services, the procedural code, a diagnostic code, and the client's name, date of birth, address, and insurance member/group information.

*** Client initials to select Private Pay and Out-of-Network Insurance Authorization: _____**

Option 3: PRIVATE PAY ONLY:

I am acknowledging that I do not want to use my insurance and I do not want Legacy Counseling Services, PLLC or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC to bill my in-network insurance or bill my insurance for "out-of-network" for possible reimbursement to me by my insurance company.

*** Client initials to select Private Pay Only Authorization: _____**

CONSENT FOR MENTAL HEALTH SERVICES

I have read the above agreement carefully and have been afforded the opportunity to ask questions so that I understand the contents. I understand that I can return to this document at any time to discuss these policies with Legacy Counseling Services, PLLC and/or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC.

I understand and agree with the professional services and business policies of Legacy Counseling Services, PLLC and April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC as described in this document, including, but not limited to, the business policies regarding professional fees, in-network insurance benefits, late cancellations / no-show policy, and the occasion use of an audio recording of my sessions if my provider is a licensed candidate.

I understand my rights and responsibilities as a client and my provider's responsibilities to me. I agree to undertake mental health services with an employee of Legacy Counseling Services, PLLC or with April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC. I understand that I can terminate therapy services at any time and that I can refuse any requests or suggestions made by an employee of Legacy Counseling Services, PLLC or by April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC.

By signing this agreement, it will represent an agreement between me and Legacy Counseling Services, PLLC or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC. I agree that I am over the age of eighteen and have the legal authority to sign this agreement.

Printed Legal Name: _____

Signature: _____ Date: _____

If Client is a Minor:

By signing below, I am agreeing that I have the ability to make health care decisions for the minor.

Printed Legal Name of Personal Representative/Legal Custodian/Legal Guardian:

_____

Signature of Personal Representative/Legal Custodian/Legal Guardian:

_____ Date: _____

Electronic Payment / Storage Authorization Form

I, (full legal name)_____*authorize Legacy Counseling Services, PLLC, on behalf of its employees or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC, to securely encrypt and store credit, debit, HSA/FSA card information for the purpose of payment for services rendered for varying sessions (individual, couples, family, groups, and/or workshop services), across multiple dates of service, for payment for late cancellations / no-shows, and/or for any outstanding balances, including balances as a result of declined insurance payments as outlined in the Consent for Mental Health Services Agreement. Insurance does not pay for missed appointments thus you will be charged the full private pay rate for a no-show or late cancellation even if you are using your health insurance to pay for services.

I authorize Legacy Counseling Services, PLLC, on behalf of its employees or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC, to collect additional payments from me for a specific date of service if my in-network insurance company changes the rates for that date of service, even after services are rendered. I understand that my in-network insurance may not pay for services that they determine are not medically necessary, and/or services that are not covered by my insurance plan, such as telehealth coverage. I understand that I am responsible for paying any co-pays, co-insurance, and/or deductibles per my insurance plan. I understand that Legacy Counseling Services, PLLC or April Reeder, LPC/Million Chances Ministries and Counseling Services, PLLC, is not allowed to waive co-pays, co-insurance, or deductible payments per their contract with my in-network insurance company.

Printed Name of Cardholder as it Appears on the Card:

_____

Full Address (Street, City, State, Zip) of Cardholder:

_____ _____, ____ _____

This card is a: Mastercard Visa American Express Discover Debit HSA FSA

Card Number:_____ Expiration Date: ____ / _____ CVV: _____

Signature of Cardholder: _____

Date of Signature: _____

RIGHT TO RECEIVE A “GOOD FAITH ESTIMATE”

- You have the right to receive a 'Good Faith Estimate" explaining how much your medical care will cost.
- Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.
- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is a least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.
- For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Printed Legal Name: _____

Signature: _____ Date: _____

BEHAVIORAL EXPECTATIONS FOR IN-PERSON OR VIRTUAL GROUPS

1. Maintaining confidentiality for who is present in the group and what we discuss is expected.
2. Being under the influence of alcohol and/or non-prescription drugs (aka, drinking or using non-prescription drugs before the meeting) is not allowed during the group.
3. Actively using alcohol and/or non-prescription drugs is not allowed during group sessions.
4. Appropriate clothing is mandatory. If you are participating in a virtual group, you are required to have on a shirt and pants. If your clothing shows private body parts or does not adequately cover your body you will be dismissed from the group for that session, and possibly from all future groups.
5. Yelling, cursing, excessive talking, name-calling, insults to others is not allowed and you will be dismissed from a session, or possibly from all future groups.
6. If you are participating in a virtual group, your microphone needs to be on mute while others are talking.
7. If you are participating in a virtual group, your camera needs to be on during the virtual group.
8. If you are participating in a virtual group, having others in the room, or allowing others to come in and out of your room, during the virtual group is not allowed. You will be given one "grace pass" if this happens by accident. From then on you will be dismissed from the group for that session, or possibly from all future virtual group sessions.
9. If you are participating in a virtual group, you can show support to other group members non-verbally so as not to interrupt the person who is speaking. You can show agreement by nodding your head, snapping your fingers, clapping, or "raise the roof" with your hands. You can show sympathy or compassion by patting one of your shoulders, hugging your shoulders, nodding your head.
10. If you are participating in a virtual group, when you have something to add or you have a question, you can write it in the Chat feature or you can "raise your hand" on the online platform.
11. Refunds will not be given if you are dismissed from a group session for violations of any violations of these expectations.

Printed Legal Name: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

FOR PROTECTED HEALTH INFORMATION

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

If you consent, the provider is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information I create and obtain in providing services to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

YOUR HEALTH INFORMATION RIGHTS:

The health record and billing records I maintain are the physical property of this office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your protected health information by delivering the request in writing to my office. I am not required to grant the request, but I will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at my office.
- Request that you be allowed to inspect and receive a copy of your health record and billing record. You may exercise this right by delivering the request in writing to my office using the form provided to you upon request.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to my office using the form provided to you upon request.
- File a statement of disagreement if your amendment is denied and require that the request for amendment and any denial be attached in all future disclosures of your protected health information
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to my office using the form provided to you upon request. The accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request.

- Request that communication of your health information is made by alternative means or at an alternative location by delivering the request in writing to my office using the form provided to you upon request.
- Revoke any authorizations that you made previously to use or disclose the information except to the extent information or action has already been taken by delivering a written revocation to my office.
- You have the right to review this Notice before signing the consent authorizing the use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

MY RESPONSIBILITIES

The provider is required to:

- Maintain the privacy of your health information as required by law
- Provide you with a notice as to my duties and privacy practices as to the information I collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if I cannot accommodate a requested restriction or request.
- Accommodate your reasonable requests regarding methods to communicate health information to you.

You may also file a complaint by mailing or e-mailing it to the Secretary of Health and Human Services. I cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment. I cannot, and will not, retaliate against you for filing a complaint with the Secretary.

NOTIFICATION:

Unless you object, I may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other persons responsible for your care, about your location, about your general condition, or your death.

COMMUNICATION WITH FAMILY: Using my best judgment, I may disclose to a family member, other relatives, close personal friend, or any other person you identify, health information relevant to that person’s involvement in your care or in payment for such care if you do not object or in an emergency.

DISASTER RELIEF:

I may use and disclose your protected health information to assist in disaster relief efforts.

FUNERAL DIRECTORS/CORONERS:

I may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

MARKETING:

I may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits or services that may be of interest to you.

PUBLIC HEALTH:

As required by law, I may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

ABUSE AND NEGLECT:

I may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

LAW ENFORCEMENT:

I may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

HEALTH OVERSIGHT:

Federal law allows me to release your protected health information to appropriate health oversight agencies or for health oversight activities.

JUDICIAL/ADMINISTRATIVE PROCEEDINGS:

I may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order. To avert a serious threat or health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public

FOR SPECIALIZED GOVERNMENTAL FUNCTIONS:

I may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel

OTHER USES:

Other uses and disclosures in addition to those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke that authorization as previously stated.

By signing below, you indicate that you have read the above Privacy Notice:

Printed Legal Name: _____

Signature: _____ Date: _____