Miss Racheal's Counseling, LLC
2498 W. New Orleans Street Broken Arrow, OK 74011-1590
www.legacycounselingservices.com **539-777-1129** **Updated 6/25/18**

CONSENT FOR SERVICES
This document contains important information about our professional services and business policies. Please read this thoroughly and write down any questions you have so we can discuss. By signing this document, it will represent an agreement between you and me.

PSYCHOLOGICAL SERVICES
Psychotherapy helps relieve emotion distress and is based on an active and collaborative relationship between the therapist and the client and is not an exact science. Psychotherapy can have risks, including uncomfortable feelings, changes in the way you think or behave that may be difficult for people in your life to adjust to thus leading to temporary relationship strain. Psychotherapy also has benefits, including 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.

EVALUATION & PSYCHOTHERAPY SESSIONS
The evaluation phase typically lasts 1-3 sessions to gather information about your current and past problem and to determine if we can provide the treatment you need. Sessions are about 50 minutes in length.

TELEMEDICINE (ONLINE THERAPY):
Telemedicine (online therapy through the computer or by phone) is an option although insurance rarely pays for these types of appointments. Telemedicine may be used if you or your mental health provide are not able to come to the office. By signing this consent form you are also consenting to engage in telemedicine with Dr. Leedy either as the main mode of treatment OR as a supplementary form of treatment. I understand that telemedicine includes 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 Dr. Leedy will verify the address of my physical location at the beginning of each telemedicine appointment. I understand that I have the following rights with respect to telemedicine:
(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 telemedicine. As such, I understand that the information disclosed by me during the course of 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 telemedicine interaction to researchers or other entities shall not occur without my written consent.

I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, 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.

In addition, I understand that telemedicine-based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine 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; and there may be a greater opportunity to prepare in advance for therapy sessions.

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 intentional misrepresentation, therapy will be terminated.

PROFESSIONAL FEES

The "hourly" (about 50 minutes) fee for psychotherapy (face-to-face or telemedicine) service is as follows: Dr. Melissa Leedy, Ph.D. - $180; Cynthia (Cindy) Fugatt, LPC - $150; Saundra (Sandy) Stone, LPC - $150; Abby Simpson, LPC - $150; Dr. Donita Smith, Ph.D., LPC - $150.00; Racheal Elrod-Edwards, LMFT – $150.

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 incrementally at the same hourly rate. If you use insurance to cover some, or all, of your counseling, you are agreeing to pay any amount your insurance carrier does not pay. This may include, but is not limited to, services and charges determined by your insurance carrier to be not medically necessary, and/or services not covered by your insurance plan.

HEALTH INSURANCE AND CONFIDENTIALITY OF RECORDS

Disclosure of personal and confidential information may be required by your health insurance carrier or other third-party payer in order to process your billing claim. There may also be instances in which your insurance company requests an audit of your records.

CANCELLATIONS AND MISSED APPOINTMENTS

You will be charged for all appointments unless a 24- hour notice of cancellation is provided. The credit, debit, or health savings account card on file will be charged for the full fee. If you pay by cash or check the full amount for the missed appointment must be paid at your next visit before additional appointments will be scheduled. The full fee for a no-show or late cancellation will be charged even if you are using your health insurance to pay for services.

BILLING AND PAYMENTS
We accept cash, check, credit, debit, and health saving cards from Visa, MC, American Express, and Discover and will charge your car on the day of the appointment. Your billing information will be securely stored in our electronic health record system. If you opt to pay for services with cash or check, payment will be taken at the beginning of each appointment. If a check bounces the associated bank charges paid by me, as well as the time associated with managing the bounced check, will be added to your balance. 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 account remains outstanding I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, the associated costs will be included in the claim.

INSURANCE REIMBURSEMENT
We accept some select health insurance plans and also offer services on a fee-for-service basis. For clients who wish to use their out-of-network benefits, we submit an invoice on your behalf and any reimbursement from your insurance company will be sent to you. This billing invoice contains confidential information, including your name, date of service, service provided, and diagnosis.

CONTACTING US
Administrative staff are available Monday-Friday between 9am – 5pm and can be reached on the main office line (539-777-1129) or through email (intake@legacycounselingservices.com). Communication through email becomes a part of your clinical/legal documentation. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician, crisis center (918-744-4800, 1-800-273-TALK (8255), call 911, or go to the nearest emergency room.

PROFESSIONAL RECORDS
We are required to 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. In the event that we do not release records to you, we will provide 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.

CONFIDENTIALITY
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. Exceptions to this include 1) if a judge orders testimony or records through a court order or subpoena, 2) if we believe that a child/minor, elderly person, or disabled person is being abused or neglected, and if 3) if we believe that you, the client, is threatening serious bodily harm to self or another person.

COURT TESTIMONY AND CUSTODY EVALUATIONS
We do not testify in court regarding custody, divorce action, or other legal matters.

CONSULTATION

We may consult with other professionals about your situation. During a consultation, we make every effort to avoid disclosing personal health information. The consultant is also legally bound to keep the information confidential.

PUBLIC ENCOUNTERS

If we encounter each other in public we will not initiate acknowledgement of any kind (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 me or the nature of our relationship.

SOCIAL MEDIA

FRIENDING ON PERSONAL SOCIAL MEDIA PROFILES

We do not accept or solicit friend or contact requests from current or former clients on any personal social networking site (Facebook, LinkedIn, Twitter, Pinterest, Instagram, Google +, etc).

COMMENTING ON BUSINESS SOCIAL MEDIA PROFILES

Legacy Counseling Service maintains social media sites (Facebook, Linked In, Google +, YouTube channel). You are welcome to view, comment, or "like" social media posts but do not comment on posts in a way that would suggest you are a client as we are not able to protect your confidentiality and anonymity.

SEARCHING FOR YOU THROUGH A SEARCH ENGINES

Only under rare and extreme situations would I consider it permissible to search for a client on a social media platform. These situations would be if I believed that you may be in danger to yourself or others and I am unable to contact you through the typical means of an appointment or phone. Such searches or contacts with those acquainted with you will be documented in your clinical chart.

SUMMARY OF INFORMED CONSENT

- Psychotherapy services are $180 (Dr. Leedy) or $150 (Mrs. Fugatt, Stone, Simpson; Dr. Smith; Miss Racheal Elrod-Edwards) per 50-minute therapy hour.
- If using insurance, you are agreeing to pay any amount your insurance carrier does not pay, including but not limited to services that insurance deems not medically necessary, and/or services not covered by your insurance plan.
- Fees for services rendered will be automatically charged to the card you have on file, unless paying with cash or check. Payment is taken at the beginning of each session.
- If you cancel less than 24 hours before your appointment, you will be billed you the full fee for the appointment unless you have had a true emergency, even if you use insurance. Please note that text messaging is NOT available as an option for contacting us.
- If you cancel twice in a row with less than 24-hour notice, or if you miss a total of two scheduled appointments without notifying me, I reserve the right to suspend services.
- I have read and understand the Social Media policy and agree not to communicate with Dr. Leedy through social media platforms. I understand that if I choose to communicate through social media

platforms that my confidentiality, privacy, and anonymity cannot be guaranteed by Racheal Elrod-Edwards, LMFT.

- I cannot guarantee around-the-clock availability and am not available before 9am or after 4:30pm Monday through Friday, or on Saturdays or Sundays. If you should experience a behavioral or emotional crisis and you cannot reach me by phone, you should contact 911 or go to the nearest emergency room. You can also call the Crisis Hotline at 1-800-273-8255.
- I understand that personal and confidential information may be requested by the insurance company for the purposes of submitting your insurance claim for payment.

CLIENT ACKNOWLEDGEMENT OF EITHER PRIVATE PAY OR INURANCE PAYMENT FOR INSURANCE COMPANIES LEGACY COUNSELING SERVICE IS CONTRACTED WITH:

____ **I authorize the release of any information**
Client Signature **by Racheal Elrod-Edwards, LMFT/Legacy Counseling Service to insurance companies the company is contracted with. I understand that release of this information is necessary to process all 3rd party claims insurance payments to be sent to Legacy Counseling Service, LLC.**

____ **PRIVATE PAY (I am not using insurance)**
Client Signature

____ **OUT OF NETWORK AUTHORIZATION: I**
Client Signature **authorize the release of any information by Racheal Elrod-Edwards, LMFT/Legacy Counseling Service to my insurance company for the purposes of submitting billing claim information for out of network insurance reimbursement.**

CLIENT CONSENT TO PSYCHOTHERAPY

I have read this statement 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 the therapist. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me.

I agree to undertake psychotherapy with a mental health provider with Racheal Elrod-Edwards (Miss Racheal's Counseling) at Legacy Counseling Service, LLC. I understand that I can terminate therapy services at any time and that I can refuse any requests or suggestions made by this therapist. I am over the age of eighteen and have legal authority to sign this agreement.

____ ____________________
Client Signature: **Date:**

____
Client Printed Name:

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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 be 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 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 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 relative, 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:

____ ________________

Signature of Client or Personal Representative **Date**

____

Printed Name of Client or Personal Representative

ELECTRONIC PAYMENT/STORAGE AUTHORIZATION

I (printed name),____, authorize Racheal Elrod-Edwards, LMFT/Legacy Counseling Service, LLC, to securely encrypted and store credit card information for the purpose of payment for services rendered or for late cancellation/no-show appointments as noted in the Informed Consent.

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service.

____ ___________________

Cardholder Signature **Date**

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OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:______________________________________Medical Record #:__________________________

Date of Birth:______________________________________Social Security #: _________________________

I hereby authorize _Miss Racheal's Counseling, LLC / Legacy Counseling Services___

to release the following information to:

____

Name and Address of Person/Organization Receiving PHI

Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked) ☐Entire Medical Record

☐ Billing Information for_______________________________________ X Mental Health Records

☐ Substance Abuse Records ☐ Medical information compiled between____________and____________

☐ Other:____

The information may be disclosed for the following purpose(s) only:

☐ Insurance X Continued Treatment ☐ Legal ☐At my or my representative's request

☐ Other:____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:____

____ ____
Signature of Patient or Legal Representative Date

____ ____
Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated

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Please provide the following information about your child:

Full Name: ____

Nick Name: ______________________________

Birth Date: ___________________ Today's Date: ___________________

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:
What does your child do that you like? What does he/she do that other people like?

Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Family History:
The name of the child's biological parents:

Mother: ________________________ Father: ______________________

Who has legal guardianship of your child?
Who are other household members with your child?

Names	Ages	Relationship to child

Who are your child's significant others NOT living with your child?

Names **Ages** **Relationship to child**

Please describe any past counseling your child has experienced

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _________ if yes, please describe:

Education History:

School: ________________________ Current Grade: _____________

What does your child's teacher say about him/her?

Has your child ever repeated a grade? If so which one(s)?

Has your child ever received special education services?

Has your child experienced any of the following problems at School?

Fighting	Lack of friends	Drug/Alcohol	Detention
Suspension	Learning Disabilities	Poor attendance	Poor grades
Gang influence	Incomplete homework		

Other Behavioral problems:

Medical History:
What is the name of your child's primary care physician? ________________________

Address: ___________________________________ Phone: ______________

Date of your child's last medical examination: ___________________________

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Has your child experienced any of the following medical problems?

A serious accident	Hospitalization Surgery	Asthma
A head injury	High fever	Convulsions/seizures
Eye/ear problems	Meningitis	Hearing problems
Allergies	Loss of consciousness	Other

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:
Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?
If yes to either question, please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?