**Client Information and Acknowledgment of Informed Consent to Treatment Form**

*Samantha Straub (or Sami) Licensed Clinical Social Worker*

I am engaged in private practice providing mental health counseling and therapy. Samantha Straub provides these services as a sole practitioner doing business as Straub Counseling and Consultation LLC. Although Straub Counseling and Consultation shares office space with other mental health providers, the practices are not affiliated in any way and each practice is an independent business.

 *Mental Health Services*

The purpose of receiving mental health services is to help you better understand your situation, change your behavior, or move toward resolving your difficulties. Using knowledge of human development and behavior, I will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to examine your own feelings, thoughts and behaviors, and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful.

I am a trained Clinician in the use of EMDR (Eye Movement Desensitization and Reprocessing). This technique can be helpful in some situations with some clients. If I determine that the use of this technique may be useful to you, I will offer information about this service and provide opportunities for you to ask questions and obtain additional information to inform you of the potential risks and benefits. This technique, and others, are offered as a helpful adjunct to psychotherapy and the decision to utilize any technique is entirely yours.

The services offered can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health services have also been shown to have benefits for people. Treatment may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

*Appointments*

Appointments are made by calling (614)450-0240 or by scheduling on line directly through my website . Please call to cancel or reschedule at least 24 hours in advance, or you will be charged fifty percent of the original fee for the missed appointment, at my option. Third party payers will not cover or reimburse for missed appointments. Appointments are 45 to 50 minutes in length, but may vary somewhat for clinical reasons. The number of appointments depends on many factors and will be discussed with you during our sessions.

*Relationship*

Our relationship is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I do not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. At any point you may determine that I am not a good fit for you. If that happens, please tell me immediately and I can offer referral therapists to you. Similarly, if I determine that I cannot help you or if you miss appointments or payments, I reserve the right to terminate the relationship.

*Goals, Purposes and Techniques*

 There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommendations and to have input into setting the goals of your therapy. As therapy progresses, these goals may change. We will jointly determine how to effect the changes you are seeking to make for yourself.

*Confidentiality*

Laws protect the privacy of all communications between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form. There are some situations where I am permitted or required to disclose information either with or without your consent or authorization. For example:

• If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your (or your legal representative’s) written authorization, or a court order. If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.

• If a government agency is requesting the information, I may be required to provide it.

 • If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend myself.

 • If you file a worker’s compensation claim, I may, upon appropriate request, have to provide a copy of your records or a report of your treatment.

There are some situations in which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about your treatment. If such a situation arises, I will make every effort to fully discuss it with you before taking action, if I feel that is appropriate, and will limit disclosure to what is necessary. These situations may include:

 • If I have reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state agency.

 • If I believe you present a clear and substantial danger of harm to yourself and/or others, I may take protective actions. This may include contacting family members, seeking hospitalization of you, notifying any potential victim(s), and/or notifying the police.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with Samantha Straub any questions or concerns you may have.

 *Electronic Communication*

Electronic messages (email, text messages, etc.) are vulnerable to breaches of privacy, despite standard safeguards, which are outside of my control. Therefore, because I am required by law to keep your information confidential, I am unable to exchange any clinical information with you by electronic communication. By signing this consent, you agree to these conditions. You further understand and agree to the fact that if you initiate an email or text message to me your identification, information that you are communicating with a therapist, and/or other Protected Health Information could inadvertently be disclosed to an outside party.

*Professional Records*

 The laws and standards of our profession require that I keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), and past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record, if you request it in writing, and tell me where you want it sent or if you want to pick it up at my office. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I therefore recommend that you initially review them with me or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge you or your personal representative a copying fee of $2.74 per page for the first ten pages, $.57 per page for pages 11 through 50, and $.23 per page for pages 51 and higher, plus the cost of any related postage. If I refuse your request for access to your records, you have the right of review, which I will discuss with you upon request.

As your therapist, I may also keep a set of psychotherapy notes which are for my own use and designed to assist me in providing you with the best treatment. These notes are kept separate from your Clinical Record. To release these psychotherapy notes, you must sign a separate Authorization form.

 *Minors*

 If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information I will discuss the matter with you, if possible, and do my best to handle any objections you may have. Minors 14 years of age and older have the right to receive a limited number of sessions without their parents’ knowledge in most situations. If this is an option you would like to pursue, please talk to me about this option and I will provide you with more detailed information.

*Authorization to Warn or Inform Third Parties*

In the event I believe that you are a danger, physically or emotionally, to yourself or another person, by signing this Client Information and Acknowledgment of Informed Consent to Treatment form, you specifically consent for Samantha Straub to attempt to warn the person in danger and to attempt to contact any person in a position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel and the person indicated as your emergency contact person.

 This information is to be provided at your request for use by said persons only to prevent harm to yourself or another person. This authorization to Warn or Inform Third Parties shall expire upon the termination of your therapy with Samantha Straub MSW, LSW, unless it involves information learned while you were in therapy with me. You acknowledge that you have the right to revoke the above authorization to warn or inform third parties, in writing at any time to the extent that I have not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could still be permitted or allowed by law as indicated in the copy of the Notice of Privacy Practices of Samantha Straub that you have received and reviewed, or as set forth previously in this document.

*After Hours Emergencies*

I can be reached at (614) 450-0240. I will attempt to return calls within 24 hours. If you have an emergency, you should go directly to a hospital emergency room, or call 911, or call Netcare Access at 614-276-2273. Current clients will be notified during session of upcoming out of town travel or vacation planned by me, although I may be unavailable for other reasons. Emergencies are urgent situations that require your immediate action and you should not wait for my return call to take action.

*Samantha Straub’s Incapacity or Death*

 By signing this Client Information and Acknowledgment of Informed Consent to Treatment, you acknowledge that in the event of my becoming incapacitated or in the event of my death, it will become necessary for another therapist to take possession of your file and records. You give consent to allow another licensed mental health professional selected by me to take possession of your records and provide you with copies upon request, or to deliver them to a therapist of your choice. You will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional of your selection.

*Consulting with Other Therapists and My Attorney*

 You agree that I may consult with your primary care physician, other therapists, and other health care providers about your care. In addition, from time to time, I may feel the need to discuss legal issues involving your case with my attorney. By signing below you consent to these consultations, which will be limited to the amount of information necessary for me to properly address issues that may arise in your therapy.

*Acknowledgment of Informed Consent to Treatment*

 The undersigned voluntarily agrees to receive mental health assessment, care, treatment, or services and authorizes Samantha Straub MSW, LSW to provide such care, treatment or services as are considered necessary and advisable.

I understand and agree I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through Samantha Straub, MSW, LSW at any time. I also understand that there are no guarantees that treatment will be successful.

 By signing this Client Information and Acknowledgment of Informed Consent to Treatment Form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and agree to abide by its terms and conditions. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client Signature date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Samantha Straub, LSW date

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices**

***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 and future physical and mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the American Counseling Association Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI

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

**How I 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. I may disclose PHI to any other consultant only with your authorization.

For Payment.

 I may use and disclose PHI so that I can receive payment for the treatment services provided to you. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations.

 I 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 and teaching purposes PHI will be disclosed only with your authorization.

 Required by Law.

 Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating and determining my compliance with the requirements of the Privacy Rule.

Without Authorization.

 Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

 • Required by Law, such as the mandatory reporting of abuse or neglect involving children, vulnerable adults, or developmentally disabled persons, or mandatory government agency audits or investigations (such as the counselor licensing board or the health department)

• Required by Court Order

 • 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.

Verbal Permission.

We may 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, but the revocation will not be effective for information already released based on the authorization.

**Your Rights Regarding Your PHI**

 You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to Samantha Straub LSW, at 3982 Powell Rd., S-173, Powell, OH 43065.

 • Right of Access to Inspect and Copy. You have the right to inspect and copy PHI that I create in providing you with care.

 • Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

• 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.

• 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. I am not required to agree to your request.

 • Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

• Right to a copy of this Notice. You have the right to a copy of this notice.

Complaints

 If you believe I have violated your privacy rights, you have the right to file a complaint in writing with Samantha Straub LSW, at 3982 Powell Rd., S-173, Powell, OH 43065 , or with the Secretary of Health and Human Services at 200 Independence Ave., SW, Washington, DC 20201, or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

**Receipt and Acknowledgment of Notice of Privacy Practices**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Straub Counseling and Consultation LLC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my rights, I can contact Samantha Straub at (614) 450-0240.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Client Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent, Guardian or Personal Representative\* Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Samantha Straub, MSW, LSW Date

**Statement of Fees Notice and Agreement to Pay for Service**

Samantha Straub, LSW, dba Straub Counseling and Consultation charges a fee for providing services. My standard fee is $125.00 for a 50-60 minute individual assessment (initial appointment) and $100 per 45 to 50 minute individual session thereafter. When seeing a group or team, standard fee is $150 for the initial assessment (50-60 minutes) to be had with the coach/team leader and $100 for 30 minute subsequent sessions or $150 for a 50-55 minute session.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. You are responsible for payment of my fee at each session and I will not seek reimbursement directly from your insurance carrier. Some health insurance policies will have benefits for mental health services and I will provide, at your request, an itemized bill, called a “super bill” with which you can seek reimbursement, however, you are responsible for full payment of my fee at the time of service.

If you request a “super bill” to submit to your insurance company, a clinical diagnosis is a necessary part of this bill which may become part of a vast data bank that is available to other entities under certain circumstances and may affect your ability to obtain other types of insurance or other unforeseen consequences.

 In the event that I become involved in legal proceedings as a result of my therapy with you, such as responding to a subpoena or attending a deposition or a hearing, you agree to pay for my fees in connection with such a proceeding. You also agree that I may consult with my attorney on how best to proceed and you agree to pay those legal costs. Time for depositions and court may involve preparation time, travel time, and waiting to testify. In such situations I may request a retainer of $1000.00 to cover my anticipated costs, which will be charged at the normal rate I charge at that time for therapy. If any money in the retainer is not used I will refund the balance to you. In the event that I don’t schedule patients in anticipation of a court proceeding and I don’t receive notice of a cancellation of the court proceeding within two days of its scheduled date, you agree to pay for time I lost with patients that I would have otherwise scheduled.

**Credit Cards**

 I process credit card payments through Square, an online app, using my iPad/iPhone (see squareup.com for security information). Other accepted forms of payment are cash and local checks.

**Client Acknowledgment of Statement of Fees and Agreement to Pay for Services**

I hereby acknowledge that I am personally responsible for the fees charged for receiving services and agree to pay as set forth in this agreement. **I also understand that I must give 24 hour notice of cancellation to avoid being charged a cancellation fee of half the rate** for failing to attend an appointment I have made.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

signature of client or parent/guardian date signed