In Pursuit Psychological Services PLLC

"You don't have to walk alone"

BILLING POLICY

Name:____ Date of Birth:___________________

After reading this carefully, please indicate your understanding and consent by signing your name and date in the space provided.

If you have any questions, please feel free to discuss them with the clinician/psychologist. Your signature below serves as Authorization for Billing. These services may involve psychological evaluation and testing, and/or therapy. This Authorization has been made freely and voluntarily.

Payment

In Pursuit Psychological Services PLLC does not participate with insurance providers. However, an invoice or super bill will be provided if you choose to submit it to your insurance company for reimbursement. It is your responsibility to contact your insurance company to determine what is needed to seek reimbursement. The agency will provide you with the information necessary, if possible.

I have read this form and understand and consent to the policies and responsibilities stated therein.

________________________________ ________________________________ ______________

Signature of client or personal representative   Print name of client or personal representative   Date signed

____

Description of representative's authority

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Credit Card on File

At the time of scheduling for the outpatient therapy or assessment, a credit card will be requested to be placed on file. The fees will also be explained for the initial appointment, as well as an estimate for the assessment. That said, evaluations are typically billed at **$250 per hour**. However, the estimate is not the exact final figure. A $100 no-show fee will be charged if the appointment is not cancelled within 48 hours of the scheduled time.

Additionally, payment for the services must be rendered at the conclusion of testing prior to the feedback meeting/release of the evaluation report. An email will be sent with the total for the assessment, including the feedback session, if applicable. Upon recognition of receipt of the email, the credit card on file will be charged for the full amount detailed in the email.

Name on Card: ____

Street Address: ____ City:_______________________

State: ___________ Zip Code:________

Card Type: ____________________________________

Card Number: ____________________________________ Expiration Date: ________________

CVC Code: ______

I hereby authorize In Pursuit Psychological Services PLLC via Square to use the above credit card, including circumstances where the credit card is not present. This credit card can be used to pay for services rendered and for any outstanding balances on this client/patient's account. Charges will be made for services as described in the Fee Schedule as outlined in the email sent, including fees for scheduled appointments, charges for missed appointments or late cancelations, and for fees associated with the services provided outside of scheduled appointment times. This authorization will be in effect through the credit card expiration date.

I have read this form and understand and consent to the policies and responsibilities stated therein.

________________________________ ___________________________________ _____________

Signature of client or personal representative | Print name of client or personal representative | Date signed

____

Description of representative's authority

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INFORMED CONSENT

Name: ____ Date of Birth:___________________

After reading this carefully, please indicate your understanding and consent by signing your name and date in the space provided.

If you have any questions, please feel free to discuss them with the clinician/psychologist. Your signature below serves as Authorization for outpatient services. These services may involve psychological evaluation and testing, and/or therapy. This Authorization has been made freely and voluntarily.

Confidentiality

All information you share about yourself will be kept confidential. Without your written permission, no information will be released to anyone outside of this agency. The only exceptions to this policy are situations involving imminent danger to you (client) or someone else, suspicion of child abuse, or possibly, if the information is mandated by court order.

As applicable, information will also be shared with the supervising licensed psychologist reviewing the final report. The current evaluator has obtained their Master's or Doctoral degree in psychology or related field, and if not licensed, is currently practicing under the supervision of a licensed psychologist. Should you have any concerns that would be most appropriately addressed by a supervisor, the supervising psychologist can be contacted at (410) 995-8204 or (717) 382-8259.

Policy on Review of Psychological Evaluation Results

Because a psychological evaluation provides considerable information on the behaviors and level of functioning of an individual, we encourage the client, or parent(s)/guardian(s) in case of a child/adolescent, to review the results with a psychologist. This will provide an opportunity for you to discuss issues and questions surrounding the evaluation results.

Consent of both parents/guardians may be required for treatment

In some cases we require the consent of both parents in order to evaluate or treat your child. These include:

1. Cases where there is shared custody for separated or divorced parents.
2. Situations in which the noncustodial parent retains rights to make or participate in medical decision for the child.
3. Situations in which there is no formal custody agreement and parents are separated or divorced.

	By initialing this box, I certify that none of the three conditions apply.

I have read this form and understand and consent to the policies and responsibilities stated therein.

__________________________________ __________________________________ ______________

Signature of client or personal representative | Print name of client or personal representative | Date signed

____

Description of representative's authority

In Pursuit Psychological Services PLLC

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CONSENT TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

Client Name: ___________________________________ Birth Date: ____________________

This form is an agreement between you, [name indicated above] and In Pursuit Psychological Services PLLC. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name above.

When we evaluate, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you, and to provide treatment to you. We may also share this information with others who provide treatment to you, or need it to arrange payment for your treatment, or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign the Consent form.

If you do not sign this Consent form agreeing to what is in our Notice of Privacy Practices, we cannot evaluate/treat you.

In the future we may change how we use and share your information, and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at (410) 995-8204 or (717) 382-8259.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

________________________________	________________________________	____________
Signature of client or personal representative	Printed name of client or personal representative	Date Signed

____	____________
Description of personal representative's authority	Date Signed

In Pursuit Psychological Services PLLC

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. In this document, we can't cover all possible situations, so please talk to our Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services, or for some other business activities which are called, in the law, health care **operations**. After you have read this NPP, we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot evaluate or treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an Authorization to allow this.

Of course, we will keep your health information private, but there are some times when the laws require us to use or share it, such as:

1. When there is a serious threat to your health and safety, or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

2. Some lawsuits and legal and court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers' Compensation and similar benefit programs.

There are some other situations like these, but which do not happen very often.

Your rights regarding your health information:

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you, such as your medical and billing records, but excluding psychotherapy notes and information compiled for use in a civil or criminal or administrative proceeding. You can get a copy of your records, but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change the NPP you can always get a copy from the Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice, or our health information privacy policies, please contact our Privacy Officer who is Stephanie Binter, Psy.D. and can be reached by phone at (717) 382-8259.

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Client's Name: ___________________________________ Date of Birth: ________________________

I hereby give consent and authorize In Pursuit Psychological Services PLLC to allow the use and sharing of Protected Health Information (PHI) about the abovementioned person to:

____

Information to be used or disclosed may include:

_____ Social History	_____ Information regarding client's ability to work	_____ Progress Notes
_____ Academic and Educational Records	_____ Referral/Treatment Summary	_____ Discharge Summary
_____ Psychological Evaluation	_____ Admission Summary	_____ Treatment Plan
_____ Aftercare Instructions	_____ Other - List specific items: _____________________	

I understand that this Authorization does not cover psychotherapy notes, which require a separate Authorization.

HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: ______Do not release these

Dates of care included: ____

I understand this information is to be used specifically for the following purpose(s): CONTINUITY OF CARE

I understand that I have no obligation whatsoever to disclose any information from my client record, that I do not have to sign this Authorization, and that my refusal to sign will not affect my ability to obtain treatment from In Pursuit Psychological Services PLLC, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this Authorization.

I understand that I may revoke or cancel this Authorization at any time, except to the extent that this agency has already acted upon it, by notifying In Pursuit Psychological Services PLLC in writing. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulation

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR AFTER SIGNATURE

I have read this form or had it explained to me, and I understand its contents.

______________________________________	___________________________________	_________________
Signature of client or personal representative	Printed name of client or personal representative	Date Signed

____ _________________

Description of personal representative's authority Date Signed

I, a mental health professional have discussed the issues above with the client and/or his personal representative. My observations of his/her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

______________________________________	___________________________________	_________________
Signature of Professional	Printed name of Professional	Date Signed

NOTICE TO RECIPIENT OF INFORMATION: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE AND FEDERAL LAW. FEDERAL REGULATIONS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

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INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy and/or psychological assessment using the phone or the Internet. When you sign this document, it will represent an agreement between you and In Pursuit Psychological Services PLLC.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy or psychological assessment services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks.

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. In Pursuit Psychological Services PLLC will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of the session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. In Pursuit Psychological Services PLLC will typically not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

Electronic Communications

You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

With regard to electronic communication between sessions, In Pursuit Psychological Services PPLC will use email communication with your permission and only for administrative purposes, unless we have made another agreement. This means that email exchanges with our office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that In Pursuit Psychological Services PLLC cannot guarantee the confidentiality of any information communicated by email.

Therefore, we will not discuss any clinical information by email and prefer that you do not either. Also, we cannot guarantee that we will regularly check email, nor can we guarantee that we will respond immediately, so these methods should not be used if there is an emergency.

Confidentiality

In Pursuit Psychological Services PLLC has a legal and ethical responsibility to make the best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that are outlined in In Pursuit Psychological Services, LLC's original Informed Consent form signed by you still apply in telepsychology. Please let us know if you have any questions about exceptions to confidentiality.

Emergencies and Technology

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, call the office at (410) 995-8204 or (717) 382-8259, or call 911, or go to your nearest emergency room.

If the session is interrupted and you are not having an emergency, disconnect from the session and the therapist/evaluator will wait two (2) minutes and then re-contact you via the telepsychology platform agreed upon to conduct therapy/assessment. If you do not receive a re-contact back within two (2) minutes, the therapist/evaluator will make an effort to contact you via telephone by the contact number that you provided.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy and assessment services. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way. In Pursuit Psychological Services PLLC will maintain a record of our session in the same way we maintain records of in-person sessions in accordance with our policies.

In Pursuit Psychological Services PLLC

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Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

____ ________________________

Client Signature Date

In Pursuit Psychological Services PLLC

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Background Information:

Name: ________________________________ Gender: _____________ Race: _________

Date of Birth: ________________ Preferred Pronouns: ______________________________

Address: ____

Phone Number: _________________________

For Children:

Mother's name: ______________________ Date of Birth: _____________Race: ___________

Mother's address (*if different form client)*:____

Father's name: ______________________ Date of Birth: _____________Race: ___________

Father's address (*if different form client)*:____

Marital Status of Parents: ________________________________Custody: ________________

For Adults:

Marital Status: ______________________________

Spouse/Partner's name:______________________ Date of Birth: ________Race:___________

Family Composition: *(list ALL individuals in the home, including other care givers, sibling, children, household members)*

Name:	Date of Birth:	Relationship

Education/Vocational

School District: ____________________________________School: ______________________

Grade/Highest Grade Completed: __________________ Curriculum: ___________________

Higher Education: _______________________________ Major: _______________________

Occupation: _____________________________ Place of Business: ____________________

Medical

Primary Care Physician:____

Current Medical Conditions/Procedures:____

____

Prior Medical Conditions/Procedures:____

____

Allergies: ____

Circle Y or N

Head Injury: **Y** **N** Loss of Consciousness: **Y** **N** Lead Poisoning: **Y** **N**

Seizure: **Y** **N** Chronic/Acute Pain: **Y** **N**

Treatment History

Current Treatment Providers:

Agency	Start Date	Provider Name

Prior Treatment Providers:

Agency	Start Date	Provider Name

Medications:

Name	Dosage	Prescribing Physician
____________________	__________	____________________
____________________	__________	____________________
____________________	__________	____________________
____________________	__________	____________________
____________________	__________	____________________

Community Involvement

Religious Affiliation:___________________________ Place of Worship:_______________

Past/ Present Leisure Activities: Date of Involvement:

______________________________ ____________________

______________________________ ____________________

Family History

Mental Health Concerns

Family Member: Diagnosis:

______________________________ ____________________

______________________________ ____________________

Substance use

Family Member: Substance:

______________________________ ____________________

______________________________ ____________________

Legal Issues

Family Member: Charge:

______________________________ ____________________

______________________________ ____________________

Abuse History (circle Y or N)

Domestic Violence: Y N Physical Abuse: Y N Sexual Abuse: Y N

Neglect: Y N Verbal/Emotional Abuse: Y N

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ELECTRONIC COMMUNICATION CONSENT FORM

I consent that In Pursuit Psychological Services PLLC can provide services and communicate with me via mobile phone, messages, e-mail, and any kind of online communications, provided that these communications comply with privacy regulations. I accept that I am responsible for notifying In Pursuit Psychological Services PLLC when my contact information changes.

Preferred Phone Number: ____

I consent that In Pursuit Psychological Services PLLC can leave messages at this number (check one): Yes No

Preferred E-mail Address: ____

My preferred method of communication is (check one): Phone E-mail

____________________________________ ________________________________

Client Signature Date