Navigating the Paperwork: Richmond Location

I am looking forward to this exciting and challenging journey that lies before us. Enclosed are forms to get us started in the process. Please take a moment and read over the documents and sign those that require your signature.

Please bring all completed forms to your first appointment

Policies for November 2020-December 2021 calendar year

Informed consent - please retain a copy for your records as well as bring a copy with initials for first appointment

Initial intake form - important contact information as well as emergency contacts

Information and agreement – outlines all policies including Confidentiality, Referral, Length of Session and Fee, Cancellation Policy, Emergencies, Litigation Limitation, and Fee and Payment Policies

HIPAA - Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information

Release of information – authorization to release information

Telehealth Release Form – authorization to receive treatment over telehealth

Policies for November 2020 – December 2021 calendar year
Informed Consent

Cancellations and No-Shows _______ **(initial)**

- Appointments cancelled prior to the 24-hour period will be rescheduled without penalty. Appointments **cancelled within the 24-hour period will be subject to cancellation fee of $75**. Appointments **cancelled less then 24 hours in advance will be charged the full fee.** Please note that Clarity has a zero tolerance policy for no-shows without calls, Client will be charged the full fee. If you reschedule for later in the week, there will still be a cancellation fee due by the next scheduled session.

Office Hours

Greater Richmond Area Location:

- Rachael Scholl, LCSW: Monday – Thursday 10am - 6pm *(Hours are subject to change)*

Virtual Practice:

- Rachael is available for virtual and phone sessions by appointment during office hours and off hours by appointment only.

Emergencies:

- Therapists at Clarity Counseling do not carry a pager nor provide 24-hour coverage. If you are experiencing a mental health emergency go to your nearest emergency room or call 911.

Emails/Communication:

Please send emails regarding cancellations and questions to your primary therapist. Please feel free to contact Alicia Ayvas by email, info@ClarityCounselingVA.com for any questions or concerns regarding the group practice. Any email with lengthy confidential information is recommended to not be sent and to call client's primary therapist with confidential updates. Emails are checked during office hours and throughout the workweek, and are not checked over the weekend. Text messages and voicemails are also checked during office hours and not over the weekend.

Expectations: As part of our work together, you can expect from your therapist:

- To be listened to
- To be provided support and resources to facilitate this process

What I expect from you is:

- To arrive on time for your scheduled sessions
- To call if you are going to be late or need to cancel your session
- Pay at each session
- Think about the work that we do outside of therapy.
- Be open to the possibilities that are presented before you.

Current Fees _______ **(initial)**

Initial Assessment 75 minute diagnostic and planning appointment $155
45 minute Individual Therapy session $120
50-60 minute therapy session $135
30 min therapy session $75
50 minute family therapy session $150
75 minute therapy session $155

Phone and Virtual Sessions ***please note these services are typically not covered under insurance. Please check with your insurance provider to inquire about reimbursement for services offered virtually or on the phone.*
$75 per 30 minute segment
$120 for 45 minutes
$35 per 15 minutes (Phone Consultation)
15 minutes $35 (Email Review)

Groups:
In person Process Groups held in Gainesville $60 per group (Paid monthly)
12-Week DBT Skills Group held in Gainesville $80 per group (Paid per module – every 3 weeks)
Phone Groups $200 per month (Paid monthly)

Case Management : $85 per hour: these fees are typically incurred during placement into a treatment center or emergency treatment at a hospital or inpatient setting. Fees cover additional documents and reports written for securing placement as well as phone consultations with potential providers as well as with family members. Emergency phone sessions are assessed at the current phone session rate.

Confidentiality Statement:
All information shared in this treatment is confidential except in circumstances governed by law. If you would like me to confer with another healthcare professional, you will need to sign a "Release of Information" form. This permission can be revoked by client/guardian at any time.

I have received the **Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information (HIPPA).** ______ **(initial)**

Financial Agreement:
Your fee per visit is payable at the time of treatment. I accept cash, check, and credit card. To have your credit card stored, please provide credit card in session for me to save information you're your Therapy Appointment account. Fees are subject to change every two years (i.e. 2021). ______ **(initial)**

Statement of Understanding

I have read and understand this information sheet and informed consent.

____ ________________________

Client/Guardian Date

Client Name: ______________________________

Date of Birth: ______________ **Age upon admission:** _____ **Admission Date:** ______________

Address: ______________________________
Street **Town** **State** **Zip code**

Phone: ( ) - ( ) - ( ) -
Check Primary Contact: ☐ **Home** ☐ **Cell** ☐ **Work**

Email: ______________________________

Parental Information: ______________________________
Full Name & Relationship **Contact info (phone)**

Parent/Guardian's Email: ______________________________

Emergency Contact: ______________________________
Full Name & Relationship **Contact info (phone)**

Emergency Contact's Email: ______________________________

Marital Status: **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widow** ☐

Individual Therapist: ______________________________

Family Therapist: ______________________________

Nutritionist: ______________________________

Additional Treatment Professionals: ______________________________
(list name, title, and contact information)

Referred By: ______________________________

Full Name & Relationship **Contact info (phone)**

Reason for Referral: ______________________________

***Credit Card Details:** ______________________ ________ ________
Credit Card Number **Expiration** **Sec. Code**

***This information can be directly provided to the provider upon payment if preferred**

INFORMATION AND AGREEMENT

You can expect courtesy, respect and strict adherence to professional ethics and standards. Clarity encourages you to ask questions and suggest ways that we can better serve you.

Confidentiality: The privacy and confidentiality of your treatment is extremely important to us. Professional ethics, State law, insurance and managed care companies require me to maintain clinical records and to safeguard all clinical documentation. Your clear consent, generally written, is necessary for me to discuss your case or to release records to those authorized. You can revoke permission any time simply by writing to your primary therapist.

The law may require primary therapist to release confidential information under some uncommon circumstances. These include the neglect or abuse of children, court-ordered services, a subpoena, when your mental-health becomes an issue in litigation, when there is a serious risk of harm to yourself or to another person and when we know or suspect violations of the State rules and regulations that govern the practice of counseling. Clarity, Eating Disorder Recovery and Counseling Center works in a team approach, which means your information, will be shared among your treatment team in order to better facilitate and support you. All members of your treatment team must have a letter of consent to communicate information for the purpose of treatment.

Referral: If we determine that another professional would be of greater service to you, your primary therapist will discuss this with you and assist you in the referral process.

Length of Sessions and Fee: Our sessions will typically last for 45 or 50-60 minutes, unless otherwise arranged. The cost for an initial 75-minute intake session is $155.00. The cost for a 45-minute on going session is $120.00. The cost for a 50- 60-minute on-going session is $135.00. The cost for a 50-minute Family session is $150.00. The cost for a 75-minute session is $155.00. The cost for a phone or virtual session is $75.00 per 30-minute segment, $120.00 for 45-minute segment, and $135.00 for 50-60-minute segment. Phone consultation is $35 per 15 minutes. Email review is $35.00 per 15 minutes. Case management is $85.00 per half hour: these fees are typically incurred during placement into a treatment center or emergency treatment at a hospital or inpatient setting. Fees cover additional documents and reports written for securing placement as well as phone consultations with potential providers as well as with family members. Emergency phone sessions are assessed at the current phone session rate.

Fee for service can be sliding scale however a conversation regarding fee for service must be discussed during the phone consultation or at the initial intake. Adjusted rates must be discussed and agreed upon by Director, Alicia Ayvas, MSSW, LCSW, CEDS-S and client.

Cancellation Policy Your appointment is reserved exclusively for you. Please notify your primary therapist as soon as possible if you do not expect to attend your appointment. **Clarity requires at least a 24-hour notice of cancellation.** Appointments cancelled prior to the 24-hour period will be rescheduled without penalty. Appointments cancelled within the 24-hour period will be subject to cancellation fee of $75. Appointments **cancelled on the same day will be charged the full fee**. Please note that Clarity Counseling has a zero tolerance policy for no-shows without calls, they will be charged the full fee.

<u>Emergencies</u>: Primary therapists do not carry a pager and do not provide "24x7" coverage; however Therapists are expected to check my voicemail regularly during their office hours. If you experience a mental health emergency, please call 911, or go to your local hospital or emergency clinic before trying to reach primary therapist. In the case of planned extended absence (e.g. vacation), backup clinical coverage will be arranged. Therapists do not check text messages, emails, and voicemails during off hours and are not held liable.

<u>Litigation Limitation:</u> It is agreed that should there be legal proceedings (such as but not limited to divorce and custody disputes, injuries, etc.) neither you nor your attorney, nor anyone else acting on your behalf will call me to testify in court or at any proceeding, nor will a disclosure of my records be requested.

<u>Fee and Payment Policies:</u> In recognition that this work constitutes a significant investment, Clarity Counseling endeavor's to provide services that are both valuable and affordable. If you are unable to render full payment, please discuss this promptly with Alicia Ayvas, LCSW, CEDS-S. It is Clarity's policy to work with clients directly rather than through most Managed Care Companies. If you choose to work with your insurance company, it is your responsibility to verify the specifics of your coverage. Clarity will gladly provide instructions, complete any paperwork that may be required to substantiate your treatment, and provide you with invoices that may use to file for reimbursement. In that case, no money will come to you through Clarity Counseling. Reimbursement funds will be sent to you directly. Payment is due at the end of each session unless other arrangements are made and will be accepted in the form or cash, check, and/or credit card. *There is a $30 charge for returned checks.* Clarity does not voluntarily participate in litigation and/or court proceedings. If Clarity is compelled by subpoena to appear for any legal or law enforcement proceedings involving your case, you will be billed for such appearance(s) at $350 per hour. Clients will be only allowed to retain the equivalent of a one-session balance and all unpaid balances will be referred to collection after 30 days unless other arrangements are made.

I have read, understand, and agree to comply with the above policies.

____

Client and/or Legal Guardian Signature Date

Notice of Privacy Practices
HIPPA

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPPA"), regulations promulgated under HIPPA including the HIPPA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization.

The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPPA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPPA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at ________________________:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to Clarity Counseling, LLC, C/O Alicia Ayvas, MSSW, LCSW at 7150 Heritage Village Plaza, Unit 201 Gainesville, VA 20155 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is November 2020.

Clarity Counseling, LLC

2540 Professional Road, Suite 2
Richmond, VA 23235

7150 Heritage Village Plaza, Unit 201 Gainesville, VA 20155

Rachael Scholl, LCSW
Licensed Clinical Social Worker

VA # 090401264
NPI# 1225631377
EIN: 81-4686835

Phone: 571-318-9141
www.ClarityCounselingVA.com
TherapyAppointment.com
ClarityCounselingVA@gmail.com

Authorization to Release Confidential Records and Information

Client Name________________________________ DOB____________

This will authorize Clarity Counseling, LLC to release information to and receive information from the following party:

Name_______________________________________

Address_____________________________________

Telephone___________________________________

Fax/Email___________________________________

The following information is authorized to be exchanged:

__ Information regarding services currently being provided
__ Information regarding past services
__ Treatment reports/summary/assessments
__ Family Involvement
__ Emergency contact
__ Substance Use Information
__ Other: _____________________________

I have had explained to me and fully understand this request and authorization and authorize the release of records and information as described above. I understand I may revoke this consent at any time except to the extent that information has already been released. This consent will automatically expire one year from the signed date, on _______________.

____
Signature of Client Date

____
Signature of Parent/Guardian (if applicable) Date

____
Primary Therapist Date

CONSENT FOR TELEHEALTH TREATMENT

1. I authorize Clarity Counseling to use telehealth services for our therapy sessions. Telehealth is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client who are not in the same physical location.

2. Electronic systems used are HIPAA-compliant and will incorporate network and software security protocols to protect the privacy and security of health information and imaging data. This system will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

3. I understand that I will need access to and familiarize myself in order to use the telehealth technology. There is a possibility that our technology may fail during a teletherapy session, and that as a result, there may be an interruption; a need to continue by phone; or a need to reschedule.

4. I have been made aware of the benefits of telehealth by Clarity Counseling, such as, but are not limited to: improved communication capabilities during times when in-office sessions are not available, continuity of care, an out-of-office location of my choosing, and reduction of lost work time. I understand and recognize that there are also inherent risks in using telehealth technology that may include: breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

5. Clarity will provide receipts to submit to your insurance for reimbursement. While most plans cover this platform, there is always a chance that services may be denied. If that occurs, you will be responsible for any incurred charges/fees and will accept all financial responsibility as such.

6. The need for telehealth services vs. in-person office sessions will continue to be evaluated and will be modified as needed. You retain the option to withhold or withdraw consent for virtual sessions at any time without affecting the right to future care or treatment.

7. You will abstain from alcohol and/or drug use before and during therapy all virtual sessions.

8. You are required to share with Clarity Counseling your location during the virtual session should an emergency arise. In addition, you authorize that your emergency contact will be notified should an emergency arise.

9. In order to maintain confidentiality, I agree that I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. In addition, I will not allow another person in the same space during a virtual session nor will I record the session without consent.

By signing below, I acknowledge that I read the above guidelines in order to engage in telehealth counseling treatment with Clarity Counseling. In addition, I fully understand my rights and responsibilities as stated above.

____

Client Signature and Date