ITherapy Agreement, Policies & Consent

PART 1: CONFIDENTIALITY*:*

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. (Florida statute 39.201). If you reveal information relative to child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect (Florida statute 415.1034). If you reveal information relative to vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself – I am required to take steps to protect your safety which may include the disclosure of confidential information. (Florida statute 491.0147 & Chapter 394).
- **Harm to Others**: Threats regarding harm to another person (Florida statute 491.0147). If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone and send you written correspondence (if I cannot get in touch with you by phone). If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Court Ordered Therapy**: If you are in therapy ordered by the court, and the court requests records or documentation of your participation in services, I will discuss the information/documentation that will be discussed/sent on your behalf prior to sending information to the court.
- **Written Request**: Your specific written request is required to disclose information regarding your psychotherapy to you or to a third party. In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("psychotherapy/process notes"), I reserve the right to provide to you or the authorized third party a report of examination or treatment in lieu of copies of the actual records, unless the third party is a treating psychotherapist (Florida Statute 456.057 & HIPAA Privacy Rule). If therapy sessions involve more than 1 party, ALL parties over the age of 18 MUST consent to release of requested information prior to information being released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the needed and adequate documentation i.e. your signature on the "Therapy Agreements and Consent" that covers the cancellation policy to your Bank or Credit Card Company should you dispute a charge that you are financially responsible for. If you have a financial balance, you will be sent a bill to the home address on the intake form unless you advise me otherwise.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to the goal of therapy for the couple. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive.
- **Dual Relationships & Public**: My relationship with you is strictly professional. In order to preserve this relationship, it is imperative that we do not have any relationship outside the counseling relationship such as a friendship, business, or social relationship. If we have contact in a public setting, I will not acknowledge you in any way that would jeopardize your confidentiality. Should you choose to acknowledge me, I may not be able to protect your confidentiality.
- **Social Media**: I do not accept requests to connect with current or former clients on my personal social media accounts. If you choose to connect with me on any of my professional social media outlets such as Facebook, LinkedIn, Pinterest, Instagram, or Twitter, you do so at your own risk. If you choose to comment on my pages or posts, you do so at your own risk and may breach your own confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform as these platforms are not confidential, nor are they monitored, and may become part of your medical record.
- **Client Case Consultation**: There is a team approach at Clarity Health Solutions. Clinicians in this office may confer with each other to provide the highest quality care by obtaining therapeutic interventions and insights to better assist in your care.
- **Electronic Communication: My preference for communicating is through phone contact. Clients will often use text or email as a convenient way to communicate, which can** introduce unique challenges into the therapist–client relationship. Below are some guidelines for to consider. **Do not use e-mail for emergencies**. If it's an emergency, call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for seeing me. If you think that you might need to be seen, please call to book an appointment. E-mails should not be used to communicate sensitive medical or mental health information. **E-mail is not confidential**. Be aware that if you send e-mails from your work, your employer has the legal right to read your e-mail. E-mail is a part of your medical record. Texting introduces some of the same

challenges. Like e-mail, it is not a substitute for seeing me or making an appointment. **Texting is not confidential**. Phones can be lost or stolen. It is imperative that you do not communicate information of a sensitive nature over a text. Further, I cannot know the person who is texting is actually you, because someone else could be in possession of your phone. Should we choose to proceed with tele-therapy at times. I will provide you with an email with a link to a HIPAA compliant platform to have a secure session. Tele-therapy comes with its own risks that need to be reviewed prior to sessions.

PART II: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: Participating in therapy can result in numerous benefits, including improving intrapersonal and interpersonal relationships, resolving the concerns that led you to therapy. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific complaint(s). A major benefit that may be gained from participating in therapy includes a reduction in distress and a better ability to handle or cope with personal, relational, family, work, and other problems as well as stress. Another possible benefit may be a greater understanding of personal and relational goals and values; this may lead to greater maturity and happiness as an individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving initial concerns brought to therapy. I will do my best to assess progress on a regular basis and solicit your feedback regarding the therapeutic process to provide you with the most effective therapeutic services. I make no guarantees as to the ultimate outcome of therapy.

EXPECTATIONS: Work outside of the counseling sessions is an essential aspect of change. I may assign tasks between sessions related to your goals. My commitment is to work as efficiently as possible and at the same time, therapy may move more slowly than you anticipated. We will collaborate to identify your therapeutic goals, periodically review your progress toward them, and modify our treatment plan as needed.

RISKS: In working to achieve these potential benefits, the therapeutic process requires that actions be taken to achieve the results you desire. Sometimes in taking these actions you may experience discomfort. Therapeutically resolving unpleasant events and relationship patterns may arouse intense, unexpected feelings. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work together for a desirable outcome; however, there is a possibility that the goals of therapy will not be met.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 60 or 90 minutes. It is difficult to initially predict how many sessions will be needed, but we will collaboratively determine what our goals are and when therapy is no longer necessary.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment you agreed upon. You agree to adhere to the following policy: ***If you are prevented from keeping a scheduled appointment, you MUST notify me 24 hours in advance. If I do not receive a 24-hour advance notice, you will be responsible for paying full fee for the session you missed, NO EXCEPTIONS.***

FEES: My fee for each 60 minute session is $175. Payment is due at the time of the session in the form of exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus $35 for any returned check), or credit/debit card. In the event that you miss your scheduled appointment time or cancel less than 24 hours, please refer to the "Appointments and Cancellations" policy above.

I reserve the right to terminate our counseling relationship if more than 2 sessions are missed without proper notification.

I charge my hourly rate in quarter hours for phone calls over 15 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed with the credit card you have on file. If we do not have a current card on file, we will send a collection notice. Please do not make me resort to this. I value my clients and I want to maintain healthy relationships.

In-home/On-site therapy services offer people comfort and flexibility. In-home/ On-site services are offered at an increased hourly rate. Cost for travel is based on the regularly hourly rate and is determined by the time it takes for me to travel from the office to your home or requested place of session and back. Time is configured by tracking and logging actual time or internet sites such as Google, Bing, Mapquest, etc. to determine travel time.

Legal or Court appearances of **any** type will be charged for both travel and consultation time at a rate of **$1200 per hour.**

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, they will be dispensed at $5 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at our office. Please allow at least 2 weeks to prepare your records.

PHONE CONTACTS AND EMERGENCIES: Office hours are from 9am to 5pm, Monday through Friday. If you need to contact me for any reason please call 561-670-6420, leave a voicemail, and I will get back to you within 24 Hours. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, dial 911.

PART III: REASONS WHY I DON'T ACCEPT INSURANCE

I would like to share with you my position on why I don't accept health insurance.

- **Reduced Ability to Choose:** Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require "preauthorization" before you can receive services. This means you or I must call the company and justify why you are seeking therapeutic services in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company's list. Reimbursement is reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.
- **Pre-Authorization and Reduced Confidentiality:** Visits are authorized several sessions at a time. When these sessions are finished, your therapist must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if you do not feel you have achieved your therapeutic goals. Your insurance company may request or require additional clinical information that is confidential in order to approve or justify a continuation of services. I cannot assure or guarantee your confidentiality when an insurance company requires this information to approve continued services. Even if the therapist justifies the need for ongoing services your insurance company may decline services regardless if you think you need continued therapy or not. Your insurance company dictates your care. You should be aware that some of your personal information might be added to national medical information data banks. For these and other reasons, many therapists openly talk about "the myth of confidentiality" whenever insurance companies become part of the therapeutic process.
- **Negative Impacts of a Psychiatric Diagnosis:** Insurance companies require the therapist to give you a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") in order to get reimbursed. Most therapists do not inform their clients of this process and place a mental health disorder diagnosis on their record without consulting or informing them of this process. Psychiatric diagnoses may come back to negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations that require revealing that you have a mental health disorder diagnosis. This includes but is not limited to applying for certain types of jobs, financial aid, and concealed weapons permit.

It is also important to note that some psychiatric diagnoses are not eligible for reimbursement. This is often true for marriage/couples therapy.

Why I Don't Take Insurance: These involve enhanced quality of care and other advantages:

1. You determine and are in control of your care, including choosing your therapist, length of treatment, etc..
2. Increased privacy and confidentiality.
3. Not carrying a mental health disorder diagnosis on your medical record.
4. Consulting with me on non-psychiatric issues that are important to you that aren't billable by insurance, such as finding skills to cope with life changes, learning more effective communication techniques for your relationships, or gaining personal insight and developing new, healthy skills.

After reading my position on why I don't accept health insurance, you still may decide to use your health insurance. If you provide me with a list of therapists on your insurance provider list, I will do my best to recommend a therapist for you.

PART V: CONSENT

1. I have read and understand the information contained in the consent and therapy agreement. I have discussed any questions that I have regarding this information with **Jennifer Hoskins-Tomko, LCSW**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Jennifer Hoskins-Tomko, LCSW** to provide counseling services that are considered necessary and advisable.

2. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Jennifer Hoskins-Tomko, LCSW to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Jennifer Hoskins-Tomko, LCSW** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

CLIENT COPY

1. I have read and understand the information contained in the consent and therapy agreement. I have discussed any questions that I have regarding this information with Jennifer Hoskins-Tomko, LCSW. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize Jennifer Hoskins-Tomko, LCSW to provide counseling services that are considered necessary and advisable.

2. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Jennifer Hoskins-Tomko, LCSW to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to Jennifer Hoskins-Tomko, LCSW prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session. If you are enrolling a minor in therapy (under age 18), please review my "minor therapy agreement" for more specific information and to address best practice standards when working with a minor.

_____

Client Signature *Date*

_____

Witness Signature *Date*

Minor's name (if applicatable): _____

REGISTRATION FORM
(Please Print)

Today's date:			Date of Birth:	
PATIENT INFORMATION				
Patient's last name: First: Middle:			Marital status (circle one) Single / Mar / Div / Sep / Wid	
Street address:		Social Security no.:		Home phone no.: ( )
City:	State:		ZIP Code:	Cell: ( )
Occupation:	Employer:			Your Email:
You Chose Clarity because/Referred to Clarity by (please check one box):		❑ Dr.		❑ Hospital
❑ Family ❑ Friend ❑ Psychology Today		❑ Google	❑ Other: _____	
Other family members seen here:				
Drug Allergies:				

RESPONSIBLE PARTY			
(Please Provide your credit card to be copied.)			
Person responsible for bill:	Birth date: / /	Relationship to Patient:	Contact phone: ( )
Is this person a patient here? ❑ Yes ❑ No		Do you need a Superbill: ❑ Yes ❑ No	

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Pharmacy:
Name: _____ Phone Number : _____

PAYMENT AGREEMENT

The above information is true to the best of my knowledge. I understand this is a "Fee for Service" provider and payment is due at the time of service. I understand if my account has an unpaid balance for over 120 days and Clarity health Solutions is unable to collect payment from me or my responsible party, this office has the right to refer me to another provider. I understand that if I do not cancel my appointment within 24 hours or I do not arrive at my appointment time, my account will be charged the full fee for that appointment. I understand my account will be charged a $35.00 fee for any returned checks and at that time my account will be placed on a "no checks" status.

Patient/Guardian signature *Date*

** Updated 10/15/17*

Elite E-Counseling LLC,
D/B/A Clarity Health Solutions
2055 Military Trail, Suite 306
Jupiter, Florida 33458
(561) 781-3333

CREDIT CARD AUTHORIZATION FORM

PATIENTS NAME _____

NAME OF CARDHOLDER _____
(As it appears on the card)

☐ SAME AS ABOVE

BILLING ADDRESS _____

CITY, STATE, ZIP CODE _____

☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER

CREDIT CARD NUMBER _____
EXPIRATION DATE_____ CSC NUMBER (Found on the back of the card) _____

I hereby authorize Clarity Health Solutions to charge the above credit card for the patient name listed above. I certify that I have full authority to make purchases on behalf of the account listed above. Please note in the event that you fail to come to your scheduled appointment, or do not provide at least 24 hour notice of your cancellation, your card will be charged a cancellation fee, as indicated by the Clarity Health Solutions policies.

SIGNATURE OF CARDHOLDER _____ DATE _____

PRINTED NAME _____

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

Clarity Health Solutions

Jennifer Hoskins-Tomko, LCSW * 561-781-3333 * jtomko@clarityhealthfl.com

2055 Military Trail, Suite 306 * Jupiter, FL, 33458

I,_____ DOB:_____

hereby give my permission to **Clarity Health Solutions** to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under Florida law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Florida or federal law.

This information will be released/requested upon request to the following:

To/From: _____

First and last name, phone, and address of person(s)

The type of information to be disclosed/requested is as follows:

To Be Released * *from* Clarity Health Solutions	**To Be Requested** * *from third parties*
____Treatment Plans	____Treatment Plans
____Process Notes	____Process Notes
____Health/Medical Records (if applicable)	____Health/Medical/Academic Records
____Letter(s) of Progress	____Psychological/Psychiatric Evaluations/Assessments
____Bio Psychosocial Evaluation/Assessment (if applicable)	____Court Documents
__ Verbal Communication	__ Verbal Communication
____Other (Specify): _____	____Other (Specify): _____

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), we reserve the right to provide a report of examination or treatment in lieu of copies of the actual records, unless requested by/for a treating psychotherapist (Florida Statute 456.057 and HIPAA Privacy Rule).*

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **Clarity Health Solutions.**

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **Clarity Health Solutions** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **Clarity Health Solutions. Clarity Health Solutions** will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that **Clarity Health Solutions** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Release:

_____

Signature Client/Next of Kin/Guardian **Date**

_____

Clinician Signature/Credentials **Date**

Request:

_____

Signature Client/Next of Kin/Guardian **Date**

_____

Clinician Signature/Credentials **Date**