Insight Into Action
THERAPY

CLIENT INFORMATION

Legal Name: DOB(Age):

Preferred Name:

Address:

City: State: Zip Code:

Home Phone: Cell Phone:

Email:

School/Employer:

Medications:

Significant Medical Concerns:

REFERRAL

How did you hear about us?

Reason for seeking therapy?

EMERGENCY CONTACT

Name:

Relationship: Phone:

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CLINICAL CONTRACT

Thank you for selecting Insight Into Action Therapy (IIAT). We are committed to providing the best care we can in each of our clinical relationships. This agreement outlines how we practice and is intended to give structure and clarity to our professional relationship.

CONFIDENTIALITY:

All clinical information is considered confidential, with the following exceptions:

1. You authorize IIAT to release or exchange information if you hereafter sign a release form
2. If we suspect sexual abuse, child abuse or elder abuse, we are required to report it
3. If you are expressing serious, foreseeable, imminent harm to yourself or someone else
4. If a court order is issued requiring us to produce records or provide information
5. To consult with IIAT staff, clinicians and consultants to coordinate your care

EMERGENCY:

IIAT is not a 24-hour facility. If an emergency does arise and you are unable to reach your therapist, please go to your nearest emergency facility or dial 911.

AVAILABILITY AND SCHEDULING:

IIAT clinicians maintain their own schedules and may offer sessions in the early mornings, evenings and/or weekends. All scheduling will be decided between you and your clinician. If, at any time, you are dissatisfied with the availability of your provider, you are invited to contact IIAT and we will assist you.

In order to achieve your treatment goals in the most effective way, our experience has proven that consistency of sessions is recommended. Initially for therapy, it may be recommended that you engage in weekly appointments. The actual frequency of sessions will be determined by you and your therapist and will be based on your needs. If you are undergoing psychological assessment, you and your psychologist will determine the number of sessions needed to complete your evaluation. You and your psychiatrist will also determine how often you meet after your intake appointment.

LENGTH OF SESSION AND FEES:

Therapy sessions are scheduled for 50 minutes in length except for groups, which are 60 minutes. To meet the needs of all of our clients, it is our policy to start on time and finish on time; therefore, if you arrive late, your session will finish at the scheduled time. The fees for services are as follows:

Diagnostic Evaluation (C-90791)	Substance Use & Process Addictions Evaluation (C-90791)	ASAP Evaluation (C-90791)
Psychiatric Evaluation (C-99204)	Couples Evaluation (C-90791)	Medication Check 20 mins (C-99213)
Couples Therapy (C-90847)	Medication Check 30 mins (C-99214)	Family Psychotherapy (with client) (C-90847)
Individual Psychotherapy (C-90837)	Psychological Testing (C-96130, 96131,96136, 96137)	Family Psychotherapy (without client) (C-90846)
Correspondence No CPT Code	Counseling (C-90837)	Case Management No CPT Code
Dual Diagnosis Recovery Program Group - Adolescent (3 groups on one night) (C-90853)	10-Panel Urine Drug Screen 80307	Dual Diagnosis Recovery Program Group - Young Adult (C-90853)
80-Hour Alcohol Test (C-80307)	Dual Diagnosis Recovery Program Group – Adult (C-90853)	Full Urine Drug Panel (C-80307)
ASAP Group (C-90853)	Missed Appointment No CPT Code	Court Appearance (Per Hour) No CPT Code

DISCLAIMER: These estimates may change as the treatment progresses and are not a guarantee of treatment frequency, length or cost. Your signature does not require you to receive psychotherapy, psychological, or medication services from IIAT.

National Provider Identification
1356735815

Tax Identification Number
32-0024383

PSYCHOLOGICAL TESTING:

There are numerous types of psychological assessments that require varying amounts of instruments and time. Assessments typically include a diagnostic interview, face-to-face testing, record review, scoring and interpreting tests, writing a report, and a feedback session. Fees for testing are $175 per hour. Your psychologist will review your testing goals with you and determine what the anticipated fee for your evaluation will be prior to engaging services.

MISSED SESSIONS:

There is a 24-hour cancellation policy. Sessions canceled with less than 24 hours notice are billed at the normal rate. The bill reflects a missed appointment, not a clinical session.

RIGHT TO RECEIVE A GOOD FAITH ESTIMATE OF EXPECTED CHARGES UNDER THE NO SURPRISES ACT:

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. The fees are outlined above.

Under the law, health care providers need to give patients (clients) who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

GFE DISCLAIMERS:

1. There may or may not be additional items or services that are recommended as part of the treatment that will be scheduled separately and are not reflected in the good faith estimate.
2. The information provided in the good faith estimate is only an estimate and actual items, services, or charges may differ from the good faith estimate.
3. The good faith estimate does not require the private pay patient to obtain psychotherapy or other services.

PAYMENT AND INSURANCE:

Payment is expected at the time of service. We accept cash, check, and all major credits cards. It is IIAT policy not to let outstanding bills exceed $200 without payment. If a credit card chargeback/reverse or returned check fee occurs, you will be responsible for those fees. IIAT does not participate in any insurance provider networks. We will provide you with an invoice for services that contains the information that most insurance companies request. It will be your responsibility to submit your bills for reimbursement. If you request, we will complete forms that are required by your insurance provider once you have signed a release of information authorizing us to provide information about your treatment.

Please note that the diagnostic and clinical information that is released will become part of the insurance company's records. Each company has it own procedures for handling and storing your information. We cannot guarantee that they will handle with the appropriate confidentiality once it leaves our office. If you have TRICARE insurance there is an additional form that needs to be reviewed and signed in order for you to seek reimbursement.

MEDICATION:

Please inform your IIAT treating psychiatrist of 1) any sudden, unexpected or drastic changes in your psychiatric condition, 2) any new lab results you may receive, 3) any new information about your medical status, 4) any new over the counter (OTC), alternative, or complimentary medications you plan to start using, and 5) any new prescriptions from other physicians, as soon as possible, so that he can make his best judgment as to how to properly advise/treat you in such instances.

Abrupt cessation /stoppage of your medication is never advisable. It may result in sudden return of or worsening of your symptoms, serious withdrawal symptoms and even life-threatening consequences in some cases. Please first discuss any medication concerns with your IIAT psychiatrist before changing/stopping medications, so that you can receive appropriate medical recommendations beforehand.

While every effort will be made to ensure that you have an adequate amount of medication in between outpatient appointments, you are responsible for notifying your IIAT psychiatrist if you are about to run out of medications and if you cannot make your upcoming appointment.

Please call at least 48 hours in advance before you run out of your medications so that they can be called in for you. If you miss your appointment (without notice) and then require a new partial refill of medications through to your next appointment, you will incur an additional charge of $50.

There will be no call-in prescriptions for controlled substances. You will have to appear in person at the IIAT office (s) for your appointment if you are on a controlled substance.

You agree to allow IIAT to utilize the Virginia Prescription Monitoring Program (VA PMP) database prior to/during prescribing of any controlled substance prescriptions, in order to: 1) determine your history of prescriptions of controlled substances by other physicians in Virginia as well as other participating states 2) avoid duplicate prescribing of controlled substances, and 3) to address any prescription drug abuse issues in your history.

CLINCIAL CORRESPONDENCE:

Please note what method you would prefer clinical correspondence such as invoices, letters, drug screen results, etc. to be delivered. Please understand that someone else may view your clinical correspondence without your authorization at the physical or electronic address that you provided, or if it is misplaced by the postal service. All client specific information sent via email should be encrypted or password protected. We recommend any updates or questions be done either in person or via telephone and that email and text messages be used only for scheduling.

☐ Address: _____

☐ Email: _____

☐ Fax: _____

NOTE: In order to protect your confidentiality and preserve the therapeutic relation, IIAT does not communicate with any clients through social media.

COURT APPEARANCE:

With the exception of court ordered evaluation and treatment, if you request that your IIAT therapist appear in court on your behalf, be aware that this may require planning time, research, document review, correspondence, and collaboration with other professionals as well as travel and court appearance time. This will be billed at the rate of $350 per hour. We will provide you with an invoice of the time involved in preparation for your matter. If we are required to testify, our testimony may include a report of your otherwise confidential information. Prior to requesting our court attendance, please discuss with your attorney how your therapist's testimony will benefit your case while balancing the possible emotional implications of having your confidential information become a part of a public court record.

TERMINATION OF TREATMENT

You may terminate treatment with IIAT at any time. IIAT recommends discussing this process with your therapist so that we can make sure that we have achieved your goals and, if needed, we can identify additional resources. If we have not heard from you for more than 90 days, we will assume that you have terminated treatment and your file will be closed and confidentially maintained as is required for 7 years. You may contact IIAT at any time to re-initiate treatment.

If you have any questions regarding this Agreement, please discuss them with us. Your signature indicates understanding of the above terms.

Name _____ Date _____

Signature _____

Parent/Guardian Printed Name _____ Date _____

Parent/Guardian Signature (if applicable) _____

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NOTICY OF PRIVACY

According to the HIPAA Omnibus Final Rule all health care providers and practitioners must maintain the privacy of Protected Health Information (PHI), provide a notice of legal responsibilities and privacy practices, and conduct business in accordance with the privacy notice. As providers we face legal consequences and potential fines if we do not keep your PHI private. Please review your rights to how Insight Into Action Therapy (IIAT) may disclose your PHI:

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 not disclose PHI to anyone else unless we have your authorization.

PAYMENT: Your name and payment information will be entered into the IIAT billing system that is secure and password protected. Your information is only accessible by your therapist and IIAT management.

While HIPPA rules allow IIAT providers to disclose certain PHI, as licensed clinicians, we adhere to more stringent guidelines according to the National Association of Social Workers' and the American Counseling Association's Codes of Ethics. Therefore IIAT will not disclose any PHI, with the following exceptions:

1. You authorize me to release or exchange information by signing a release form,
2. I suspect sexual abuse, child abuse or elder abuse,
3. You are expressing serious, foreseeable, imminent harm to yourself or someone else,
4. A court order is issued in a judicial proceeding, or
5. To consult with other IIAT clinicians who have expertise relevant to your needs.

You have the following rights with respect to your PHI:

- Right to Access, Copy, Inspect, and Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communication
- Right to Breach Notification and what you can do to protect yourself
- Right to a Copy of this Notice

If you feel your privacy rights have been violated, you may make a complaint to:
Cynthia Turner, LCSW, LSATP at (703) 646-7664 or by email at cturner@insightactiontherapy.com or 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.

Client Name: _____ Client Signature: _____

_____Check here if client refuses to sign

Effective Date: _____

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AUTHORIZATION FOR RELEASE OF MENTAL HEALTH AND/OR SUBSTANCE USE DISORDER TREATMENT INFORMATION

Client_____ Birthdate _____

This authorizes Insight Into Action Therapy to release and/or exchange information to the following organizations/ individuals/ professionals:

Name _____ Contact Info _____

The following information will be released:

- ☐ Assessment
- ☐ Current Treatment Update
- ☐ Discharge/Transfer Summary
- ☐ Medication Management Information
- ☐ Psychiatric Evaluation
- ☐ Psychotherapy Notes
- ☐ Other _____
- ☐ Billing and/or Insurance Information
- ☐ Demographic Information
- ☐ Educational Information
- ☐ Presence/Participation in Treatment
- ☐ Psychological Evaluation
- ☐ Toxicological Reports/Drug Screen
- ☐ Continuing Care Plan
- ☐ Diagnosis
- ☐ Nursing/Medical Information
- ☐ Progress in Treatment
- ☐ Psychosocial Evaluation
- ☐ Treatment Plan or Summary

PURPOSE: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

CONDITIONS: I further understand that Insight Into Action Therapy will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

NOTE: IIAT cannot guarantee that the recipient(s) of said information will adhere to the HIPAA standards of confidentiality. However, the recipient is held responsible for maintaining the HIPAA standards of confidentiality.

AUTHORIZATION: I certify that this request was made voluntarily, that I have read the release, and I understand its purpose and sign it willingly. I understand that I may revoke this authorization at any time by notifying Insight Into Action Therapy in writing. I understand that any request for revocation will not have any effect on any actions taken prior to its submission. This authorization will expire with the termination of treatment unless otherwise stated.

_____ _____

Signature of Client Date Signature of Parent/ Guardian (If applicable) Date

_____Check here if client refuses to sign authorization

If you are signing as a personal representative of the individual, please describe your authority to act for this individual. _____

Prepared and Witnessed by: _____

IIAT Therapist Date

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

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CREDIT CARD CONSENT

This is to acknowledge that Insight Into Action Therapy (IIAT) has permission to hold my credit card information on the company's electronic health record. IIAT is authorized to charge my/our:

- ☐ Visa
- ☐ Master Card
- ☐ American Express
- ☐ Discover

Last four digits of credit of card _____

Expiration Date_____

For all services provided to the individual(s) named below. In addition to the clinical services, charges will include:

- MISSED SESSIONS at the regular session rate, in the event of a no show or cancellation is less than 24hours of the appointment
- CASE MANAGEMENT &/OR CORRESPONDENCE, if there is a need for supplemental professional services (i.e., extended reports, inter-disciplinary meetings, court appearances) that have been discussed with you in advance.

_____

Individual(s) receiving services

If a dispute arises regarding any charges made by IIAT, the signature below authorizes IIAT to submit a copy of this document and a copy of invoices to my Credit Card Company, bank, and/or merchant services as proof of my authorization for charges to the credit card number on this form. By signing below, IIAT is authorized to discuss any credit card disputes with my Credit Card Company, bank, merchant services, and responsible party.

Please treat this document as a copy of my signature on file. I understand that by signing this form I give authorization to IIAT to charge my credit card for services for the above listed individual(s) and agree to abide by the policies identified in the Therapy Agreement. There will be no refunds of any kind for these charges.

Please note that credit card statement charges should show as InsightThrpy but may also show as TheraNest or Braintree.

Signature: _____ Date: _____