**OUTPATIENT SERVICES CONTRACT**

Welcome to Ivory Howell Counseling, LLC. This document is intended to offer you information about therapy and establish the boundaries and expectations for entering into a counseling relationship with me, Ivory Howell, LPCC. Please let me know if you want clarification on any of the topics discussed in this Outpatient Services Contract, or if you have any questions that are not addressed here. When you sign this document, you are stating that you understand and will adhere to the information in this Outpatient Services Contract.

**THERAPY SERVICES**

I provide therapy services for adolescents, adults, couples, and families. The first appointment serves as an intake appointment. I will want to hear about the difficulties that led to you making an appointment, goals for therapy, and general information about yourself and your current life situation. By the end of this first appointment, I will give you some initial recommendations on what I think will help. If I do not think I am able to best assist you, I will give you names of other professionals who I believe would work well with your particular issues. If you do not agree with my treatment recommendations or do not think my personality style will be a good match for you, let me know and I will do my best to suggest a different therapist who may be a better fit.

If we decide to work together in therapy, we will collaborate on a treatment plan that incorporates effective strategies to help with whatever difficulties you are hoping to reduce in therapy. Sometimes more than one approach is helpful. Individual, couples, and family therapy sessions last 45-60 minutes (depending on your insurance benefits) unless otherwise arranged. Oftentimes, sessions are set for once each week, but this frequency varies based on what seems most appropriate for your particular situation.

Therapy can be extremely helpful and fulfilling, and it takes work both in and out of sessions to be most effective. It requires active involvement, honesty, and openness in order to change thoughts, emotional reactions and/or behaviors. There are benefits and risks to therapy. Potential benefits include increased healthy habits, improved communication, and stability in relationships, and reduced distress. Some potential risks include increased uncomfortable emotions as you self-explore and changes in dynamics or communication with significant people in your life. Sometimes couples that come for therapy choose to end their relationships. Although there are many benefits to therapy, there is no guarantee of positive or intended results. If during our work together, noncompliance with treatment recommendations becomes an issue, I will make effort to discuss this with you to determine the barriers to treatment compliance. At times, treatment noncompliance may necessitate termination of therapy service. I encourage you to discuss any concerns you have about our work together directly so that I can address it in a timely manner. Other factors that may result in termination of therapy include, but are not limited to, violence or threats toward me, or refusal to pay for services after a reasonable time and attempts to resolve the issue.

Deciding when therapy is complete is meant to be a mutual decision, and I will discuss how to know when therapy is nearing completion. Sometimes people begin to schedule less frequently to gradually end therapy. Others feel ready to end therapy without a phasing out period. I may, at times, seek consultation with other therapists to ensure I am helping you in the most effective manner. I will give information only to the extent necessary, and I make every effort to avoid revealing the identity of my clients. The consultant is also under a legal and ethical duty to keep the information confidential.

**MY TRAINING AND APPROACH TO THERAPY**

I completed a Master’s Degree in Mental Health Counseling from Western Kentucky University in 2005 and have been a Licensed Professional Clinical Counselor (#104689) since October of 2008. I have training in trauma-related disorders as well as mood disorders. I employ Cognitive-Behavioral, Person-Centered, and Inner Child interventions in my practice. You can obtain proof of license at http://oop.ky.gov/lic\_search.aspx.

**MEDICATION MANAGEMENT SERVICES**

I do not provide medication management services, however, I will be happy to offer you a referral to local providers who specialize in mental health medication management.

**CONTACT INFORMATION AND AVAILABILITY BETWEEN SESSIONS**

My primary business address is 100 West Third Street, Suite 304, Owensboro, KY 42303. Faxes may be directed to 270.698.9778. If needed, you can leave me a message on my 24-hour voicemail box at 270.302.1669. Please understand that this is a business cell phone that is password protected. When you leave a message, include your telephone number even if you think I already have it, and best times to reach you. I make every effort to return calls in a timely manner, however, if you do not hear back from me within one day, please leave a second message. If I am unavailable for an extended time, such as on vacation, I will inform you of the contact information for the therapist on-call during my absence. If you prefer the option to use text messages and/or email with me for non-clinical information such as billing questions and scheduling-related content, you may indicate permission at the end of this document to consent to these types of interactions. Please understand that text messages and emails are not secure communications. With documented consent, however, I allow non-clinical text correspondence to my cell phone (270.302.1669) or email at ivory@ivoryhowellcounseling.com. As with voicemail, I make every effort to be timely with responses, however, if you do not hear from me within the same business day of your text or email, please contact me again.

**If you are in an emergency situation and cannot wait for me to return your call, go to the nearest emergency room or call 911. Ivory Howell Counseling, LLC is not a crisis facility. Do not contact me by email or fax in an emergency, as I may not get the information quickly.**

**RATES AND INSURANCE**

Therapy is a commitment of time, energy and financial resources. If you have health insurance, it is important for you to verify your mental health benefits, so you understand your coverage prior to your appointment. Some insurance companies require a precertification before the first appointment, or they will not cover the cost of services. My current fees are as follows:

• Initial Intake Appointment: $150.00 (limited reduced-rate sessions available)

• Counseling Sessions: $150.00 (limited reduced-rate sessions available)

• Patients with Insurance: the negotiated rate with each insurance company

• Non-Session Tasks (i.e. FMLA form completion, phone calls): $50/half-hour

• Returned Check Fee: $50.00

• Records Requests: First copy is Free. Subsequent copies- flat $10.00 fee + $.30/page

*These fees are reviewed annually, and increases may apply.*

I am happy to file claims to your insurance company on your behalf. However, you, not your insurance company, are responsible for payment of the fee for therapy. Acceptable forms of payment include cash, check and major credit cards, and payment is expected at the time of service. **Cancellations or missed appointments without 24-hours notice will be subject to full fee charge, and insurance companies do not pay charges for missed appointments.** If fees for services are not paid in a reasonable amount of time, and attempts have been made to resolve the financial matter to no avail, a client account may be sent to a collection service. **In addition, I do not bill secondary insurance.**  **I check insurance benefits as a courtesy for my clients. There are times when insurance misquotes benefits. In the event of a misquote, clients are still responsible for their copay/coinsurance/deductible amount that insurance reports after claims are submitted.** Clients can call their insurance company to check their own benefits as well by calling the number on the back of their insurance card. Most insurance agreements require you to authorize me to provide a clinical diagnosis and sometimes additional clinical information. If you request it, I will provide you with information to send to your insurance company. This information will become part of the insurance company's files. Insurance companies claim to keep information confidential, but you should check with your insurance company directly if you have questions about their confidentiality practices.

**SOCIAL MEDIA AND ADVERTISING POLICY**

In order to maintain your confidentiality and my respective privacy, I do not interact with current or former clients on social networking websites. I do not accept friend or contact requests from current of former clients on any social networking sites including Twitter, Facebook, LinkedIn, etc. I will not respond to friend requests or messages through these sites. I have and Instagram and Facebook business page that anyone is welome to follow/like, however, I will avoid publicly interacting with you on these platforms.

I will not solicit testimonials, ratings, or grades from clients on websites or through any means. I will not respond to testimonials, ratings or grades on websites, whether positive or negative, in order to maintain your confidentiality. My hope is that you will bring concerns about our work together to the therapy session so we can discuss.

**INCLEMENT WEATHER POLICY**

In the event of inclement weather, it is the policy of IHC that clients will not be penalized for missing scheduled appointments. IHC will contact clients in the event that the office will be closed due to weather events that are predicted to be dangerous or that currently pose threat to safety. IHC asks clients to contact IHC if they deem it unsafe for their travel to a scheduled appointment so that an appointment may be rescheduled.

**PROFESSIONAL RECORDS**

Both law and the standards of my profession require that I keep appropriate treatment records. If I receive a request for information about you, you must authorize in writing that you agree that the requested information may be released, with some exceptions outlined in the next section. IHC will, periodically, destroy financial and health information records, the timing depending on state law and contracts with related insurance companies. Hard copies of documents related to your treatment and your financial arrangement with IHC will usually be uploaded to be included in your electronic health record, and the original copy will be destroyed.

**CONFIDENTIALITY**

In general, law protects the confidentiality of all communications between a client and a mental health clinician, and I can only release information to others with your written permission. There are, however, a number of exceptions, which are indicated below. More information is provided about this in your *Notice of Privacy Practices* document.

In judicial proceedings, if a judge orders your records released, I have to comply. In addition, I am ethically and legally required to take action to protect others from harm even if taking this action means I reveal information about you. For example, if I believe a child, elderly person, or disabled person is being abused or neglected, I am mandated to report this abuse or neglect to the appropriate state agency. If I believe a client is threatening serious harm to another person, I must take protective action (through notifying the potential victim, the police, and/or facilitating hospitalization of my client). If I believe a client is a serious threat to harming him/herself, I must take protective action (arranging hospitalization, contacting family/significant others for notification, and/or contacting the police). I would make reasonable effort to discuss any need to disclose confidential information about you, and I am happy to answer any questions you have about the exceptions to confidentiality.

**POLICY ON SUICIDAL/HOMOCIDAL CLIENTS**

In the event that a client poses a threat to self or others, IHC will contact appropriate third-parties, disclosing the minimum amount of information necessary to protect the safety of any individuals who may be at risk. These contacts may include phoning law enforcement, emergency contacts, and any individual(s) whom may need to make safety provisions in the event that a client threatens to harm another. Said disclosures will be documented in client’s chart or kept on file at the offices of IHC as appropriate.

**POLICY ON INJURY ON PREMISIS**

In the event that a client is injured on the property at which IHC provides services, client is to report injury to Ivory Howell, LPCC immediately so that action may be taken as appropriate (such as connecting client to medical care for injury, resolving any on-site hazards, etc). It is important to note that IHC is located in a building owned by The Malcolm Bryant Corporation, and said injuries outside of Suite 304 in this building are not the responsibility of IHC, as IHC does not have any control over common hallways, entrances, elevators, etc. for the building.

**MINORS**

If you are under 12 years of age, please be aware that the law may provide your parents the right to examine your treatment records. If you are between the ages of 12 and 18, the law may provide your parents the right to examine your treatment records, if, after being informed of your parents’ request to examine your records, you do not object or your therapist does not find that there are compelling reasons for denying the access to the records. Notwithstanding the above, your parents are always entitled to the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what is prepared to discuss.

**COURT-RELATED SERVICES**

I do not provide or perform evaluations for custody, visitation, or other forensic matters. Therefore, it is understood and agreed that I cannot and will not provide any testimony or reports regarding issues of custody, visitation, or fitness of a parent in any legal matters or administrative proceedings. If I am contacted by an attorney regarding your treatment (either at your behest or related to a legal matter you are involved in) please note the following:

* I charge a $1500 retainer prior to any preparation or attendance of legal proceedings.
* I charge $200/hour to prepare for and/or attend any legal proceeding and for all court-related services.
* Charges for court-related services are not covered by insurance.
* Court-related services include: talking with attorneys, preparing documents, traveling to court, depositions, and court appearances.
* If the court or attorneys do not pay my fee, you will be charged for the time I spend responding to legal matters.
* You will also be charged for any costs I incur responding to attorneys in your case, including but not limited to fees I am charged for legal consultation and representation by my attorneys.

**COMPLAINTS**

If you have a concern or complaint about your treatment or about your billing statement, please talk to me about it. I will take your criticism seriously, openly, and respond respectfully. If you have a serious complaint against my actions as a therapist, please contact the Kentucky Board of Licensed Professional Counselors.

**Receipt and Acknowledgement of Outpatient Services Contract:**

Please ask before signing below if you have any questions about therapy or my office policies. Your signature indicates that you have read my Outpatient Services Contract and agree to enter therapy under these conditions. Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement. Also, please fill the boxes below to indicate communication and electronic signature preferences:

☐ I authorize non-clinical text communication from Ivory Howell Counseling, LLC to/from her cell phone number 270.302.1669 to/from my cell phone number:

[ ]  I authorize the receipt of appointment reminders via text to my cell number:

[ ]  I authorize email communication with ivory@ivoryhowellcounseling.com and ivoryhowell@gmail.com for non-clinical correspondence and psychoeducational and homework attachments to email:

[ ]  I do not authorize any text communication.

[ ]  I do not authorize any email communication.

[ ]  I would like to opt out of electronically signing this document and sign a hard copy instead.

[ ]  I would like a copy of this document.

Client Name:

Client Signature: Date:

Guardian Name (if minor):

Guardian Signature: Date:

Witness Signature: Date:

 **IVORY HOWELL COUNSELING, LLC NOTICE OF PRIVACY PRACTICES**

This notice, effective January 1, 2020, describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Ivory Howell, LPCC is the privacy officer for Ivory Howell Counseling, LLC and may be reached at 270.698.9777 or ivory@ivoryhowellcounseling.com.

**Your Rights**

**To Get an electronic or paper copy of your medical record**

* You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
* We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**To Ask us to correct your medical record**

* You can ask us to correct health information about you that you think is incorrect or incomplete.
* We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**To Request confidential communications**

* You can ask us to contact you in a specific way or to send mail to a different address.
* We will say “yes” to all reasonable requests.

**To Ask us to limit what we use or share**

* You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
* If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

**To Get a list of those with whom we’ve shared information**

* You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
* We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**To Get a copy of this privacy notice**

* You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**To Choose someone to act for you**

* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
* We will make sure the person has this authority and can act for you before we take any action.

**To special protection for substance abuse treatment information**

* We will never disclose any substance abuse treatment information without your written permission.

**To File a complaint if you feel your rights are violated**

* You can complain if you feel we have violated your rights by contacting our privacy officer.
* You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [**www.hhs.gov/ocr/privacy/hipaa/complaints/**](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.**
* We will not retaliate against you for filing a complaint.

**Your Choices Regarding What We Can Share**

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

* Share information with your family, close friends, or others involved in your care
* Share information in a disaster relief situation
* Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission:**

* Marketing purposes
* Sale of your information
* Most sharing of psychotherapy notes

**In the case of fundraising:**

* We may contact you for fundraising efforts, but you can tell us not to contact you again.

# Uses and Disclosures of Your Health Information

We typically use or share your health information in the following ways:

**To Treat you:** We can use your health information and share it with other professionals who are treating you. (*Example: A doctor treating you for an injury asks another doctor about your overall health condition.)*

**To Run our organization:** We can use and share your health information to run our practice, improve your care, and contact you when necessary. (*Example: We use health information about you to manage your treatment and services.)*

**To Bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities. (*Example: We give information about you to your health insurance plan so it will pay for your services.)*

We are allowed or required to share your information in other ways as well– usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**To Help with public health and safety issues such as:** Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; and Preventing or reducing a serious threat to anyone’s health or safety.

**To Do research:** We can use or share your information for health research.

**To Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**To Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations.

**To Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**To Address workers’ compensation, law enforcement, and other government requests:**

* For workers’ compensation claims
* For law enforcement purposes or with a law enforcement official
* With health oversight agencies for activities authorized by law
* For special government functions such as military, national security, and presidential protective services

**To Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

# Our Responsibilities

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

# **Changes to the Terms of this Notice**: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**Receipt and Acknowledgement of Ivory Howell Counseling, LLC Notice of Privacy Practices**

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Ivory Howell Counseling, LLC Notice of Privacy Practices.

[ ]  I would like to opt out of electronically signing this document and sign a hard copy instead.

[ ]  I would like a paper copy of this document.

Client Name:

Client Signature: Date:

Guardian Name (if minor):

Guardian Signature: Date:

Witness Signature: Date: