· CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS ·

Jennifer Savitz-Smith, Ph.D., LPC
2016 Assembly Street · Columbia · SC 29201
Phone: 803-254-4460, ext. 2 · Fax: 803-771-7666

I consent to the use or disclosure of my protected health information by **Jennifer Savitz-Smith** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by **Jennifer Savitz-Smith** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Jennifer Savitz-Smith** is not required to agree to the restrictions that I may request. However, if **Jennifer Savitz-Smith** agrees to a restriction that I request, the restriction is binding on **Savitz-Smith**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Jennifer Savitz-Smith** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my counselor, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Jennifer Savitz-Smith** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Jennifer Savitz-Smith**. The Notice of Privacy Practices is also provided in the waiting room. This Notice of Privacy Practices also describes my rights and **Jennifer Savitz-Smith** duties with respect to my protected health information.

Jennifer Savitz-Smith reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice please contact our Privacy Contact at: 2016 Assembly Street, Columbia, South Carolina 29201

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN CONSENT

You will be asked by your counselor to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your counselor will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your counselor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the counselor's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the counselor's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other counselors who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a counselor to whom you have been referred to ensure that the counselor has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another counselor or health care provider (e.g., a specialist or laboratory) who, at the request of your counselor, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your counselor.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as-needed, your protected health information in order to support the business activities of your counselor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of counseling students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to counseling students that see patients at our office. We may also call you by name in the waiting room when your counselor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your counselor or the counselor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your counselor may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your counselor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your counselor or another counselor in the practice is required by law to treat you and the counselor has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your counselor or another counselor in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the counselor determines, using professional judgement, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws. **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process. **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred. **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual. **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized. **Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs. **Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your counselor created or received your protected health information in the course of providing care to you. **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your counselor and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your

care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your counselor is not required to agree to a restriction that you may request. If counselor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your counselor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your counselor. You may request a restriction by calling our office at 803-254-4460 or asking your counselor.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

YOU MAY HAVE THE RIGHT TO HAVE YOUR COUNSELOR AMEND YOUR PROTECTED HEALTH INFORMATION. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMATION. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, at (803) 254-4460 or for further information about the complaint process.

This notice was published and becomes effective on April 1, 2003

· ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES ·

You May Refuse To Sign This Acknowledgement

I _____, have received a copy of this office's Notice of Privacy Practices.

_____
{ Please Print Name}

_____
{Signature}

_____
{Date}

FOR OFFICE USE ONLY

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual Refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other {Please Specify}

_____

_____

· PATIENT INFORMATION ·

NOTE: Each family member that will meet with Dr. Savitz-Smith should fill out a separate form.

Patient's Last Name: _____ First Name: _____ M.I:.____

Preferred Name: _____ DOB: _____ Gender:_____ Marital Status: _____

Employment Status:_____ Referred by: _____ Home

Address: _____

City:_____ State:_____ Zip:_____

CONTACT INFORMATION:

CONTACT ONE (The patient, or if applicable: any parent/s of minors who are responsible for billing):

Name (if not 'self'): _____ Relationship to Patient: _____

Primary Phone: _____ Email: _____ Can

we leave messages for you at both of the above?: _____

What kind of appointment reminder would you like?: email __ text __ phone call___ none___
Please note: you will be charged the full appointment fee if you show late, or do not show to an appt., or cancel with less than 24 hours AND 1 business day's notice. Our business hours are M-Th, 9am-4pm.

Are you responsible for payment for the patient?: Yes: _____ No:_____ Other: _____

***

CONTACT TWO (OPTIONAL. If applicable: any parent/s of minors who are responsible for billing):

Name (if not 'self'): _____ Relationship to Patient: _____

Primary Phone: _____ Email: _____ Can

we leave messages for you at both of the above?: _____

What kind of appointment reminder would you like?: email __ text __ phone call___ none___
Please note: you will be charged the full appointment fee if you show late, or do not show to an appt., or cancel with less than 24 hours AND 1 business day's notice. Our business hours are M-Th, 9am-4pm.

Are you responsible for payment for the patient?: Yes: _____ No:_____ Other: _____

***

CONTACT THREE (OPTIONAL. If applicable: any parent/s of minors who are responsible for billing):

Name (if not 'self'): _____ Relationship to Patient: _____

Primary Phone: _____ Email: _____ Can

we leave messages for you at both of the above?: _____

What kind of appointment reminder would you like?: email __ text __ phone call___ none___
Please note: you will be charged the full appointment fee if you show late, or do not show to an appt., or cancel with less than 24 hours AND 1 business day's notice. Our business hours are M-Th, 9am-4pm.

CREDIT CARD ON FILE, BILLING AUTHORIZATION FORM:

Please note about billing! **All fees are due and payable at the time services are rendered.** Professional services are rendered and charged to the client. You are responsible for all charges incurred on your account. If you are the one present at the appointment, but are not responsible for payment, we will still ask you to pay for service; however, we can provide you with a receipt for you to seek payment from the responsible party.

For appointments not canceled with 24 hours AND 1 business day's notice, a charge of the amount of service will be charged to your account. Our business hours are M-Th, 9am-4pm. In addition, any account that is $50.00 or more past due will be charged to your credit card.

Information to be completed by the cardholder:

The undersigned agrees and authorizes Jennifer Savitz-Smith, Ph.D. to charge the credit card indicated below for any account balances which include, but are not limited to, co-pays, coinsurance, written correspondence, outpatient consult with attorneys or medical professionals, fees for late cancel and no show appointments.

Name as it appears on the Credit Card: _____

Type of Credit Card: MasterCard: _____ Visa: _____ Other:_____

Billing Zip Code: _____

Card Number: __ __ __ __ - __ __ __ __- __ __ __ __- __ __ __ __

Expiration Date (month/year): _____/_____ Security Code (3 or 4 numbers on back of card): ____ ____ ____

I, _____ authorize Jennifer Savitz-Smith, Ph.D. to process the above credit card as "Signature on File" for any balance due on my account. I understand this authorization will expire upon payment in full of account.

_____

Signature **Date**

· PATIENT MENTAL HEALTH INFORMATION ·

YOUR REASON FOR SEEKING COUNSELING:

Prior Counseling: (Please circle): Yes No

If yes, when and where?

PSYCHOTROPIC MEDICATIONS: (Please list names of meds, dosages and dates when they were prescribed)

1. DOSE: DATE:_____

2. DOSE: DATE:

3. DOSE: DATE:

FAMILY MEMBERS: (Name, Age and Relationship)

RECENT CHANGES IN YOUR LIFE:

Jennifer Savitz-Smith, Ph.D., LPC
2016 Assembly Street · Columbia · SC 29201
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PLEASE CIRCLE ALL THAT APPLY TO YOU AT THE PRESENT TIME:

FEELINGS:

Helpless	Anxious
Depressed	Out of control
Shameful	Afraid
Angry	Numb
Guilty	Relaxed
Hopeless	Happy
Lonely	Excited
Sad	Hopeful

Other: _____

THOUGHTS:

Confused	Racing
Unintelligent	Obsessive
Worthless	Distracted
Unmotivated	Disorganized
Unattractive	Paranoid
Unlovable	Suicidal
Confident	Sensitive
Worthwhile	Honest

Other: _____

BEHAVIORS:

Eating less	Acting out sexually
Procrastinating	Acting aggressively
Attempting suicide	Disorganization
Poor concentration	Impulsivity
Crying	Recklessness
Withdrawing socially	Irritability
Skipping classes	Passivity
Binge drinking	Using drugs
Injuring self	Exercising regularly
Overeating	Being good to yourself
Compulsivity	Socializing

Other: _____

PHYSICAL SYMPTOMS:

Insomnia
Fatigue
Weight gain or loss
Pain
Headaches
Tightness in chest
Dizziness or light-headedness
Numbness or Tingling
Nausea or vomiting
Rapid heart beat
Dry mouth

Other: _____

ANY MEDICAL CONDITIONS:

ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOU:

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· INSURANCE INFORMATION ·

We are out-of-network with all insurance and you will be responsible for the entire amount at the time of service. As a courtesy to you, and at the discretion of the treatment provider, we may file insurance on your behalf. We may also file if you have a qualifying health condition. Please see the "About Insurance" section below on risks of filing insurance.

Name of Insured Person: _____ Sex of Insured (circle): M F Other

Insurance Co: _____ Insurance ID number: _____

Patient's Relationship to insured: self___ spouse____ child ____ other_____

Insured's Home Address: _____ City:_____

State: ____ Zip: _____ Phone: _____ Insured's DOB: _____

Employer: _____ Occupation: _____

Work Phone Number: _____

I have read Dr. Savitz-Smith page on insurance issues before deciding to file insurance knowing the patient will be given a mental health diagnosis.

_____ _____
Signature Date

Please initial all that apply (for insurance billing, you must initial all with exception to the last one):

_____ I authorize use of this form on all of my insurance submissions.

_____ I authorize release of information to all my insurance companies.

_____ I understand that I am responsible for my bill.

_____ I authorize the provider to act as my agent in helping me obtain payment from my Insurance companies.

_____ I authorize payment direct to the provider.

_____ I permit a copy of this authorization to be used in place of the original.

SIGNATURE **DATE**

Jennifer Savitz-Smith, Ph.D., LPC
2016 Assembly Street · Columbia · SC 29201
Phone: 803-254-4460, ext. 2 · Fax: 803-771-7666

· ABOUT INSURANCE ·

About Health Insurance

I am a therapist because I enjoy helping people. However, it is also the way I make a living. Professional relationships work best when client and professional have a shared understanding about financial issues. For the past twenty years, most people have partly funded therapy with health insurance. It was a system that worked reasonably well, but that is now changing. Because of this, using benefits for therapy may lead to new problems and highlight some long standing ones. Before you make a decision, please consider both sides. Unfortunately, it has become a complicated question.

Benefits of Using Health Insurance

The primary benefit is clear. You paid premiums for health insurance, either directly or indirectly through your employer. It was an investment. One return on that investment is reimbursement for part of your therapy bill.
Court and Custody Cases

We do not usually take insurance for court and custody cases. The reasons are multifold. Primarily, most children and families going through a divorce do not meet diagnostic criteria for a clinical diagnosis to file with insurance. In addition, even when some people have those diagnoses, they are not the primary focus of treatment. Often, I am asked about an adjustment disorder. While it is true that divorce and separation is an adjustment, the individual or family receiving therapy may not meet the criteria for a disorder. There are some therapists who do not view cases this way, however, I do not feel it is legal or ethical to assign a diagnosis where one does not exist or is not being the primary focus of treatment. Please read the effects of doing so below.

Complications of Using Health Insurance Benefits

Problems come in three areas: loss of confidentiality, loss of control of treatment, and the effects of having a psychiatric diagnosis.

1) Increasing Loss of Confidentiality: In the past, therapists only needed to provide insurance companies with a diagnostic code, identifying information, and dates of service. Now insurers usually want a thorough description of your problems, history, symptoms, family life, work life and so on. This information may be reviewed by employees of both the insurance company and a separate managed care company. Many employees of these companies do not have the same training in confidentiality as professionals. Unfortunately, there have been increasing reports of disturbing breaches of privacy, and I have no control over confidentiality procedures once the information leaves my office. Insurance and managed care companies put your information into their computers. Managed care company ownership has been changing rapidly. Smaller companies are bought by bigger ones, which are swallowed by even bigger ones. Therapists are concerned about what will happen to client information as changes in ownership take place. Decreases in privacy may lead to decreases in your openness. The more that is true, the less effective our work together is.
2) Loss of Control of Treatment: Managed care companies use the information we must provide to decide if treatment is medically necessary in the first place, and, later, if it should continue. Many who make these decisions have limited training in psychotherapy. Managed care companies make money by reducing how much treatment occurs. Therapists worry that economic goals may color their decisions. In other words, the criteria they use may be quite different from those you and your therapist use. Reviewers have formulas they must follow in making decisions. Some formulas are economic. Others are based on “average” cases. However, formulas and averages cannot account for human individuality. Therapy done by formulas cannot provide the careful listening that years of scientific research have shown to be the cornerstone of effective therapy. Therapists who belong to some managed care panels are pressured to follow formulas or lose membership on those panels. The two people who can best make treatment decisions are the client and therapist, in partnership. It used to work that way. Today, if

you depend upon health insurance benefits, it may not. Control over treatment is also lost because some kinds of services and problems are not covered. For example, marital counseling is usually not covered even though its effectiveness is well known; and therapy for long term personality problems is almost never covered by managed care. Managed care companies usually agree to cover treatment only to the extent that it focuses on symptoms. They usually refuse to cover treatment aimed at the underlying problems that cause symptoms. Managed care is a system that works best in dealing with crises. However, if people do not come to terms with the underlying issues, new crises are likely.

3) The Effects of Having a Psychiatric Diagnosis: Health insurance benefits can only be used for the treatment of illness. This means that your therapist must make a formal psychiatric diagnosis about you before the benefits will be available. A psychiatric diagnosis can usually be made when people are in psychological distress, but many personal and life problems do not require a formal psychiatric diagnosis to be treated. We are increasingly seeing diagnoses come back to haunt people. Many people have found that using health insurance benefits for therapy has actually cost them money because, after making a claim, their premiums went up. This is despite overwhelming scientific evidence that therapy improves general health and reduces total medical bills. Life and disability insurance applications have been held up. Employers are sometimes notified about all medical care visits, including therapy, by the insurance company. The very existence of psychiatric diagnoses creates a false impression that most people sail through life without serious problems and only the ill need help. That is just not true. All of us, in our fast paced, highly stressful society, have hard times. None of us today can be expected to automatically have all the coping skills we need. Therapy helps people develop skills they have not yet had a chance to develop. The system of psychiatric diagnoses is only one way of looking at human problems. Its biggest advantage is that it helps get health insurance benefits, an advantage that is waning. Psychiatric diagnoses do not usually describe issues in ways that help people actually solve problems. In fact, diagnoses often get in the way. Other ways of looking at human problems are more helpful. Choosing not to use health insurance benefits means you do not have to have a psychiatric diagnosis. That means as people make decisions about you in the future, such a diagnosis will not be an issue.

I have had to write letters for clients who have applied for disability and life insurance. I have had clients denied for other health insurance due to psychiatric diagnoses. Also, I have had clients need letters when applying to take the bar exam to become attorneys. I have also had clients be denied for military service due to psychiatric diagnoses.

· INFORMED CONSENT FORM ·

Welcome to my practice. This document contains important information about my professional services and business policies. Read it carefully and note any questions you might have so that we can discuss them at our next session. When you sign this document, it will represent an agreement between us.

Appointments

Our services are by appointment only. Length of appointment is **50 minutes**. Because appointments are reserved for you specifically, **I must charge for appointments not canceled 24 hours in advance, AND 1 business day. For any missed visit, the client will be charged the full fee.** Insurance does not cover appointments that are not kept. Patients requesting or in need of longer sessions can negotiate this with the therapist. When appointments run over the arranged time, the visit will be prorated for each additional 15 minutes until the session concludes.

Initial Appointment

Your initial appointment will be for the purpose of history taking, defining the problem that needs to be addressed, and determining if this service is appropriate for you.

Counseling Services

Counseling is not easily described in general statements. It varies depending on the personalities of the counselor and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling also has been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional. If intervention is needed outside this office, the appropriate referral will be made after discussion with you. Part of the treatment plan may include evaluation for medication that would require a referral to a physician, or nurse practitioner.

Phone Calls/Emails

Because I conduct outpatient evaluation and therapy, I cannot promise that I will be available at all times. In addition, I usually do not take telephone calls when I am with a client. You can always leave a message and I will return your call as soon as possible, please understand that I am with clients all day and that most operational situations can be handled with my assistant. If my schedule allows, I would prefer to meet with you in person rather than have a phone call there will be a charge for telephone consults. If you have a behavioral or emotional crisis and cannot reach me or my assistant immediately by telephone, you and your family members should call one of the following community emergency agencies the Richland County mental health office at 737-5550, or go to the emergency room of your local hospital. I would ask that emails be for informational

purposes only. You will be charged for the time for me to read and respond to emails. Do not send any emergency information by email. Email should be used infrequently as a means of therapeutic communication.

Confidentiality

Clients are assured of confidentiality at all times. I will only release information verbally or in writing to those whom you authorize by written release of information in my office. Legal exceptions to confidentiality include:

1. I will notify others if I judge that a client intends to harm another individual or him/herself;
2. I must also report any suspected child molestation, neglect, or abuse to protect the children involved as mandated by law;
3. I must report cases where I suspect an elderly person is being abused or neglected.
4. In legal cases, a court can order my testimony or records.

If any of the above conditions should occur, I would notify you of my action.

Payment

Payment is expected at each session. There will be a fee charged for missed appointments and for late cancellation. I reserve the right to turn over any uncollected debt (over 60 days) to a collection agency and/or magistrate's court. Insurance does not cover these types of services. If you have an outstanding balance equal to or greater than your cost of two sessions, I reserve the right to refuse scheduling of another appointment until payment is received. If a collections agency becomes involved, you will be responsible for all associated fees. Any balance due after 30 days will accrue 5% interest for each 30-day period. We keep a credit card on file for all patients. If I have a phone call with you or on your behalf, your card will be charged. Likewise, you will be charged if you miss an appointment. I do not run balances for clients. All payment is due at the time services are rendered.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans, summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

What To Expect From Our Relationship

As a licensed professional counselor (LPC), I will use my best knowledge and skills to help you. This includes the rules and standards of the state of South Carolina and my professional code of ethics, which puts limits on a

relationship between and LPC and his/her client. Let me explain these limits, so you will not think they are personal responses to you.

First, I am licensed and trained to practice counseling – not law, medicine, or any other profession. I am not able to give you good advice from these other professional viewpoints.

Second, state law requires me to keep what you tell me confidential (that is, private). You can trust me not to tell anyone else what you tell me, except in certain limited situations. I explain what those are in the "confidentiality" section of this paperwork. Here I want to explain that I try not to reveal who my clients are. This is part of my efforts to maintain your privacy. If we meet on the street or socially, I may not say hello or talk to you very much. I will allow you to address me first.

Third, in your best interest and following the ACA standards, I can only be your therapist. I cannot have any other role in your life. I can never have sexual or romantic relationships with any clients during, or after, the course of therapy.

Professional Records

The laws and standards of my profession require that I keep treatment records. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If for any reason, you would like to have my professional opinion in writing, then I will provide a written summary upon request, and after a release of information has been signed. Clients will be charged an appropriate fee for any time spent in preparing information requests.

Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment if they ask. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Termination

Termination of treatment may occur at any time and may be initiated by the client and/or by the counselor. I may terminate treatment with you if:

- In the course of the counseling we feel that your needs might be better served by a physician or another community resource, and we talk about making an appropriate referral. If I do not feel I am the best clinician for your needs.
- You do not cooperate in the treatment plan we have set up together, for example, multiple missed appointments, failure to follow through with a referral, arriving at appointments under the influence of substances, or other extreme circumstances.
- You have an outstanding balance and are not able to form and adhere to a payment plan.
- You do not show for one or more scheduled appointments.

I have read and understood the above information. I also give consent for treatment by Jenny Savitz-Smith.

Signature: _____ **Date:** _____

· PARENTAL AGREEMENT FOR CONFIDENTIALITY OF ADOLESCENT OR CHILD SESSIONS ·

Jennifer Savitz-Smith, Ph.D., LPC
2016 Assembly Street · Columbia · SC 29201
Phone: 803-254-4460, ext. 2 · Fax: 803-771-7666

Dear Parent or Guardian,

A young person is more likely to disclose sensitive information to a counselor if he or she is provided with confidential services and has time alone with the counselor to discuss his or her issues. The most practical reason for clinicians to grant confidentiality to an adolescent or child client is to facilitate accurate and appropriate treatment.

Experienced clinicians recognize that candid and complete information can be gathered only by speaking with the adolescent or child patient alone at times and by clarifying with whom the information will be shared. If an assurance of confidentiality is not extended, this may create an obstacle to the safe environment of the counseling relationship.

I encourage teenagers and children to share information about their emotional and mental health with their parents or guardians. However, there will be some things that your son or daughter would rather talk about exclusively with a counselor.

Work with an adolescent or child is generally more productive if parents voluntarily agree to not request information about the private sessions. I ask your permission to keep what is discussed in our sessions confidential. "Confidential" means I will only share information with you if your son or daughter says it is acceptable to do so. The counselor agrees to share with the parent(s) any information that is necessary for the safety of the child.

It is important that parents understand that confidentiality does not work both ways. I may tell your child or adolescent what you say just as I may tell the other parent of the child or adolescent what you say. I will make that judgment based on what is best for the child.

I agree that the therapist will determine what information, in his or her professional judgment, is appropriate to be shared with the parent/guardian(s) concerning treatment issues, and what information, in the discretion of the therapist, will remain confidential between my child and the therapist. I also understand that anyone else participating in counseling with Dr. Savitz-Smith does not have confidentiality within the sessions. While Dr. Savitz-Smith will not tell outside persons what is said in sessions without a release, she may need to tell my child's other parent, my spouse, or my child information that is shared in sessions.

_____ _____

Parental/Guardian Agreement Date

_____ _____

Witness Date

Jennifer Savitz-Smith, Ph.D., LPC
2016 Assembly Street · Columbia · SC 29201
Phone: 803-254-4460, ext. 2 · Fax: 803-771-7666