THERAPIST-CLIENT RESPONSIBILITIES

Client Preferred Name: _____

➢ At *Inspire Behavioral Health*, we are committed to using our professional expertise to help you with whatever problems or concerns you bring to therapy, or identify during sessions. Together, we will establish your goals for therapy, and we will clarify them from time to time.

➢ Please carefully read the following and discuss with me any questions you have before signing. You may request a duplicate copy of these policies for your records.

THERAPY APPOINTMENTS:

➢ Your appointment time is being reserved for you. It is scheduled according to your personal needs and appointment availability. Standard therapy appointments are approximately 50-60 minutes.

PHONE CALLS/AVAILABILITY:

➢ A receptionist will not answer the office phone. For all non-emergencies, you can call the office at (**734) 929-4741** or my direct line and leave a voicemail. I will return most phone calls in the evenings and/or on the weekend, and will return your phone call within one business day. If you are experiencing an emergency, immediately call 911 or go directly to the nearest hospital emergency department.

CANCELLATIONS:

➢ *You will be charged **$130.00** for a missed therapy session that you have failed to cancel within 24 hours prior to the scheduled appointment time, unless you cancel due to an unavoidable emergency. These fail-to-cancel visits are not billable to your insurance. Payment will be expected at the time of your next appointment.*

FINANCIAL AGREEMENT:

➢ I agree to pay *Inspire Behavioral Health* the agreed upon fee for services at the time of service, and will notify staff of inability to pay or any other concerns or questions related to payment ***prior*** to receiving services.

➢ I hereby authorize my insurance benefits to be paid directly to *Inspire Behavioral Health* for services rendered. I also authorize *Inspire Behavioral Health* to release any information necessary to my insurance provider in order to process claims made.

CANCELLATION POLICY

When you schedule an appointment with me, you are purchasing that time. It is yours unless you cancel it ***prior*** to 24 hours ahead of your appointment time. As you read in the above stated policy, the charge for a scheduled appointment that is ***not*** canceled prior to 24 hours ahead of time is **$130.00**, unless it is an emergency.

Emergencies are considered events beyond your control such as inclement weather, accidents, funerals, hospitalizations or illnesses that are contagious or prevent you from attending work/school.

The cancellation fee applies to a missed appointment (that you did not previously cancel) due to discontinuation of therapy, an appointment you forget, an appointment which conflicts with another one you have made or if you choose to do something that is important to you rather than come to your scheduled therapy session.

Charges for late cancellations and fail-to-cancel therapy sessions are not billable to your insurance company. You will be responsible for this fee, and payment will be due at your next appointment. After **two** late cancellation or fail-to-cancel visits, we will no longer be able to hold a standing appointment time for you. After **three** late cancellations or fail-to-cancel visits, you will be discharged from services. If you cancel two appointments within a month's time, we will discuss your goals for therapy, and whether you are able to commit to therapy at this time, before rescheduling your appointment.

If at some point you decide to discontinue therapy services, please call our office or my direct line and leave a message, especially if you have appointments scheduled. This will allow me to provide therapy services to another person in your place at that time, and to assist you in setting up alternative therapy services if necessary.

CLARIFICATION:

It is my intention to provide you with the greatest possible selection of appointment times. If you have ever waited for a cancellation appointment, you can appreciate someone who cancels in sufficient time for you to take that appointment. During the time we work together, YOU are my priority. I am happy to hear from you and will do my best to accommodate you within the guidelines of this policy.

OFFICE COVERAGE:

➢ If I am ill or have a personal emergency, and I am unable to call to cancel your appointment, another therapist in our practice has agreed to notify you. Please indicate if you would like to be called by another therapist in our practice if this situation were to occur.

(CIRCLE ONE): YES NO Initials: _____

FEES AND INSURANCE INFORMATION

- All copayments, coinsurance and fees for therapy sessions are payable at the time of service. We accept cash, most major credit cards and checks (payable to *Inspire Behavioral Health*). A **$25.00** fee will be applied for any returned checks. Our fee for collateral visits or phone consultations (e.g. court, school, medical) is **$150.00** per hour. These fees are not billable to your insurance, and therefore will be your responsibility.

- Some insurance companies require pre-authorization. Some do not. If you intend to utilize your insurance to cover all or some of the cost of therapy, then it is your responsibility to provide the pertinent information regarding your insurance coverage. Failure to provide accurate information regarding insurance coverage and copayment or coinsurance amounts may result in a balance due for which you will receive a bill.

- Every effort will be made to utilize your insurance. Although knowledge of your insurance coverage is your responsibility, we will do what we can to help you determine the specific coverage your policy allows for behavioral health services. In the event your insurance does not cover all or part of the visit(s), or benefits have been exhausted for this calendar year, you will be responsible for all or part of the visit(s), including deductibles and copayments as indicated by your insurance provider.

- We will submit claims for all insurances for which we are an in-network or out-of-network provider. Please notify me if at any time your insurance coverage changes, or you would prefer not to utilize your insurance.

- If you choose to pay for services with a credit card, a small processing fee will be added to your total charge. The rate our credit card processing company charges for credit cards that are swiped at the point of sale is **2.75%**. In the event that your card is entered manually, the credit card processing company charges a fee of **3.5% + $0.15**.

- Please let me know if there are any questions I can answer regarding our fees for service. If there are any questions regarding claims submissions or rejections/denials, please direct these questions to your insurance company. You are also welcomed to reach out to our billing company, ***HMS Midwest, LLC*** at **(219) 926-8320**.

STATEMENT REGARDING CONFIDENTIALITY

➢ All information shared in this office is confidential unless a specific release of information is signed by you, with the following exceptions:

· · · You express your planned intention of harming yourself or your emotional/mental state is observed by me to put you at risk.

· · · You express that you intend to do bodily harm to another person. (In that event, I am obligated by law to take reasonable precautions to ensure others' safety.)

· · · You share that you have in the past and/or present emotionally, physically or sexually abused a minor or vulnerable adult.

· · · You are a minor or vulnerable adult and you share that you are currently, or have in the past, been physically or sexually abused, or I determine that you are at significant risk.

· · · You are 14 years of age or younger and you disclose that you are abusing drugs and/or alcohol, or you have requested that I assist you in finding services to terminate a pregnancy. (In this event, I am obligated by law to inform your parent/legal guardian.)

· · · Your insurance company requests information relative to payment of your claim, or another process is required to collect unpaid fees, or any legal defense is required by your therapist or *Inspire Behavioral Health*.

· · · Your therapist, or a representative of *Inspire Behavioral Health* receives a signed order by a judge to testify in court, or to provide records.

· · · You complain of physical symptoms, or you develop any physical symptoms while receiving therapy. In this event, you will be requested to obtain a physical examination to rule out medical basis for symptoms, and be asked to allow me to speak with your physician.

· · · You are currently receiving mental health services and/or are taking medication for a mental health condition, or if you need psychiatric care while receiving services, or if you have had previous mental health services. In this event, you will be requested to permit your treatment provider to speak with your prescribing physician, therapist or clinic for coordination of care purposes only.

➢ In the above instances, I will take appropriate action to ensure your safety and confidentiality. Otherwise, I may not reveal any information about you without your written permission. I have no control over the confidentiality of any information once it is disclosed outside of this office. If you have any questions about who has access to your information, please contact others to whom you have authorized information to be released.

SUBSTANCE USE DISCLAIMER

➢ I understand that I will be expected to be sober at the time of my therapy session, and that if I arrive under the influence of any substance, the session will not proceed.

➢ I understand that if my therapist suspects I may be under the influence of alcohol, I may be breathalyzed. In the event that I refuse a breathalyzer test, or if the breathalyzer indicates that I am intoxicated, the therapy session will not proceed.

➢ I understand that my safety is the most important priority, and that if my therapist believes I am under the influence of a substance, they will do all they can to assist me in finding safe transportation home or to the hospital. If I refuse, and my therapist observes me getting into and driving a vehicle under the influence of a substance, they have a legal obligation to contact the police.

STATEMENT REGARDING RELEASE OF INFORMATION

➢ I understand that I may be asked to sign a release of information to permit *Inspire Behavioral Health* to speak with my physician(s), and/or provide pertinent medical records. I understand that I have the right to refuse to sign a release of information.
Client Initials: _____

➢ I understand that, when applicable, I will be asked to sign a release of information to permit *Inspire Behavioral Health* to speak with current or previous service providers, and/or provide mental health records. I understand that I have the right to refuse to sign a release of information.
Client Initials: _____

➢ I understand that, if I choose to utilize my insurance, I will be asked to sign a release of information if I want *Inspire Behavioral Health* to contact my insurance company for referrals, authorizations or to submit claims.
Client Initials: _____

➢ I understand that if, at any time, *Inspire Behavioral Health* determines that I need a different type of treatment or care, my needs will be discussed with me and I will be transferred to another provider if necessary.
Client Initials: _____

CONFIRMATION OF UNDERSTANDING AND TREATMENT AGREEMENT

➢ I have read and understand the above policies, rights and responsibilities on this page and the preceding pages, and agree to the conditions stated.

Client Signature: _____Date:_____

Witness Signature: _____Date:_____