The Counseling Center of Florence, LLC

PHONE: (843) 673-0054
FAX: (843) 667-1549
616 S. COIT ST.
FLORENCE, SC 29501

PATIENT INFORMATION

DATE: _____ ☐NEW PATIENT ☐UPDATE

PATIENT: _____
LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

_____
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

_____
SCHOOL/LOCATION

CLIENT DATE OF BIRTH: _____ PATIENT SSN: _____

MAILING ADDRESS: _____
ADDRESS

HOME: _____

_____
CITY STATE ZIP CODE

CELL: _____

_____ ☐YES ☐NO
EMAIL REMINDERS OKAY?

WORK: _____

REFERRAL? ☐YES ☐NO REFERRED BY: _____

PRIMARY INSURANCE PLAN NAME: _____

GROUP NUMBER.: _____ ID NO.: _____

IS THE PRIMARY INSURANCE SUBSCRIBER THE SAME AS THE IDENTIFIED CLIENT? ☐YES ☐NO **(IF NO, COMPLETE INSURANCE INFORMATION BELOW.)**

INSURANCE INFORMATION FOR PRIMARY INSURED

SUBSCRIBER: _____
LAST FIRST MI PREFERRED TITLE

SUBSCRIBER DATE OF BIRTH: _____ SUBSCRIBER SSN: _____

SUBSCRIBER ADDRESS: _____
CITY STATE ZIP CODE

SUBSCRIBER PHONE NUMBER: _____ PATIENT RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

SUBSCRIBER EMPLOYER: _____

PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the staff at the next appointment without fail. I hereby authorize payment directly to The Counseling Center of Florence, LLC. If I have provided my insurance information in the box above, I hereby authorize The Counseling Center of Florence, LLC to bill my insurance for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

SIGNATURE: _____ DATE: _____

Patient Name: _____ Insurance ID: _____

This page is completed for minors only

*Our office recognizes that often extended family members and friends help many of our families with minor children. A legal guardian is required to sign all forms for a minor client to enter counseling with our office. This information is provided to help us better protect your privacy. Please **ONLY** fill out the information below that pertains to your case:*

_____ _____
Biological Mother's Name Phone Number

_____ _____
Biological Father's Name Phone Number

Biological Parents Are: ☐ Married ☐ Separated ☐ Divorced ☐ Cohabitating ☐ Not married, living separately

If living separately, please tell us who child lives with the majority of the time: _____

If biological parent(s) are divorced and still have custody, please tell us if either parent has remarried and enter the stepparent's names below:

_____ _____
Stepmother's Name Phone Number

_____ _____
Stepfather's Name Phone Number

Has there been a termination of rights for either or both biological parent: ☐ **YES** ☐ **NO**

If yes, please enter parent name(s):_____

Was there an adoption for this client: ☐ **YES** ☐ **NO** If yes, please enter the date of adoption: _____

_____ _____
Adoptive Mother's Name Phone Number

_____ _____
Adoptive Father's Name Phone Number

Is this child currently in foster care: ☐ **YES** ☐ **NO** If yes, please complete the following:

_____ _____ _____
Caseworker's Name Agency Phone Number

_____ _____
Foster Mother's Name Phone Number

_____ _____
Foster Father's Name Phone Number

Is there a current DSS kinship agreement in place? ☐ **YES** ☐ **NO** If yes, please complete the following:

_____ _____
Kinship Caregiver's Name(s) Phone Number

Is there a current court order in place giving anyone **other than** the biological parents guardianship, custody or rights to client mental health information: ☐ **YES** ☐ **NO**

- **Our office requires a copy of any current custody, visitation, guardianship orders or active DSS kinship agreements to be on file prior to the client seeing the counselor.**

By signing this form, I am agreeing that all the information provided is correct to the best of my knowledge. I further understand that this sheet is only for informational purposes for this office. If I wish to sign a release for anyone listed on this form, I will complete a separate release of information form. ***Please ask the front office staff for an additional release form should you require one.***

_____ _____
Client or Parent / Guardian Signature Date

_____ _____
Staff Signature Date

Patient Name: _____ Insurance ID: _____

Outpatient Behavioral Health Consent for Treatment Form

*The majority of this document is mandated by both South Carolina State Law and Public Law 104-191; it is provided for **your** protection. The Counseling Center of Florence, LLC has tried to anticipate any risks you may face as a result of being in therapy. If you have any questions regarding the documents you have received, please feel free to discuss them with The Counseling Center of Florence, LLC.*

Contact Information

The Counseling Center of Florence, LLC is located at 616 S. Coit St. in Florence, SC 29501. This is also our mailing address. Our usual office hours are Monday through Thursday 7:30 am to 7:30 pm. Our clients are seen by appointment only. Our telephone number is (843) 673-0054 (the voicemail is secure and confidential) and our fax number is (843) 667-1549.

Please understand that any relationship that you have with counselors and staff at The Counseling Center of Florence, LLC is considered a professional relationship. Therefore, any communication between you and any staff member may become part of your or your child's permanent file. This includes, but is not limited to, information pertaining to scheduling, insurance, billing, and clinical information.

Counseling Services

Counseling has both benefits and risks. Risks may include uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of counseling often requires discussing the unpleasant aspects of your life. However, counseling has been shown to have benefits for individuals who undertake it. Counseling often leads to a significant reduction in feelings of distress, increase satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees about what will happen. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss *outside* of sessions. The first 1-2 sessions will involve a diagnostic assessment for your needs. Based on the presenting symptoms, you may be diagnosed with a mental illness. Diagnoses are required for insurance and billing purposes, but it may follow you or affect your life. If you choose to not have an identified diagnosis, you may choose to self-pay. By the end of the assessment, your counselor will be able to offer you some initial impressions of what work might include. At that point, treatment goals will be discussed, and an initial treatment plan will be created. You should evaluate this information and make your own assessment about whether you feel comfortable working with your designated counselor. If you have questions about treatment, discuss them with your counselor whenever they arise. Please understand that in no way will there be any sexual relations between you and your counselor during or after treatment. Counselors are also not allowed to receive gifts of any kind. No blogs or public writings created by any counselor from this office represent any specific client. ***Counselors cannot have contact through any or all forms of social media including but not limited to Facebook, Facebook Messenger, Instagram, Twitter, or Yahoo Messenger. We currently do not permit contact through electronic means, such as email or text.***

Patient Name: _____ Insurance ID: _____

Fees

It is customary to pay for professional services at the time they are rendered. The billing rate for face to face and telehealth services are $155 for an initial assessment and thereafter will be billed at $105 for individual 45-minute therapy, $112 for 50-minute family and couples' therapy and $120 for 60-minute extended individual therapy. Each 45-60-minute session that is missed may accrue a missed appointment fee. If your counselor accepts your insurance, you will only be required to pay a copay and/or coinsurance unless your deductible has not been met. Patients with insurance are responsible to pay their co-pay and/or coinsurance at the beginning of each session. If you do not know whether your deductible is met, you will be charged the full insurance contract rate, then refunded when your insurance company pays. Legal services that include talking with an attorney, writing reports and/or court time will be billed at a session rate per hour. Please see the front office for explanation of or questions regarding legal fees. By signing this form, I give permission for my insurance to be billed and payments to be collected by The Counseling Center of Florence, LLC. I understand that clinical information may need to be shared to obtain eligibility, authorization for services and to file claims on my behalf. There may be other instances that my clinical information will be shared with my insurance company on my behalf.

Payments

Payment is due at the time of the session unless other arrangements have been made. Our office will file your in-network primary insurance claim(s), but you are responsible for deductibles, co-insurance, and co-payments. We do not file secondary insurance(s). If we are not a participating provider for your insurance plan, we will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, we will refer you to another counseling practice or facility. It is your responsibility to familiarize yourself with your insurance benefits. If your claims are denied, your coverage has been terminated, or if you are in your HIX grace period due to lack of premium payments with your insurance company, you are responsible for paying your account in full. Our administrative staff will be happy to assist you with any questions, comments, or concerns that you may have.

Services Provided by

- **David Kahn, Ph. D., LPC, LPCS** (License #2173, #3847) is a Licensed Professional Counselor, Licensed Professional Counselor Supervisor, and is the Clinical Director of The Counseling Center of Florence, LLC
- **Erick Lownsberry, MA, LPC, LPCS Candidate** (License #7358) is a Licensed Professional Counselor
- **Leslie McCall, Ph.D., LPC** (License #2882) is a Licensed Professional Counselor
- **Jackie Griffin, M.Ed., LPC** (License #7669) is a Licensed Professional Counselor
- **Carisa Gerald, MA, LPC** (License #7838) is a Licensed Professional Counselor
- **Tai Yancey, MA, LPCA** (License #7490) is a Licensed Professional Counselor Associate and is supervised by David Kahn, Ph.D., LPC, LPCS and Erick Lownsberry, MA, LPC, LPCS Candidate
- **Clyde Talmadge Padgett Kahn, MA, LPCA** (License #7781) is a Licensed Professional Counselor Associate and is supervised by Erick Lownsberry, MA, LPC, LPCS Candidate
- **Samantha Dukes, MS, LPCA** (License #7559) is a Licensed Professional Counselor Associate and is supervised by David Kahn, Ph.D., LPC, LPCS and Erick Lownsberry, MA, LPC, LPCS Candidate

******Full Professional Disclosure Statements for each counselor are available upon request.******

Other Rights
If you are unhappy with what is happening in therapy, we hope that you will speak with your counselor so a response can be given to your concerns. Such comments will be taken seriously and handled with care and respect. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about your counselor's specific training and experience. Our office has interns from various colleges. You may be asked for interns to observe your session. You have the right to say "no". Please note that interns follow the same confidentiality regulations of our office.

Telehealth
If you are interested in telehealth, your counselor will determine if you are appropriate for this service, and we will make our best effort to inform you if your insurance will cover these services. Should your insurance provider change their policies regarding telehealth services, we will do our best to notify you of these changes, but it is ultimately your responsibility to understand your plan. Additional information regarding telehealth services can be found under the Informed Consent for Telemental Health Services and Telehealth Policies and Procedures.

Appointment Reminders
As of 11/11/2021, our office is able to offer email reminders for appointments. In addition to appointment cards and the patient portal, this will aid patients in remembering scheduled appointments. Please be advised, the email will be for informational purposes only. If you need to cancel your appointment, you will need to contact the office by phone. Our missed appointment/cancellation policy will still apply (see the missed appointment agreement page for additional details). If you would like to receive email reminders for your appointments, please ensure you have opted in on the front page. Please notify the administrative staff should you have any questions.

Consistency in Treatment
During counseling it is common to have a temporary increase in problem behaviors. Consistency is key to recovery. It is crucial that you be on time for your appointments and consistent with your scheduling in order for you to meet your treatment goals. If you fail to show for sessions, you may be asked to sign a consistency agreement. Your counselor will help you address the need for consistency as it pertains to your treatment. If you fail to comply with your consistency agreement, you may be referred back to your referral source to find alternative care. It is also important to follow the treatment recommendations of your counselor as to how often you should be seen. **If there is a lapse in treatment exceeding 45 days, your counselor is required to terminate services. You can return to counseling after a termination based on availability.**

Emergency Protocol
You hereby authorize The Counseling Center of Florence, LLC to take any reasonable steps on your or your child's behalf in the event of an accident, injury, or illness during counseling sessions. This includes, but is not limited to, emergency first aid, nurse and/or ambulatory services. You agree to be liable for the cost of any such action taken on your behalf and hereby release The Counseling Center of Florence, LLC from liability thereof. You assume risk, by this consent, of any illness, accident, or injury to yourself while attending at The Counseling Center of Florence, LLC and release The Counseling Center of Florence, LLC from any liability thereof.

Confidentiality
Each parent, whether the custodial or non-custodial parent of the child, has equal access and the same right to obtain all educational and medical records of the minor child (SC Law 20-7-100). Additionally, according to South Carolina Law, confidentiality may be breached in an attempt to collect unpaid fees for services rendered. In the event that there are unpaid fees, client's accounts are sent to a collection agency and a 30% service charge is added to the bill. A 10% late charge may be added to each month the payment is late, including late

payments on previously arranged payment plans. Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." Information can only be shared with outside professionals after written consent is given by the patient. The information you share in counseling is protected health information (PHI) and is generally considered confidential by South Carolina statute law and federal regulations. Your therapy file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system. However, there are limits to the privilege of confidentiality. These situations include:

1. When you sign a release for a person or office.
2. Suspected abuse or neglect of a child, elderly person, or a disabled person.
3. When it is believed you are in danger of harming yourself or another person or you are unable to care for yourself.
4. If you report that you intend to physically injure someone, the law requires this practice to inform that person as well as the legal authorities.
5. In an emergency, where your life or health is in immediate danger.
6. If our office is ordered by a court to release information as part of a legal involvement. This includes a Guardian ad Litem (GAL) (A GAL routinely has a court order to access records.)
7. When you are being seen for court-ordered evaluations or treatment.
8. When your insurance company is involved, e.g., in filing a claim, insurance audits, case review or appeals, etc.
9. In natural disasters whereby protected records may become exposed.
10. Children under the age of 18 (We do maintain a reasonable right to privacy.).
11. Treating couples and families (We have a mixture of responsibilities to different family members.).
12. During a malpractice case or a disciplinary board hearing against a counselor.
13. If you use your mental condition as a defense in court.
14. In workman's comp cases.
15. As required by the Patriot Act.
16. As required by the Partner Notification Act.
17. When otherwise required by law.
18. Consultation, Supervision: Information about you may be discussed in confidence, without revealing your identity, with other counseling professionals for the purpose of consultation and providing you the best possible service. If you are working with a Licensed Professional Counselor Intern or Licensed Clinical Social Worker Intern, your clinical mental health counselor is required to discuss your case on a regularly scheduled basis with his/her supervisor. This will include your name, diagnosis, and content of therapy. The Supervisor is also required to maintain your confidentiality under the same legal guidelines as your clinical mental health counselor.

    If applicable, your clinical mental health counselor will complete the following for your information:

    I am being supervised by:

    - ☐ David A. Kahn, PhD, LPC, LPCS
    - ☐ Erick Lownsberry, MA, LPC, LPCS Candidate
    - ☐ _____
    - ☐ _____

Patient Name: _____ Insurance ID: _____

IF THERE HAS BEEN A DIVORCE OR THERE IS A PERMANENT OR TEMPORARY COURT ORDER PERTAINING TO CUSTODY OR VISITATION, WE WILL NEED A COPY OF THAT ON FILE TO PROTECT THE RIGHTS OF ALL PARTIES INVOLVED.

Appointments

Appointments are usually scheduled for 45-60 minutes. The practice's hours are by appointment only. Clients are generally seen weekly or more/less frequently as schedule availability dictates. You may leave a voicemail 24 hours a day, but calls are ONLY returned during regular office hours, Monday through Thursday. In the event of an emergency, you need to call or go to your primary care physician, your psychiatrist, or the local emergency room.

Record Keeping

A clinical chart is electronically maintained describing your counseling goals and progress, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

Ethics

Counselors follow the Code of Ethics of the following organizations:

- The South Carolina Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-educational Specialists.

  Website: https://www.llr.sc.gov/POL/Counselors/

Consent for Counseling

You will be asked to sign the last page of this document. By signing below, you are stating that you have read and understood this policy statement, and you have had your questions answered to your satisfaction. You accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or counseling. You understand that you may withdraw from counseling at any time.

You further understand that:

- Treatment isn't always successful and may open unexpected emotionally sensitive areas.
- We have no physicians on staff, and no one here can prescribe medications to anyone.
- Your counselor may need to consult with your physician, attorney, or other counselor.
- Your counselor is not available 24 hours a day.
- Appointments may be successfully canceled without fees as late as 24 hours prior to the scheduled time.
- Your counselor is licensed through the SC Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists; this Board is located in The Synergy Center (Kingstree Building) in Columbia, SC at (803) 896-4652 (mailing address is P.O. Box 11329, Columbia, SC 29211-1329).
- The Administrative Director for The Counseling Center of Florence, LLC is Marlena Hanna-Lownsberry. She is a confidential administrator under state and federal law. She will be your major contact for problems, complaints, and commendations.

I acknowledge that I have received and read The Counseling Center of Florence, LLC or Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights. I further acknowledge that I seek and consent to treatment with my counselor.

I agree that I will be financially responsible for 100% of replacement or repair costs if myself or my minor child/family member damage or destroy any property of TCC or the counselor.

_____ _____

Client or Parent / Guardian Signature Date

_____ _____

Staff Signature Date

Patient Name: _____ Insurance ID: _____

Missed Appointment Agreement

Effective January 1, 2019

Our office wants to work with you and your family to meet your treatment goals and gain the most out of your therapy sessions. Your time is important, and your appointment time is for you only. Our office does not double book clients. If you miss your appointment there is an automatic consequence for the counselor as they do not get paid for their time. There are fees when you miss an appointment.

As of 1/1/2019 missed appointment fees are $40.00 for the 1st missed appointment and will increase by $40.00 for each one thereafter. Example: 1st missed appointment is $40.00, 2nd missed appointment is $80.00, 3rd is $120.00, and so on. Our office **CANNOT** bill your insurance company for a missed appointment. You are responsible for missed appointment fees and **CANNOT** be rescheduled until the missed appointment fees are paid. *Medicaid clients can not be charged for missed appointments. Medicaid clients may be referred back to their referral source after missing two appointments.*

IF YOU MISS AN APPOINTMENT AND FAIL TO CONTACT THE OFFICE, OUR SYSTEM REMOVES ANY FUTURE SCHEDULED APPOINTMENTS. IT WILL ALSO REMOVE ANY APPOINTMENTS FROM ACCOUNTS WHICH YOU ARE THE GUARANTOR ON.

The following are ways to avoid missed appointment fees:

1) Be on time and at each scheduled appointment.
2) Schedule appointments that you know will work for you and your family.
3) Give 24 hours' notice if you will have to miss an appointment. Our system counts down to the very minute. Providing 23 hours and 59 minutes is still a missed appointment. **You may call our office 24 hours a day, 7 days a week, and leave a message on our secure and confidential voicemail system if it is outside of normal business hours.**

Your counselor nor the front office can waive your missed appointment fee. Please contact the office and ask for the Director if you have any questions.

SOME OF OUR COUNSELORS ARE AVAILABLE TWO SATURDAYS PER MONTH. PLEASE BE ADVISED, IF YOU SCHEDULE A SATURDAY APPOINTMENT AND MISS OR CANCEL WITHOUT 24 HOURS' NOTICE, WE ARE UNABLE TO SCHEDULE ANY FUTURE SATURDAY APPOINTMENTS.

_____ _____

Client or Parent / Guardian Signature Date

_____ _____

Staff Signature Date

Patient Name: _____ Insurance ID: _____

INFORMED CONSENT FOR TELEMENTAL HEALTH SERVICES
The Counseling Center of Florence, LLC

This Informed Consent for Telemental Health Services contains important information focusing on doing psychotherapy utilizing our secure Telemental Health platform. Please read this carefully and let our office know if you have any questions. When you sign this document, it will represent an agreement between yourself and your clinician.

Benefits and Risks of Telemental Health: Telemental Health refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing. One of the benefits of Telemental Health is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. Please note, counselors are subject to the requirements set forth by their licensure board as for where Telemental Health services may take place. *Please notify administrative staff prior to your session if you will be located outside of South Carolina at the time of your appointment*. Telemental Health is also more convenient and takes less time. However, it does require technical competence in order to be beneficial. Although there are benefits of Telemental Health, there are some differences between in-person psychotherapy and Telemental Health, as well as some risks. For example:

- Risks to confidentiality- Because Telemental Health sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. Our office and staff will take reasonable steps to ensure your privacy. It is important for you to find a private location for your session where you will not be interrupted. It is also important for you to protect the privacy of our session on your device. You should only participate in therapy while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology- There are many ways that technology issues might impact Telemental Health. For example, technology may stop working during a session, other people might be able to gain access to your private conversation, or stored data could be accessed by unauthorized people or companies.
- Crisis management and intervention- Usually, clinicians will not engage in Telemental Health Services with clients who are currently in crisis and require high levels of support and intervention. In any event, there will be an emergency response plan to address potential crisis situations that may arise during Telemental Health sessions.
- Efficacy- Most research shows that Telemental Health is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications: Our office uses a HIPAA-compliant Telemental Health platform for video conferencing. There is no additional cost to you for using this service. You will need to have a secure tablet or PC that has audio and video capabilities to use video conferencing. You will also need a reliable internet service. It is best if you are as close to your Wi-Fi router as possible to ensure a strong connection.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. If an urgent issue arises, you should contact our office by phone. Your clinician or the Administrative Director will try to return your call within 24-hours, except on weekends and holidays. If you are unable to reach our office and feel you cannot wait for a return call, contact your primary care physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

Confidentiality: Our office and staff have a legal and ethical responsibility to make the best efforts to protect all communications that are a part of your Telemental Health Services. However, the nature of electronic

communications technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will utilize updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for Telemental Health sessions and having passwords to protect the device you use for Telemental Health). The extent of confidentiality and the exceptions to confidentiality discussed in the consent for treatment form which you signed at the inception of your psychotherapy services still apply in Telemental Health. Please let our office know if you have any questions regarding these policies.

Appropriateness of Telemental Health: From time to time, we may request that you schedule an in-person session to "check-in". Your clinician will let you know if they decide Telemental Health is not a good option for you. If this is the case, we would discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology: Assessing and evaluating threats and other emergencies can be more difficult while engaging in Telemental Health services than in traditional in-person therapy. To address some of these difficulties, we are creating an emergency plan before engaging in Telemental Health services. You must identify an emergency contact person who is near your location who can be contacted in the event of a crisis or emergency to assist in addressing an emergent situation. By executing this document, you are authorizing your clinician to contact your emergency contact person as needed during such a crisis or emergency.

My emergency contact person is: _____

This person can be reached at: _____

If the session is interrupted for any reason **and you are having an emergency**, do not attempt to reconnect with your clinician. Instead, call 911 or go to your nearest emergency room. Call the office back after you have called or obtained emergency services. Another option in case of an emergency might be to call the National Suicide Prevention Hotline at 1-800-273-8255.

If the session is interrupted and you are not having an emergency, you may attempt to rejoin the session via the Telemental Health platform on which therapy was being conducted. If you are unable to rejoin the session within two (2) minutes, call our office at (843) 673-0054. We will attempt to help you reconnect with your clinician. TIP: If you are not plugged in, be sure your device is fully charged and/or close to somewhere you can plug in. If you are tethering to your phone/mobile hotspot for internet access, be sure that device is also fully charged and that you are ready to plug in if it starts to go dead.

As we are only ethically permitted to bill your insurance company for the time you are in session, you will be billed privately for any difference in the time you have scheduled and the time you were able to attend the session. This includes logging in late or leaving the session early for any reason, including technical difficulties or connection failure. This will be determined based upon your insurance provider's policies.

Patient Name: _____ Insurance ID: _____

Records: The Telemental Health sessions shall not be recorded in any way unless agreed to in writing with mutual consent. Records of your Telemental Health session are maintained in the same way records of in-person sessions are in accordance with office policies.

Informed Consent: This agreement is intended as a supplement to the general informed consent you signed and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____ _____
Client or Parent / Guardian Signature Date

_____ _____
Staff Signature Date

Patient Name: _____ Insurance ID: _____

Telehealth Policies and Procedures

The following policies and procedures must be followed in order to provide telehealth services for you or your minor child.

All clients must be seen in person for the initial session. This allows for all paperwork to be completed properly, allows staff to scan your insurance and ID card into your account per insurance compliance, and allows your counselor to determine if you are a good candidate for telehealth sessions. It is not uncommon for a counselor to ask that you continue to be seen in person.

Insurance companies require all telehealth sessions to have an uninterrupted connection with synchronous audio and visual in order for the service to be billed to and covered by your insurance provider. Cell phone notifications will disconnect a telehealth session. To better serve you, we request you use a secure tablet or PC with a reliable, strong internet connection. Alternatively, you may switch your phone into airplane mode and connect to a secure internet source such as private WI-FI or personal internet hotspot.

Your Therapy Notes patient portal, which is required for telehealth services, must be set up at least 48 hours prior to the telehealth appointment. After your patient profile has been created, the office will send a link to the email address you provided so you may set up your portal account. This takes about 2 minutes and requires you to enter the patient name and create a password. Please keep your password in a safe place. The office does not know or see your password. If needed, the office is able to reset your password, but this must be done at least 15 minutes prior to your scheduled appointment. Please note, only one email address can be attached to the patient portal. If services are being provided to a minor child, please ensure they are aware of the email address you provided for the log in purposes. If the email address needs to be changed, a new password will need to be created and the previous email address will no longer have access to the portal. To return to the patient portal for future appointments, you can go directly to the following web page: therapyportal.com/p/counseling29501/

Telehealth sessions cannot be performed while you are a driver or passenger in a vehicle. You must be in a confidential setting, just as you would be if you were inside the counseling office.

Clients are required to sign in on time for all telehealth sessions. Clients are also required to schedule their appointments for when they can be present the entire session. If you sign in late or leave the session early, you will be asked to pay the difference in what can ethically be billed to your insurance company and the time scheduled that we cannot bill. This will be based on each insurance company's policies. We cannot bill your insurance company for time that is scheduled that you were not present.

All copayments or fees are required to be paid at least 15 minutes prior to your session so the office can let your counselor know to begin the session. The office does not call you for payments. You must call the office at least 15 minutes prior to your session, or you can put a card on file that will be run the day of your appointment. A card on file will also be used for missed appointment fees.

Most insurance companies require the client to be present for all telehealth sessions. This means we cannot bill your insurance provider for telehealth sessions in which the identified client is not present. Should you request this type of session, the payment would come directly from you. Please let the administrative staff know if you have any questions.

_____ _____

Client or Parent / Guardian Signature Date

_____ _____

Staff Signature Date

Patient Name: _____ Insurance ID: _____

Fee Agreement and Financial Policy

Thank you for choosing The Counseling Center of Florence, LLC. Please review this Fee Agreement and Financial Policy, which describes our fees for services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancelations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions, **please ask the front office staff prior to signing this Agreement and Policy.**

Service Rates with Corresponding Health Insurance Billing Codes

This reflects the most common services provided by our staff and is not a comprehensive list. Additional codes may be used by your counselor as deemed appropriate.

• 90791	Initial Intake	45-60 minutes	$155
• 90837	Individual Therapy	53-60 minutes	$120
• 90834	Brief Individual Therapy	38-45 minutes	$105
• 90832	Brief Individual Therapy	25-30 minutes	$60
• 90847	Family with Client	50 minutes	$112
• 90846	Family without Client	50 minutes	$112

_____
Initial

Charges Not Covered by Insurance

- Medical Records Requests
  Our office follows the fee schedule set forth by South Carolina Legislature which states records are billed at $0.65 per page for 1-30 pages, and $0.50 per page for each additional page. There may be additional processing or shipping fees, if applicable. The maximum charge is $150.00 per request for electronic records and $200.00 per request for paper records.

- Case Management $15 per 15-minute increment **(unless specified below)**
  Case Management includes indirect services provided outside your scheduled session time such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), coordinating adjunct and Court Advocacy services, and completing forms or reports. On occasion you may request that we testify or be present in court proceedings on your behalf of subpoena from the court; ***the time is billed from port to port regardless of testimony given****.*
  - Letters $75 for 1 page, $50 for each additional page
  - Court Time $150 per hour

- Phone consultations $25 per 15-minute increment

_____
Initial

Additional Fees

- Processing Fee for Credit Cards 3.5% **(beginning 3/31/2022)**
- Late Cancelations/Missed Appointment $40/$80/$120
  **Fewer than 24 hours prior to appointment*
- Non-sufficient funds (bounced) check $40
  **Includes checks returned due to insufficient funds*
- Past-due Accounts $25 per month
  **Over 30 days*

_____
Initial

Patient Name: _____ Insurance ID: _____

Payment

You will be expected to pay for either each session in full, or your insurance co-payment at the time of services provided under the **Consent for Services**, which will be provided to you along with this Agreement and Policy and our **Notice of Privacy Practices**. Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to *The Counseling Center of Florence, LLC.*

Insurance Reimbursement

The Counseling Center of Florence, LLC accepts and processes insurance payments through a variety of insurance providers and Employee assistance plans. If you are using insurance or Employee assistance to pay for services, then we will:

1. Expect and accept payment of your copayment amount at the time of service;
2. File your claim with the primary insurance provider;
3. Receive payment from your insurance provider;
4. Expect that you will pay your portion due of copay, co-insurance, deductible, or fee difference at the time of your appointment.

PLEASE NOTE

The Counseling Center of Florence, LLC files insurance as a courtesy to you, and you (not your insurance company) are ultimately responsible for your bill. If your insurance company denies a claim filed on your behalf, then you are responsible for paying The Counseling Center of Florence, LLC the difference between the standard rate and the amount previously paid as copayment.

I agree to: (1) allow The Counseling Center of Florence, LLC to bill my insurance directly for services provided under Consent for Services; (2) give The Counseling Center of Florence, LLC permission to release any information the insurance company may require in order to process payment; appoint The Counseling Center of Florence, LLC as my authorized representative to act for me in obtaining payment; (3) assign all of my rights to claims and payment by my insurance to The Counseling Center of Florence, LLC; and (4) agree to assist with the claims process as required by The Counseling Center of Florence, LLC or my insurance provider. I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in counseling are reimbursed by insurance companies.

_____ _____

Client or Parent / Guardian Signature Date

_____ _____

Staff Signature Date

Private/Self-Payment for Services

I will self-pay for services at The Counseling Center of Florence, LLC. I agree to the fee schedule in this document. I understand that payment for services is due at the time services are provided.

_____ _____

Client or Parent / Guardian Signature Date

_____ _____

Staff Signature Date

Patient Name: _____ Insurance ID: _____

Cancelations & Missed Appointments

Insurance carriers will not pay for late cancelations or missed appointments. Once an appointment is scheduled, that time is reserved specifically for you. Cancelations must be made at least 24 hours in advance by calling the office at (843) 673-0054. If a staff member is unavailable to take your call, please leave a message with your name, date of birth and the date and time of the appointment which you wish to cancel. Our secure voicemail system will time stamp the call and as long as the message is left more than 24 hours in advance of your scheduled appointment time, it will not be considered a late cancellation or missed appointment. Although 24 hours is the minimum, if you need to cancel or reschedule, please give as much notice as possible. Late cancellations will incur a fee of $40.00 for the initial missed appointment, $80.00 for the second, and $120.00 for the third or more missed appointment.

Past Due Accounts

Amounts past due by more than 30 days will incur a late fee each month of $25.00. If your account has not been paid for more than 45 days and arrangements for payment have not been agreed upon, The Counseling Center of Florence, LLC may resort to legal means to secure payment. This may involve hiring a collection agency, an attorney or going through small claims court. If such legal action is necessary, you will be responsible for those costs.

_____ _____

Client or Parent / Guardian Signature Date

_____ _____

Staff Signature Date

Credit Card on File

Upon scheduling your first appointment you have the option to provide credit card information which will be kept on file to be used as a form of payment for fees incurred for co-pays, co-insurance, deductibles, late cancelations, missed appointments, returned checks, or past due account balances. A receipt will be uploaded to Therapy Notes portal.

Type of card (circle one):

Visa Mastercard American Express Discover HSA

Card#: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration: _____/_____

Security Code: _____

Billing Address for Card: _____

Address City State Zip Code

Name on Card: _____

I authorize The Counseling Center of Florence, LLC to charge this credit card as needed according to the terms specified in this Agreement and Policy.

Signature of Card Holder: _____ Date: _____

Patient Name: _____ Insurance ID: _____

I have read the Agreement and Policy above, and I have been offered a copy for my records. I understand the policy and by my signature below I agree to be bound by its terms in association with outpatient services provided to me by The Counseling Center of Florence, LLC.

_____ _____

Client or Parent / Guardian Signature Date

_____ _____

Staff Signature Date