Date: ____________

Welcome to Hope Restored Services!

Policies and Procedures

The Therapeutic Relationship and Scope of Treatment

As a patient of Hope Restored Services, you have the right to participate in the creation of your treatment plan and understand the therapist's clinical approach. You have a right to ask questions and seek information. The duration of your treatment and the frequency of your visits are issues that will be discussed with you and influenced by your preferences. If the therapist believes that you would be best served by another behavioral health professional, a referral will be provided along with an explanation of why that referral is being offered to you.

Initials ____

Appointments

Appointments typically run for 45-60 minutes to allow for record keeping and preparation. Please note that appointments for patients under the age of 18 usually begin with a "parent component" in which the patient waits in the waiting room while the therapist meets briefly with the parent/caregiver to review any strategies being attempted in the home or community and to review observed progress or concerns. Hope Restored Services does not provide after hours or weekend care. In the event of an emergency, dial 911 or proceed to the nearest emergency room for evaluation.

Initials ____

Fees

Payment for services is expected prior to the start of each session. Hope Restored Services charges $100 for each session for private pay for individual and $130 for couples sessions. The office accepts cash and check payments (returned checks by the bank will be charged a $35.00 fee). Credit card payments will be processed through the Venmo app or Square. For payments made with Square a transaction fee will apply. Receipt for payment is available upon request. The office will file with your insurance company and accept the agreed upon deductible, coinsurance or copayment as long as the office is a participating provider with your insurance company. You are welcome to file independently if the office is not a participating provider with your insurance company. There is a ***$60 fee applied for any missed visits or visits cancelled within the 24 hours prior to the appointment time***. That fee must be processed before another visit may be scheduled. More than three no-shows or cancellations within the 24 hour timeframe will result in the transfer of treatment to an appropriate community resource or termination of the therapy.
Note: In case of an unavoidable emergency, the fee will not apply.

Initials ___

Authorization
My signature below attests that I approve payment to be made to Hope Restored Services for services that I receive. I understand that I may be responsible for payment in the event that my benefits do not cover the services provided. I authorize Hope Restored Services to release required information to my insurance company to justify services being covered.

____
Signature

Confidentiality

- I understand that the services provided by this office are designed to promote personal growth. Such growth is not always easy and may require challenging your usual ways of thinking, and cause temporary emotional distress. There is no guarantee of a positive outcome simply based upon your attendance at counseling sessions.
  Initials ____
- I understand that I have a right to ask questions about my treatment plan and the treatment modalities used. Initials ____
- I understand that communication shared within each clinical session and recorded in the medical record is confidential as governed by law and will not be released without the patient or legal guardian's written consent. Initials ____
- I understand that there are special conditions that may mandate the release of confidential information to provide for the protection of the patient, a named person under the age of 18, or a disabled or aged adult. Such information may be shared if the following exists: patient is a danger or potential harm to themselves or a specifically named child, the patient requires hospitalization because they are a threat to themselves or others, the patient requires a court ordered examination, the patient discloses information about the abuse or neglect of a child, aged, or disabled adult, or if the patient's mental condition is being used as a legal defense in any type of legal scenario. Insurance companies may request a clinical summary or other information from the medical record to justify provision of benefits. Initials ____
- I am informed as to the HIPPA Notice of Privacy Practices. Initials ____

Record Keeping
The patient has a right to review their medical records. Hope Restored Services will maintain medical records for seven years from the time of termination of services. Any time a patient desires records to be released; a written release of information must be completed and added to the file.

Clinical summaries are occasionally requested by patients and their families. Such summaries are available at a fee of $100 to be paid prior to the completion of the report. Completion of reports or forms that are able to be done during the clinical session will not require an additional fee but will require a release of information form to be completed. Hope Restored Services does not complete any type of legal reporting.
Initials ____

Consent for Evaluation and Treatment
I hereby consent for Hope Restored Services to provide evaluation and psychotherapy services to myself or my minor child. (***circle one***). Initials____

Legal Involvement

If your visit to our office will require our involvement in a legal process such as a deposition, court ordered evaluation, court appearance, or involvement in custody disputes, or other legal proceedings, we cannot guarantee confidentiality. Although we will follow our statutory obligations to honor your privacy and your confidentiality, the court can order our disclosure under specific circumstances beyond our control. Please consult with your attorney prior to your first session if you believe our services will involve the legal system.

Please be aware that our fees for involvement in the legal process are $230.00 per hour with a three hour minimum, plus any related travel time involved. Any clinical summaries, court updates, and 504 recommendation letters are billed at $100.00 per report. More in depth reporting is billed at a rate of $230.00 per hour. The legal process is time sensitive and often requires us to cancel or reschedule appointments with other patients. In order to recoup our expenses for legal processes, we must collect these fees in advance. The minimum of three hours of time (a total of $690) is due one week prior to any scheduled court appearance or deposition date. If the patient is a minor, the individual signed below will be responsible for the fees incurred as a result of legal proceedings. If the individual signed below is not the minor's parent or legal guardian, Hope Restored Services must have legal documentation of responsibility on file prior to the first session with the child.

The fees for involvement in the legal process are not billable or reimbursed by your insurance carrier. All fees are your responsibility and are payable in advance. Hope Restored Services will not bill third parties or attorneys. We will accept cash or check for our fees.

For information of a legal nature please consult and follow the advice of a competent attorney. If your attorney requests information regarding your sessions with us, you will need to execute a signed written waiver of confidentiality.

As in all legal proceedings, final disposition is the responsibility of the court.

Hope Restored Services does NOT provide disability determination or custody studies.

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Patient or Responsible Party Signature

Communication with Hope Restored Services

At Hope Restored Services, we strive to maintain excellent communication with our patients.

Below, please list a method of communication that you prefer for confirmation calls and other types of communication. If more than one type of communication is acceptable, please complete both boxes.

___ Text me at: ____
Phone number

__ Email me at: ____
Email address

I understand that by listing the information above, I am agreeing to allow Hope Restored Services to utilize such communication methods to reach me. I understand that Hope Restored Services uses a confidential email account to reach patients. I agree that I am solely responsible for the security of emails that I send/receive and that Hope Restored Services is not responsible for a breech of privacy, confidentiality, or security for emails that I send/receive.

____
Signature

Initial Release of Information

Many insurance companies are recommending communication between the patient's primary care physician and mental health provider to best coordinate care. Please indicate below whether you would like this office to communicate with you or your child's primary care provider.

__ Yes, please inform the primary care provider that I am working with your office.

__ No, please do not have any communication with my primary care provider unless I request such communication in the future.

Doctor/Group Name: ____
Doctor/Group Address: ____
____
Doctor/Group Phone: ___________________________

I understand that by listing the contact information above, I authorize Hope Restored Services, to have direct communication with the above named individual. I understand that I may revoke this release of information at any time by submitting a change in writing.

___________________________________ ___________________________________
Print Name Signature