3939 West Ridge Rd. Suite B-45
Erie, PA 16506
Tel: 814-240-1011
Fax: 814-240-1048

Therapist-Client Services Agreement

Welcome to Innovative Therapy Services (ITS). This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use of disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them in entirety and very carefully. We can discuss any questions that you have about the procedures and practices. When you sign this document it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on ITS unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process of substantiate claims made under your policy; or if you have not satisfied any financial obligations that you may have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy 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.

Psychotherapy 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, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But 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, we 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 us. 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, we will be happy to help you set up a meeting with another mental health professional for a second opinion. In addition psychology training, ITS therapists have extensive training and experience with spiritual issues. We are quite comfortable discussing and assisting you with any of concerns of a religious nature as well. It may be beneficial/necessary to consult your pastor/minister/priest for further assistance.

MEETINGS

We normally conduct an evaluation that will last from 2 to 3 sessions. During this time, we can decide if the therapist you are meeting with is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, you will usually be scheduled for one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours (1 business day) advance notice of cancellation [unless it is agreed upon by your ITS therapist and yourself that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. (If it is possible, we will try to find another time to reschedule the appointment.)

PROFESSIONAL FEES

See payment information on website.

CONTACTING US

Due to varying schedules, your therapist may often not be immediately available by telephone. When unavailable, our telephone is answered by an answering service, with the direct extension of your therapist indicated. Please leave a detailed message and your therapist will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach someone and feel that you can't wait for a return call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. In addition, Crisis Services is available 24 hours per day to immediately address your needs. Crisis Services can be reached at 814/456-2014. If your therapist will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a therapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of the client. The other professionals are also legally bound to keep the information confidential. If you don't object, you will not be told about these consultations unless your therapist feels that it is important for your work together. All consultations will be noted in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- Innovative Therapy Services is a Limited Liability Corporation formed as a partnership between Jolene Franz, LPC and Shana Bennett, LCSW. Payments will be made to Innovative Therapy Services and any therapists working in this practice may be consulted on a confidential basis for case management purposes.

- You should be aware that since the practice contains other mental health professionals and administrative staff such as billing personal, in most cases, your protected information will need to be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- There may also be contracts with business outside of this office (i.e. such as billing and collection services). As required by HIPAA, we will have a formal business associate contract with this/these business (es), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If a client seriously threatens to harm himself/herself, your therapist may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services you were provided with, such information is protected by the psychologist-client privilege law. No information can be provided without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a client files a complaint or lawsuit against ITS, we may disclose relevant information regarding that client in order to defend ourselves.

- If we are treating a client who files a worker's compensation claim, we may, upon appropriate request, be required to provide otherwise confidential information to your employer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a client's treatment. These situations are unusual in our practice.

- If the therapist has reason to believe that a child who they are evaluating or treating is an abused child, the law requires that they file a report with the appropriate government agency, usually the Department of Public Welfare. Once such a report is filed, the therapist may be required to provide additional information.

- If the therapist has reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), the law allows us to report this to appropriate authorities, usually the Department of Aging, in the case of an elderly person. Once such a report is filed, we may be required to provide additional information.

- If the therapist believes that a client presents a specific and immediate threat of serious bodily injury regarding a specifically identified or a reasonably identifiable victim and he/she is likely to carry out the threat or intent, they may required to take protective actions, such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization

If such a situation arises, ITS makes every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have now or in the future with your therapist. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, Innovative Therapy Services (ITS) keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records received from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others or where information has been supplied to me by others confidentially, or the record makes reference to another person (unless such other person is a health care provider) and we believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee and for certain other expenses. The exceptions to this policy are contained in the attached Notice Form. If your request is refused, you have a right of review (except for information supplied to ITS confidentially by others) which will be discussed with you upon request.

In addition, each therapist keeps a set of Psychotherapy Notes. These Notes are for their own use and are designed to assist your therapist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of conversations, your

therapist's analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal in session that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that ITS amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. Your therapist will be happy to discuss any of these rights with you.

MINORS & PARENTS

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes ITS policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, parents will then be provided only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Parents will also be provided with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless the therapist feels that the child is in danger or is a danger to someone else, in which case, parents will be notified of the concern. Before giving parents any information, the matter will be discussed with the child, if possible, and the therapist will do their best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If ITS is required to invoice you on a monthly basis as a result of an outstanding balance, a $25.00 fee will be late fee will be assessed. Payment plans will be negotiated in rare cases and will each be assessed a $25.00 monthly processing fee. If the identified client is a minor with the primary payer residing at a different address and is requesting to be invoiced for all co-payments, a written agreement will be created with the financially responsible party. As previously stated, any outstanding balance at the end of the month (regardless if a written agreement is present) will be assessed a $25.00 late payment fee.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, ITS has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require ITS to disclose otherwise confidential information. In most collection situations, the only information released regarding:

A client's treatment is his/her name, the nature of services provided, and the amount due. (If such legal action is necessary, its costs will be included in the claim.)

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. Your ITS therapist will fill out forms and provide you with whatever assistance they can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of 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, your therapist will provide you with whatever information they can based on their experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, ITS will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. (Some managed-care plans will not allow ITS to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy.)

You should also be aware that your contract with your health insurance company requires that ITS provide them with information relevant to the services that are provided to you. We are required to provide a clinical diagnosis. Sometimes, we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we make every effort to release only the minimum information about you that is necessary for the purpose requested. 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, we 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. ITS will provide you with a copy of any report submitted, if you request it. By signing this Agreement, you agree that Innovative Therapy Services can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above (unless prohibited by contract).

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client Name:

____

Signature:

____

Date: ____

Parent Name:

____

Signature:

____

Date: ____

INNOVATIVE THERAPY SERVICES

"nurturing growth & change"

3939 West Ridge Rd. Suite B-45
Erie, PA 16506
Tel: 814-240-1011
Fax: 814-240-1048

Client Information Form:

In order to accurately submit claims for services to your insurance company it is essential that you present a current insurance identification card and the client information form must be filled out completely and accurately. Any omission of necessary information will result in your being responsible for the charges for services you receive.

In addition, you are solely responsible for notifying the office PRIOR to your scheduled appointment with any changes in your insurance coverage and/or will be responsible for immediate payment on any service that is denied or not covered by your insurance company including, but not limited to all deductibles, co-insurances, and co-payments.

I have read and understand the above statement.

Client Signature:

____

Date: ____

Parent Signature:

____

Date: ____

STANDARD RATES:

For your information this section lists the fees for the more common services offered. There may be times where other services may be provided (including but not limited to: letters, summaries of treatment and/or legal/court issues) and if necessary I will inform you of the fees for those services at the time of request.

- Initial Evaluation (90791) $125.00
- Individual Therapy (50 minutes) (90837) $ 90.00
- Individual Therapy (40 minutes) (90834) $ 75.00
- Family Therapy (90847) $ 80.00
- Late Cancel/No Show $ 90.00
- Monthly Late Fee *(outstanding balances only)* $ 25.00

INNOVATIVE THERAPY SERVICES

"nurturing growth & change"

3939 West Ridge Rd. Suite B-45
Erie, PA 16506
Tel: 814-240-1011
Fax: 814-240-1048

Client Intake Form

Please provide the following information and answer the questions below. Please note that information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session.

Date: ____

Name:

____
(Last) (First) (Middle Initial)

Client Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Address:

____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ( )_____________________________ May we leave a message? □ Yes □ No

Cell/Other Phone: ( )__________________________ May we leave a message? □ Yes □ No

E-mail: ____

May we email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication and will be utilized in rare cases only**

Marital Status:

□ Student □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Children- If Applicable (first name & ages)

____
____
____
____
____

Referred by (if any):

____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner:

____

Why did you stop treatment?

____
____
____
____
____

Are you currently taking any prescription medication?

□ Yes

□ No

Please list:

____
____
____
____
____
____

Have you ever been prescribed psychiatric medication?

□ Yes

□ No

Please list and provide dates:

____
____
____
____

____
____

FAMILY MENTAL HEALTH HISTORY:
In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).
Please Circle and List Family Member

Alcohol / Substance Abuse yes / no ____

Anxiety yes / no ____

Depression yes / no ____

Domestic Violence yes / no ____

Eating Disorders yes / no ____

Obesity yes / no ____

Obsessive Compulsive Behavior yes / no ____

Bipolar Disorder yes / no ____

Suicide Attempts yes / no ____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

   Poor   Unsatisfactory   Satisfactory   Good   Very good

Please list any specific health problems you are currently experiencing:
____
____
____
____
____
____

2. How would you rate your current sleeping habits? (please circle)

   Poor   Unsatisfactory   Satisfactory   Good   Very good

Please list any specific sleep problems you are currently experiencing:
____
____
____
____
____

3. Please list any difficulties you experience with your appetite or eating patterns:
____
____
____
____
____

4. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No □ Yes

If yes, for approximately how long?
____

5. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No □ Yes

If yes, when did you begin experiencing this?
____
____
____
____
____

6. Are you currently experiencing any chronic pain?
□ No □ Yes

If yes, please describe:
____
____
____
____
____

7. Do you drink alcohol more than once a week? □ No □ Yes

Type ____________________________ Frequency______________________________

8. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

ADDITIONAL INFORMATION:
1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?
____
____
____
____

Do you enjoy your work? Is there anything stressful about your current work?

2. If you are a student what school do you attend? What grade/year?

Extracurricular activities (if any):

3. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, please describe your faith or belief:

4. What do you consider to be some of your strengths?

5. What do you consider to be some of your weaknesses?

6. Why have you sought therapy treatment at this time?

7. What would you like to accomplish out of your time in therapy?

____
____
____
____
____
____
____

8. What else do you feel I should know about you to best help you as your therapist?

____
____
____
____
____
____
____

Primary Care Physician Authorization Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate for the purposes of continuity of care.

I, ______________________________ authorize Innovative Therapy Services, to release
(Please Print Name)

Please check one:

__________ **to release any applicable information to my PCP**
__________ **to release medical information only to my PCP**
__________ **NOT to release information to my PCP**

This information should only be released to (name and address of person to whom the information is to be released)
____
____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).
____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the ITS office address. However, your revocation will not be effective to the extent that ITS has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

____
Signature of Client/Date

____

Authorized Signature/ Relationship to Client

If the authorization is signed by a personal representative of the client, a description of such a representative's authority to act for the client must be provided.

A copy or Fax of this document is considered as valid as the original.________

A copy of this ROI was accepted___________ or declined_________ by client.

General Release of Authorization Form

This form when completed and signed by you, authorizes Innovative Therapy Services to release protected information from your clinical record to the person you designate for the purposes of continuity of care.

I, ______________________________ authorize Innovative Therapy Services, to release
(Please Print Name)

Please check one:
__________ **to release any applicable information to**_________
__________ **to release medical information only to**____________
__________ **NOT to release information to** ____________

This information should only be released to (name and address of person to whom the information is to be released)
____
____
____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).
____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the ITS office address. However, your revocation will not be effective to the extent that ITS has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

____
Signature of Client/Date

____
Authorized Signature/ Relationship to Client

If the authorization is signed by a personal representative of the client, a description of such a representative's authority to act for the client must be provided.

A copy or Fax of this document is considered as valid as the original.________

A copy of this ROI was accepted___________ or declined_________ by client.