Building Bridges for Brianna
Counseling and Financial Agreements

Client's Name: ____ Date: ______/_______/______

Important Information:

• I understand that if I cannot reach Building Bridges for Brianna that I can always call 911 or go directly to my local emergency department for emergency care. I will do this should I believe I am at risk for hurting myself or someone else.

The staff at Building Bridges for Brianna (hereafter referred to as the clinic or BB4B) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services and is financially responsible for paying funds at the time of service. . Payments not received after 120 days are subject to collections. A 1% per month interest rate is charged for accounts over 60 days. I understand that I am responsible and agree to pay for any and all fees incurred for BB4B and I am responsible for any/all collection fees and attorney fees when the account is turned over for collection to an attorney whether or not a suit is filed.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of minor) is responsible for payments for the child at the time of service. Payment methods include check, cash, or the following charge cards: Visa/MC/Debit. . I understand that if I write a check with insufficient funds I will incur a charge of $40 Payment made by charge cards will have a service charge added.

Payment Contract for Services:

Part One: Fees for Professional Services

I (we) agree to pay Building Bridges for Brianna hereafter referred to as the clinic, per clinical unit (defined as 45- 50 minutes), one of the following rates: • $ **35.00** with a Licensed Professional Counselor.

A fee is charged for missed appointments or cancellations with less than 24 hours' notice. This fee is equal to the above mentioned rates.

I (we) have read, understand, and agree with these.

Person responsible for account: ____ Date ____/_____/_____

Co-responsible party: ____ Date ____/_____/_

Release of Information Authorization to Third Party:

I (we) authorize Building Bridges for Brianna Counseling Center to disclose case records (diagnosis, case notes, psychological/testing results, and any/all information regarding alcohol and/or drug use/abuse or other requested material) to the third-party payer or insurance company for the purpose of receiving payment directly to Building Bridges for Brianna Counseling Center.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice. I (we) have been informed that information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and understand that a copy may be obtained upon request.

Person(s) responsible for account: ____ Date_____/_____/_____

Person(s) receiving services: ____ Date_____/_____/_____

Person(s) or guardian(s):____ Date_____/_____/_____

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The contents of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of nonemancipated minor clients have the right to access the client's records.

Client's name (please print): ____

Client's (or guardian's) signature: ____

Date: ______/______/______

Other Provisions

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic.

If an individual changes therapists, I understand that my file will open and available to the new therapist.

In the event in which the clinic or mental health professional must telephone/text/email the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please make sure that the number(s) that we have on record are the only phone numbers that you desired to have us call. In other words, if there are numbers that you do not desire to be contacted, please alert the office staff of this so that the numbers can be deleted from our system.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client's name (please print): ____

Client's (or guardian's) signature: ____

Date: ______/______/______

Phone: 717-801-2965

Treatment Contract

I give my permission for the therapist of BB4B to provide counseling services to me and/or my family. In providing this informed permission, I understand that it would impede the counseling process if the therapist and/or the clinical records are requested or required by subpoena to be presented to the Court or the attorneys. Therefore, I agree that I will not request or require the therapist to testify in Court matters regarding me and/or my family, nor will I request or require (by subpoena) that the therapist's records be presented to the Court or the attorneys involved with my family. I also agree that I will never allow for an attorney to request that a judge or any other court official subpoena records or any person connected to BB4B. If I refuse to sign this contract, I understand that the therapist has a right to refuse treatment to me and/or my family, given that he or she cannot provide quality services under these conditions. I understand that this agreement may only be negated by the therapist, if he or she feels it would be in the best interest of me or my family to testify in Court or present clinical records to the Court.

I understand that if by some means, I find a way around the above portion of this contract and have any therapist or staff member from BB4B subpoenaed for any reason to any court procedure, I agree to immediately pay to BB4B a fee of $2,500. In addition to this, I agree to pay BB4B in the amount of $225 per hour, over and above this $2,500 fee for any and all fees related to this endeavor, including but not limited to record review, travel time, travel expenses, and time spent in court. In addition to the above fees, for any date that a member of BB4B receives a subpoena, I agree to pay BB4B the amount of $1,800 ($225 x 8 hours). If the court hearing is canceled or rescheduled, I clearly understand that I will pay this amount anyway. If another court date is scheduled and a subpoena is again sent, I clearly understand that I will immediately pay another $1,800. I agree to pay the amounts listed above regardless of whether the subpoena is generated by me, an attorney or a judge.

____

Signature Date

____

Signature Date

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I (we) authorize BB4B TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

(Information related to the scheduling of meetings or other appointments, Information related to billing and payment, completed forms, including forms that may contain sensitive, confidential information information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment, my health record, in part or in whole, or summaries of material from my health record).

BY THE FOLLOWING NON-SECURE MEDIA:

Regular Email (Unsecure email).
Regular SMS text message (i.e. traditional text messaging) or other type of Unsecure "text message."
Regular Cell Phones (Unsecure cell phones).
Other media.

Please know that if we use electronic communications methods, such as email, texting, online video, cell/mobile phones, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others.

Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

TERMINATION: This authorization will terminate when you notify BB4B in writing that you would like it to end.

I (we) acknowledge that this is informing me (us) of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means.

BB4B suggests that there not be contact between clients and clinicians via any form of social media such as Facebook, Linkedin, etc.

Client's name (please print): ____

Client's (or guardian's) signature: Date: ______/______/______