Stoneburner & Associates, LLC

An Association of Independent Practitioners

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Dear Prospective Client,

Welcome to Stoneburner & Associates, LLC! Please consider filling out this paperwork prior to your appointment date so you may thoroughly read it and ask any questions you may have. We recommend contacting your insurance company prior to your initial appointment so you are familiar with your benefits as well as any copay or deductible you may have.

1) Prior to your first visit, you must insure you have all information listed on the Insurance Information Form. While this information is generally on your insurance card, you can always call the insurance company if you are having trouble with an item.

2) Some Employee Assistance Programs require an authorization number. This is needed in order to cover your services here at our office. If authorization is not obtained before your initial appointment, your service may be denied, and you will be charged the therapist's full fee.

We look forward to working with you!

Client Information and Acknowledgement of Informed Consent to Treatment

STONEBURNER & ASSOCIATES, LLC
5655 N. High St., Suite. 208, Worthington, OH 43085 – Ph: 614-505-6977

I am independently licensed as a **Licensed Professional Clinical Counselor (LPCC) and/or a Licensed Independent Social Worker (LISW)** and am engaged in private practice providing mental health services. I am associated with Stoneburner & Associates, LLC as an Independent Contractor.

Mental Health Services

The purpose of mental health services is to help you better understand your situation, change your behavior or move toward resolving your difficulties. Using my knowledge of human development and behavior, I will make observations about situations and help you to develop new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur.

The services offered can have risks as well as benefits. Treatment often involves discussing unpleasant issues, and you might experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health care may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Appointments

Appointments are made by calling 614-505-6977. **Please call to cancel or reschedule at least 24 hours in advance, or you will be charged $80 for the missed appointment or a reduced fee at my discretion.** Third party payers will not cover or reimburse for missed appointments. Appointments are 45 minutes in length, but session length may vary for clinical reasons. The number of appointments depends on many factors and we will discuss this as part of your treatment planning. Since there is no way a counselor can see another client when they have a late arrival, no reductions are provided when a client arrives late for an appointment. Some insurance companies will only pay for the actual time during which services are rendered. In this case you, the client, will be billed for the portion of the appointment time when no services could be rendered.

Relationship

My relationship with clients is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Please do not attempt to “friend” me on Facebook or on any other social media site.

Goals, Purposes and Techniques

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment I recommend and to have input into setting the goals of your therapy. As therapy progresses these goals may change. You and I will jointly determine how to effect the changes you are seeking to make for yourself. You always have the opportunity to seek either another opinion or a different therapist. I will let you know if I feel that we are not a good fit or if you might obtain better help elsewhere. I will always retain the right to terminate my therapy with you in the event that I feel you would be

better served elsewhere, if I feel you are not complying with treatment requests that I make, or if payments due to me remain unpaid. In the event that I terminate services with you I will offer you referrals.

Confidentiality

Laws protect the privacy of all communications between a client and a therapist. In most situations I can only release information about your treatment to others if you sign a written authorization. There are some situations where I am permitted or required to disclose information either with or without your consent or authorization. For example:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, I cannot provide such information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order me as your therapist to disclose information;
- If a government agency is requesting the information, I may be required to provide it;
- If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend myself;
- If you file a worker's compensation claim, I may be required, upon appropriate request, to provide a copy of your records, or a report of your treatment.

There are some situations in which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm, and in such cases I might have to reveal some information about your treatment. If such a situation arises, I will make every effort to fully discuss it with you before taking any action, if I deem that to be appropriate under the circumstances, and will limit disclosure to what is necessary. For instance:

- If I have reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state or local agency;
- If I believe you present a clear and substantial danger of harm to yourself and/or others, I may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and notifying the police.

I may need to discuss your situation with colleagues from time to time and you agree that I may do that. If I do that I will only release the information necessary in order for me to provide help to you, the client.

You agree that I may release information about your claim(s) to the Ohio Department of Insurance in connection with any insurance company's failure to properly pay a claim in a timely manner as well as to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.

You agree that from time to time I may have the need to consult with my practice attorney regarding legal issues involving your care (this is an infrequent occurrence, but does happen from time to time). My practice attorney is bound by confidentiality rules also. In addition, I will reveal only the information that I need to reveal to receive appropriate legal advice in connection with those contacts.

This summary is designed to provide an overview of confidentiality and its limits. It is important that you read the Notice of Privacy Practices form that has been provided to you for more detailed explanations, and that you discuss with me any questions or concerns that you have.

Legal Situations

If you become involved in legal proceedings that require my participation you will be expected to pay for all of my professional time, even if I am called to testify by another party. I will ask that a retainer be paid of $1,000 at least one week prior to providing these services, and any additional fees that may have been accrued need to be paid within one week after services are delivered. My professional time for legal proceedings may include preparation (document review or letter preparation), phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that I wait in court prior to or after I may be called to testify. Due to the time-consuming and often difficult nature of legal involvement, I charge $250 per hour for these services, with a minimum fee of $1,000. You will also be responsible for any legal fees that I may incur in connection with the legal proceeding, which may include responding to subpoenas.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress towards those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record if you request it in writing. If the law allows it, and if I determine that for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, I may exercise the option of turning the records over to another mental health therapist designated by you. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, I therefore recommend that you initially review them with me, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so I will let you know what the charge is at the time that a record request is made.

As your therapist, I may also keep a set of psychotherapy notes which are for my own use and are designed to assist me in providing you with the best treatment. These notes are kept separate from your Clinical Record. They are not routinely released to others with your Clinical Record, except in rare legal circumstances. Their release requires a separate authorization in addition to one for the Clinical Record. I will discuss with you whether or not I am maintaining psychotherapy notes on you.

Fees, Payments, and Billing

Payment for services is an important part of any professional relationship. This is even more true in therapy; one treatment goal is to make relationships and the duties and obligations they involve clear. You are responsible for seeing that my services are paid for. Meeting this responsibility shows your commitment and maturity. Payment methods include check, cash, VISA, Mastercard, or debit card. Health Savings Account (HSA) cards are also accepted, provided they bear the Mastercard or VISA logo. I can answer questions about financial policies.

My current regular fees are as follows. You will be given advance notice if my fees should change.

Regular therapy services are $200 for the first session, with following sessions at $150 for each 45 minute session. Please pay for each session before or at its end. I have found that this arrangement helps us stay focused on our goals, and so it works best. It also allows me to keep my fees as low as possible because it cuts down on my bookkeeping costs. I suggest you make out your check or provide payment before each session begins, so that our time will be used best. Other payment or fee arrangements must be worked out before the end of our first meeting.

If you choose to not have me send information to your insurance company, you must select this option before each session and then pay for the session in full. I will then not report any information to your insurance company about that session. Although insurance companies say that they maintain confidentiality, oftentimes they report information to a national data bank that may later affect your ability to obtain other types of insurance.

Telephone consultations: I believe that telephone consultations may be suitable or even needed at times in our therapy. If so, I will charge you my regular fee, prorated over the time needed. At my discretion, if the call is less than 15 minutes I may not charge for that call. If I need to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about this, please be sure to discuss it with me in advance so we can set a policy that is comfortable for both of us. Of course, there is no charge for calls about appointments or similar business issues.

Extended sessions: Occasionally it may be better to go on with a session, rather than stop or postpone work on a particular issue. When this extension is more than 10 minutes I will tell you, because sessions that are extended beyond 10 minutes will be charged on a prorated basis. Insurance may not pay for extended potion of a session.

Reports: I will not charge you for my time spent making routine reports to your insurance company.

Disability forms: I may charge a fee for filling out disability forms.

If you think you may have trouble paying your bills on time, please discuss this with me. I will also raise the matter with you so we can arrive at a solution. If your unpaid balance reaches $300 I will notify you by mail. If it then remains unpaid, I may stop therapy with you if we cannot agree on a payment plan. Fees that continue unpaid after this may be turned over to small-claims court or a collection service and you agree to allow me to do that. If I choose to do that I will report only enough information to collect fees due to me.

A late payment fee of $25.00 may be charged each month that a balance remains unpaid, since I will incur costs to rebill and other accounting costs.

Because I am a licensed mental health therapist, many health insurance plans will help you pay for therapy and other services I offer. Because health insurance is written by many different companies, I cannot tell you what your plan covers. Please read your plan's booklet under coverage for "Outpatient Psychotherapy" or under "Treatment of Mental and Nervous Conditions." Or call your employer's benefits office to find out what you need to know.

If your health insurance will pay part of my fee, I will help you with your insurance claim forms. However, please keep two things in mind: 1. I had no role in deciding what your insurance covers. Your employer or you (if you have individual coverage) decided which, if any, services will be covered and how much you have to pay. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth. Your insurance contract is between you and your insurance company; it is not between me and the insurance company unless I have signed a separate agreement with that particular company; 2. You are responsible for paying the fees we agree upon. If you ask me to bill a separated spouse, a relative, or an insurance company and I do not receive payment on time, I will then expect this payment from you. In addition, the plan may have rules, limits, and procedures that we should discuss and I

may not be on one of their panels. Please bring in your health insurance plan's description of services to one of our early meetings, so that we can talk about it and decide what to do.

I will provide information about you to your insurance company with your consent, and by signing below you agree that I may do that. If I have a contract with your insurance company then billing will be sent in accordance with the contract I have with that company. If I am not with the standard diagnostic and procedure codes for billing purposes, the times we met, my company or third party payer does not pay within 60 days, you will be responsible for the charge.

Minors

If you are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order. Before giving parents any information I will discuss the matter with you, if possible, and do my best to handle any objections you may have. In addition, if one parent brings in a child and the therapy only involves the child, under Ohio law generally both parents have access to the child's records and anything the other parent says in the sessions, unless that access is blocked by a court order. I also retain the right under Ohio law to provide client records to another therapist if I believe the release of the records could have an adverse effect on the client. Minors 14 years of age and old should be aware that they have an option to see me on a limited basis without their parents' knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of my intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option.

Emergencies and After-Hours Care

I will make every effort to return messages within 24 business hours; however, I may not always be able to do that. Current clients will be notified during sessions of upcoming travel or vacation. If you have an emergency you should go directly to a hospital emergency department, call 911, or call Netcare Access at (614) 276-2273 Emergencies are urgent situations and require your immediate action.

Incapacity or Death of Therapist

In the event that I am incapacitated or die, it will be necessary for another therapist to take possession of your file and records. By signing this form you consent to allow another licensed mental health professional whom I designate to take possession of your file and records, provide you with copies upon request, or to deliver them to a therapist of your choice. In signing this form below you agree that if you select a successor therapist that you will notify the licensed mental health professional designated by me to maintain your records of that choice.

Email and Texting

I do not like to use e-mail or texting for communications. If you decide you want to utilize either form of communication you acknowledge that there are confidentiality risks inherent in such communications and you accept those risks. I, your therapist, will use my discretion in using this form of communication. If you wish to use texting or e-mail for communications, please place your initials in the space below:

_____(By initializing this section you agree that you understand the risks involved in texting and e-mailing and agree to accept such risks in communications from either me to you or you to me that involve scheduling and/or therapy)

Acknowledgment of Informed Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize you to provide such care, treatment or services as are considered necessary and advisable, and to make all payments described herein.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through you at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor is the client I am signing on behalf of the minor as the authorized parent/guardian. (Information on Minor rights will be shared with the minor)

I also acknowledge receipt of Stoneburner & Associates, LLC's Notice of Privacy Practices.

Client Name(s) (please print)

_____

_____

Client(s) Signature

_____ _____
Date

_____ _____
Date

Parent(s) or Guardian Signature (for minor child or children or disabled adults)

STONEBURNER & ASSOCIATES, LLC

A Practice of Independent Mental Health Professionals

CLIENT INFORMATION SHEET

For Staff Use:	**Checklist:**
Assigned Clinician: JLS SM KH KCYN JSCH DV CH JK	**Claims Address _____**
	Authorization Number _____
Insurance Type	**All Intake Date Completed _____**
PPO HMO EAP Medicare County	**All Signatures Obtained _____**
	Copied Insurance Card _____
DX Code: _____	**HIPAA_____**

Initial Information **Today's Date: _____**

Please make sure that all information is complete before your session begins. If we do not have this information, we cannot bill your insurance company.

Client Name: _____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

E-mail: _____

DOB: _____ Age: _____ Sex: _____ Social Security #: _____

Employer/school: _____ Occupation/Grade: _____

Employer/school telephone number: _____

Marital Status (of client): _____ Spouse's Name: _____

Emergency Contact: _____ Contact # _____

Relationship to patient:_____Address:_____

Parent(s)/Guardian(s) (if client is a minor):

Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Home phone: _____	Home phone: _____
Cell phone: _____	Cell phone: _____
Relationship to client: _____	Relationship to client: _____
Employer: _____ phone: _____	Employer: _____ phone: _____

Responsible Party Information: **If the client is not financially responsible for payment of services, please complete the following information concerning the responsible party.**
*****RESPONSIBLE PARTY MUST BE PRESENT IN ORDER TO FILL OUT AND SIGN ADDITIONAL FORMS; OTHERWISE, BILLS WILL GO DIRECTLY TO CLIENT***

Responsible Party First Name: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Birthdate: _____

Relationship to Client: Parent(s) ____ Guardian _____ Spouse _____ Other_____

Home Phone: _____ Work Phone: _____ Cell Phone _____

If we need to contact you, messages can be left at (check all that apply):

_____ Home voice mail/answering machine _____ Cell phone voice mail

_____ Work voice mail/answering machine _____ E-mail (please provide) _____
**please note, email is not encrypted*

Who Referred You To This Office? Court _____ Agency _____School_____ Other_____

Name _____ Position _____

Address _____ Phone _____

_____

_____

If referred by a court, please provide the following information:

Attorney Name _____Phone: _____

Opposing Counsel _____ Phone: _____

Guardian ad Litem _____ Phone: _____

Magistrate/Judge _____ Court: _____

If county funded, please provide the following information:

County Name _____

Case Manager _____ Phone: _____

Primary Care Physician Name: _____
First Last

Physician Street Address: _____

City: _____ State: _____ Zip: _____

Physician Phone: _____

Primary Insurance/Medicare Information

*** You must complete this section if the subscriber is someone other than the client.**

Primary Insurance Company Name: _____

Identification Number on Card: _____

Group Number (if applicable): _____

Subscriber's Name: _____ _____ _____
(person who holds the policy) FIRST MIDDLE LAST

Subscriber's Social Security Number: _____

Subscriber's Street Address: _____ City: _____

State: _____ Zip: _____

Subscriber's Phone: _____ Client's Relationship to Subscriber: _____

Subscriber's Birthday: _____ Subscriber's Sex: _____

Subscriber's Employer: _____ Subscriber's Work Phone: _____

Authorization Number: _____

In order for us to bill EAP, the section below is required. You must have already set up your EAP with your employer prior to this visit or your primary insurance will be billed instead. **If you have EAP visits and do not fill out the section below, your primary insurance company will be billed. We can only bill EAP from the point we receive the information forward. Thank you.

EAP: Employee Assistance Program

***If you are utilizing your EAP benefits, please fill out the following information completely.**

Insurance Company: _____

EAP benefits phone number: _____

Employer: _____

Employer phone: _____

Authorization Number: _____

Number of sessions allowed: _____Coverage dates: _____

Behavioral Health/ Medical Information

To assist us in helping you, please fill out this form as fully and honestly as possible. All information is held in the strictest confidence within the legal limits. If certain questions do not apply to you, please leave them blank.

Presenting Problem: _____

How long has this problem persisted? _____

Have you previously been involved in counseling for any reason? _____

□ No □ Yes If yes, previous therapist/practitioner: _____

Are you currently seeing a psychiatrist? _____

If yes, please name: _____

Have you ever been psychiatrically hospitalized? _____
If yes, please provide further information:

1. Date of Hospitalization: _____ Number of days _____

Hospital name: _____

Chief Reason: _____

2. Date of Hospitalization: _____ Number of days _____

Hospital name: _____

Chief Reason: _____

3. List any and all allergies to medications, food, or environment: _____

_____

Are you currently taking any medications (for psychiatric reasons or other reasons)? _____
If yes, please list:

Medication Name: _____ Medication Name: _____

Daily Dosage: _____ Daily Dosage: _____

Purpose: _____ Purpose: _____

Prescribing Physician: _____ Prescribing Physician: _____

Medication Name: _____ Medication Name: _____

Daily Dosage: _____ Daily Dosage: _____

Purpose: _____ Purpose: _____

Prescribing Physician: _____ Prescribing Physician: _____

STONEBURNER & ASSOCIATES, LLC

Crisis Response Plan

When thinking about suicide or otherwise feel that I am in a crisis situation, I agree to do the following:

1. Try to identify what is upsetting me, then write out and review more reasonable responses to my suicidal or other harmful thoughts, including thoughts about others, the future, and myself.

2. Do things that help me feel better for about 30 minutes, including listening to music, having tea, going for a walk.

3. If I do not feel better, I will contact a family member or a friend to discuss the matter.

4. I can call my therapist and/or psychiatrist.

5. If the thoughts continue, get specific and I find myself preparing to do something to harm myself, I will call the Emergency Number, which is 614-276-2273, the Netcare Access 24 hour hotline and/or go to the Emergency Room of the nearest hospital closest to me.

_____ (Patient Signature)

STONEBURNER & ASSOCIATES, LLC

Dear Client:

Please be aware of the fee policy for canceling or missing appointments. If you need to cancel your appointment, please do so within 24 hours (Tuesday through Saturday; Monday appointments must be cancelled on Friday by noon.) Neglecting to cancel with sufficient notice will result in a charge to your account. There is also a standing fee for missing or late canceling a group session. Late cancellation and no-show fees are at the discretion of the clinician. Fees will be assessed as follows:

Late cancellation:	$60.00
No show:	$80.00
Missed Group appointment	$30.00

By signing this agreement, you are acknowledging that you have read and understand this fee agreement.

Client Name _____

Signature _____

Date_____

Witness_____

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At Stoneburner & Associates, LLC, it is our business policy not to accept returning patients that have delinquent accounts/or that have been sent to collections.

Also, it is our policy to have the option of ending your treatment if your account balance goes above $300.00. We can refer you to other treatment facilities.

It is also our policy to release from treatment any patient that has numerous broken appointments, whether it is 'no show' cancellations or 'late' cancellations. We require 24-hour notice for cancellations. Again, we can refer you to other treatment facilities.

Thank you,

Stoneburner & Associates, LLC

_____ _____
Date Signature of Patient or Personal Representative

_____ _____
Witness Patient's Name (please print)

_____
Name of Personal Representative (If applicable)

_____
Description of Representative's Authority to Act for Patient (e.g., Legal Guardian. Responsible Party)