AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____, date of birth _____ hereby voluntarily authorize the disclosure of information from my health record. This information is to be disclosed by Williamson Therapy and Consulting, LLC. Williamson Therapy and Consulting, LLC can be contacted at 217-621-3037. Protected Health Information is to be released/provided to:

Name of person/organization/entity/facility: _____

Address, City, State, Zip: _____

_____

_____

Phone Number: _____ Fax Number: _____

The purpose or need for this disclosure is: (circle all that apply)

- ☐ Insurance billing
- ☐ Employment reasons
- ☐ Further medical care
- ☐ School/educational
- ☐ Legal
- ☐ Other: _____

The information to be disclosed from my health record: (circle all that apply)

- ☐ Billing records
- ☐ Treatment plans
- ☐ Treatment attendance

- ☐ Fee payment history
- ☐ Diagnosis
- ☐ Progress notes by provider
- ☐ Entire record
- ☐ Only information related to: _____

I understand that I may revoke this authorization in writing submitted at any time to Williamson Therapy and Consulting, LLC, except to the extent that action has been taking in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature. I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule. I understand that I have the right to receive a copy of this authorization upon request. If I have any questions about the disclosure of my health information, I may contact Sara Williamson, (217) 621-3037.

_____ _____

Signature of client or personal representative Date

_____ _____

Signature of Witness Date

SARA WILLIAMSON
THERAPY & CONSULTING, LLC.

Consent to Treat

I hereby consent to take part in treatment provided by Williamson Therapy and Consulting, LLC. I agree to participate fully in the therapeutic process. I understand no guarantees have been made to me regarding results of treatment or any services provided by my therapist. I understand that for therapy to be most effective I must take an active role in my treatment. This can include attending appointments consistently and practicing skills learned between sessions. I understand I can stop treatment at any time I choose to do so. I understand there could be consequences of terminating treatment services including worsening symptoms. I understand my therapist may recommend other services necessary or end the therapeutic process at any time if deemed clinically appropriate.

I fully understand the expectations of the therapeutic process and have no questions regarding the above mentioned information.

_____ _____

Client Name Printed Date of Birth

_____ _____

Client Signature Date

_____ _____

Guardian signature (of minor) Date

_____ _____

Witness Date

Face Sheet

Name: _____Date of Birth:_____

Age:_____

Home Address:_____

_____

City:_____

State: _____Zip code:_____

Insurance Provider: _____

Insurance policy Number:_____

Insurance Contact Number:_____

Emergency Contact:_____

Emergency Contact Phone Number:_____

Guardian Name:_____

Guardian Phone Number: _____

SARA WILLIAMSON
THERAPY & CONSULTING, LLC.

Cancellation/Late/No Show Policy

Sessions: Are typically scheduled weekly or biweekly and occur on the same day and time each week. Your therapist will assess how frequently sessions need to occur and make recommendations. Sessions typically last 50 minutes. Session are typically scheduled every hour.

Late: If you are 15 minutes late for your scheduled appointment your session will be cancelled, and you will be charged at late fee of $30. If you are late to more than 3 appointments your therapist will refer you to another agency or provider and you will no longer be seen by this provider.

No Show: If you have 3 no shows (appointments in which you do not show up to and do not cancel within 24 hours of your appointment) your therapist will refer you to another agency or provider and you will not longer be seen by this provider. If you no show your appointment you will be immediately charged a $30 no show fee.

Late fees: All late fees (No shows or late) will be billed to you individually, not your insurance.

I understand the importance of being respectful to the time of both other clients and my therapist. I understand the following expectations related to late/no show policy.

_____ _____

Client Printed Name Date of Birth

_____ _____

Client Signature Date

_____ _____

Witness Date

Financial Responsibility (Rates and Insurance)

You are responsible to provide your therapist with your insurance information at the initial session. Your therapist is happy to assist in the billing process however you must provide the accurate information. If your insurance coverage changes or lapses, you are responsible for informing your therapist immediately and provide them with your new information. If you no longer have insurance coverage, you will be responsible for the full session fee listed below.

You are responsible for verifying and understanding the limits of your insurance coverage. You are responsible for obtaining prior authorization for treatment from your insurance carrier. If you are needing assistance you can provide your insurance with the therapist's contact information. Please note that there are times when insurance misquotes benefits. In the event of a misquote, you are still responsible for your copay/coinsurance/deductible amount that insurance reports after claims are submitted. In the event that your insurance denies your claim, you are responsible for the session fee. Please discuss any questions or concerns that you may have about this with your therapist.

If you choose to engage in therapy through Williamson Therapy and Consulting and your insurance does not have a contact with this provider, you may be responsible for paying the session fee up front and getting reimbursed by your insurance company on your own. We can provide you with a "super bill" that outlines the date of service, the session fee, your mental health diagnosis, and your therapist's contact information that will allow you to submit the claim to your insurance company. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. A valid credit/debit card must remain on file in order to do this. You authorize this office to charge this credit/debit card for late cancels, no-shows, co-pays, deductibles, insurance denial for payment and any check returned from your bank.

Acceptable forms of payment include cash, check and major credit cards, and payment is expected at the time of service. There will be a $50 fee for all cancelled checks. If for some reason you find that you are unable to continue paying for your therapy, please inform your therapist. Your therapist will help you to consider any other options that may be available to you at that time.

Current Fees:

Initial Intake Appointment: $130.00

60 Minute Counseling Sessions: $100.00

Patients with insurance: the negotiated rate with each insurance company

Sliding Scale rates can be discussed with individual therapist, therapist decision is final

Copies of records, written reports, and/or letters: prorated hourly rate of $100

Returned Checks: $50

Delinquent Accounts: You understand that if you are not making payments within 60 days of services, your services could be terminated, or your provider could turn such payments into collections.

Acknowledgement

By signing below, Client(s) acknowledge that Client(s) have reviewed and fully understand the terms and conditions of this Agreement. Clients(s) have discussed such terms and conditions with the therapist and have had any questions regarding its terms and conditions answered to Clients(s)' satisfaction. Client(s) agree to abide by the terms and conditions of this Agreement

I,_____ understand that I am financially responsible for payment for all services rendered and that I am obligated to pay all charges denied by my insurance carrier. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my therapist to collect money on my behalf.

_____ _____

Client Printed Name Date of Birth

_____ _____

Client Signature Date

_____ _____

Guardian if Minor Date

_____ _____

Witness Date

New Client Form

Name:_____ Nickname: _____

Address: _____

_____

Phone number: _____

Have you previously participated in therapy services? If yes please describe:

_____

_____

_____

Have you previously been hospitalized for mental health conditions? If yes please describe:

_____

_____

_____

Please list any health conditions you have:

_____

_____

_____

Are you currently employed? _____

Explain_____

What has brought you to therapy?_____

_____

What are some strengths you have?_____

_____

List any recent stressors:_____

_____

SARA WILLIAMSON
THERAPY & CONSULTING, LLC.

Billing information

Type of Card:_____

Name on Card:_____

Card Number:_____

Security Code (3 digits):_____

Expiration Date:_____

I give authorization to bill above mentioned card for therapy services through Williamson Therapy and Consulting, LLC.

_____ _____

Cardholder Name Date of Birth

_____ _____

Cardholder Signature Date

_____ _____

Witness Date

Notice of Privacy Practices

We are required by law to maintain the privacy of Protected Health Information (PHI) and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to follow 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 sending a copy to you in the mail upon request or providing one to you at your next appointment.

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 ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules.

In the event Sara Williams is unable to provide care due to death or medical issue, Brenda Sommer, LCPC will provide needed services and arrange care. Brenda will serve as custodian for Sara Williamson's practice if needed.

Effective date: 8/3/2020

We will only release healthcare information about you in accordance with federal and state laws and ethics of the social work profession. Williamson Therapy and Consulting, LLC has and will continue to respect client's confidential information. This notice describes our policies related to the use and disclosure of your healthcare information.

PHI will only be released when: Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources. When consulting/ supervising a client's name and specific information will remain left out of such discussions. Only when referring elsewhere would patient contact information need to be released.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

Limits of Confidentiality: Other uses or disclosures of your information which do not require your consent: There are some instances where we may be required to use and disclose information without your consent. As a mandated reporter, therapists are required by law to report any suspected abuse. Suspected abuse is not considered "confidential" and will be reported as specified in mandatory reporting laws. If you are assessed to be a danger to yourself; cannot guarantee your physical safety against the intention of suicide; and/or have immediate suicidal plans, this information is not considered to be "confidential." Actions by your therapist may be taken to ensure your safety. If you are assessed to be a danger to others; cannot guarantee their safety; have an immediate, specific plan to cause fatal injury/harm to another person, this information is not considered to be "confidential". Actions may be taken to protect the safety of others. The police may be notified of your intentions as well as the intended victim. Court order/subpoenas may require your provider to relinquish a copy of your written Mental Health Record to the appropriate Courts. Mental Health Providers can also be subpoenaed to testify in court without your consent. Clinical records, psychotherapy notes and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information.

I hereby understand Notice of Privacy Practices and agree to engage in therapy services at this time.

_____	_____
Client Printed Name	Date of Birth
_____	_____
Client Signature	Date
_____	_____
Client Guardian (if Minor)	Date
_____	_____
Witness	Date

SARA WILLIAMSON
THERAPY & CONSULTING, LLC.

Informed Consent to Participate in Telehealth Services

What are Telehealth services and when are they used?

Telehealth services are used when a mental health provider or the client cannot be physically present while providing services. The mental health provider will be located at a different location than the client. Telehealth services use a video camera and computer to send both voice and personal images between you and the mental health provider so not only can you talk to each other, but you can also see each other. These services have been made more available due to COVID-19 to ensure service are being received. Services will be conducted through TherapyNotes.com.

How do Telehealth Services work?

Your provider will provide you with information on TherapyNotes.com portal and process of connecting via telehealth services for appointments.

I, _____, am consenting to telehealth services with this provider and understand that I will be informed of my diagnosis and proposed clinical treatment plan. I understand that I will be receiving health care services through interactive video and/or audio conferencing equipment. I understand that, at this time, there are no known risks involved with receiving my care in this way.

I understand that my privacy and confidentiality will be protected. I also understand that the likelihood of a video and/or audio conference being intercepted by an outsider is similar to the potential interception of a phone call.

I have read this document and I hereby consent to participate in receiving behavioral health services via telehealth under the terms described above. I understand this document will become a part of my medical record.

☐ I agree to participate in and receive behavioral health services via telehealth.

Client Name (print)	Client Date of Birth
Signature of Client	Date/Time
Signature of Legal Representative if Client is a minor or unable to sign	Relationship
Witness Signature	Date/Time

SARA WILLIAMSON
THERAPY & CONSULTING, LLC.

I consent to allow Williamson Therapy and Consulting, LLC to use services through TherapyNotes.com in order to perform services needed during the therapy process. Service including but not limited to billing, appointment reminder calls, and telehealth platform.

_____ _____

Client Name Date of Birth

_____ _____

Client Signature/Guardian if Minor Date

_____ _____

Witness Date