Green House Group, PA

Psychotherapy and Consultation

250 Commercial Street, Suite 3004 * Manchester, NH 03101 * (603) 668-3050 * Fax (603) 668-8666

INFORMED CONSENT, PRIVACY PRACTICES, AND FINANCIAL POLICY
TREATMENT SERVICES AGREEMENT

Welcome to the Green House Group. This document contains important information about our professional services and business policies. It is intended to serve as a formal contract between you and your therapist.

This document also contains information about the Health Insurance Portability and Accountability Act (HIPAA) as related to your treatment relationship with your clinical provider and the Green House Group. HIPAA is a federal law which requires us to provide you with a Notice of Privacy Practices that protects patient rights regarding the use and disclosure of your Protected Health Information (PHI) for purposes of treatment, payment, and health care management. Detailed information related to HIPAA and our Privacy Practices are provided elsewhere in this document.

Please read this document carefully and let your therapist know if you have any questions. Your signature indicates that you are aware of these HIPAA regulations and have read, understood and agree to abide by the terms of this agreement.

Psychological/ Therapeutic Services

All clinicians at the Green House Group, PA are licensed by the NH Board of Mental Health Practice and/ or the NH Board of Psychologists. Each therapist is bound to the ethical standards of their specific licensing guild. Your provider can answer any questions regarding their professional credentials, confidentiality, your diagnosis and treatment recommendations.

Psychotherapy is not easily described in general statements due to its unique and highly personal nature. Your satisfaction with this process is largely influenced by your willingness for open participation and a clear understanding between you and your therapist regarding treatment goals, the nature of this relationship and expectations you have of the therapist.

Participation in psychotherapy has benefits and risks. Its benefits tend to be manifested through an individual's diminished feelings of distress, improved relationships and/ or resolution to specific problems. Risks can include the possibility of experiencing uncomfortable feelings such as sadness, guilt and anger, and the possible recollection of disturbing memories from the past. Your therapist will provide support, understanding and guidance moving through these challenges towards your goal of improved coping with issues you have defined together.

The process of defining and implementing your treatment goals may require several sessions to develop a full understanding of the problems you want to address, and to determine what methods and frequency of meetings would be most productive to achieve these goals. You have the right to terminate services at any time. However, it is strongly recommended that you first discuss these concerns directly with your therapist.

You should also be aware that there may be alternatives to the type of mental health services we offer; for example, joining a community support group for individuals with similar challenges and goals.

The therapy hour is typically between 45 to 50 minutes in length. While individual needs vary, sessions scheduled about once weekly tend to provide the most effective approach to meaningful resolution of difficulties. Individuals in the midst of crisis may require more frequent meetings.

If you are seeking psychological and/ or forensic evaluation services, additional policy and procedures apply to those arrangements. Your provider will address such issues as appropriate to the services requested.

It is Green House Group policy that our therapists do not become directly involved in any form of legal dispute/ litigation, i.e. divorce, child custody disputes. Under certain conditions we may agree to accept such treatment cases but only under the following conditions: Consensual agreement that neither the therapist nor their clinical records and/ or any other administrative employee of the practice would ever be requested to provide therapy documents, testimony or deposition by subpoena, to the Court or another attorney/ Party for purposes of actual or intended litigation.

Should a Court with legitimate jurisdiction order that the Green House Group release an individual's record, we would assist the client in resolving the issue to the degree possible within the legal and ethical standards to which we must adhere. Should the Court's mandate prevail, we would require a signed copy of that Order to release your clinical record.

Contacting Your Therapist

Our therapists are usually not immediately available by telephone and do not take calls when in session with clients. All telephone calls are directly routed to that therapist's confidential voice mail and every effort will be made to return your call promptly. You and your therapist should discuss their availability related to contact outside regular sessions.

Due to security and practical constraints, Green House Group policy discourages the use of text and email communication between therapist and client for any other purpose than scheduling of appointments. As necessary, you and your therapist can determine acceptable arrangements for these forms of contact.

Electronic communications would never be considered acceptable or appropriate for emergency contact.

And for ethical and practical considerations, Green House Group policy prohibits our therapists from accepting friend or contact requests from current or former clients on any social networking site (e.g. Facebook, LinkedIn, Twitter, etc.).

Emergency Coverage

Our practice provides twenty-four hour emergency telephone coverage to current clients. Instructions for accessing emergency services are located in the Green House Group telephone greeting and each therapist's voice mail. Every effort will be made to locate your personal therapist should this need occur. However, given the timing of that call your particular therapist may not be immediately available - at which point our on-call clinician is available to provide immediate assistance. Information from that contact would then be shared with your therapist for discussion and follow up.

Under emergency conditions and at your discretion, you should also consider accessing community resources such as calling 911 and/ or going to the Emergency Room at the closest hospital.

Telehealth Consultation and Psychotherapy (Please Refer to the attached Informed Consent For Telehealth/ Consultation and Psychotherapy)

A separate document and authorization are required for a client's participation in Telehealth Consultation/ Psychotherapy with our mental health clinicians. This document describes the conditions and forms of electronic media acceptable for this practice as well as its associated benefits and potential security risks.

This form of treatment may or may not be fully covered by your medical insurance, especially by health plans which are self-insured. For this reason you may wish to consult with your medical insurer and certainly discuss this issue with your therapist.

Financial Responsibilities

Unless other agreements are made with you or your health insurance provider, all clients are expected to make full payment at the time of service.

Copays should be paid to the Green House Group, P.A. and remitted directly through your therapist at the time of service, preferably by cash or check although we do accept most major credit cards. Credit card payments of $300 or greater will incur a 2% service fee at the time of transaction. You have the option to leave a credit or debit card on file to facilitate regular payments at the time of services.

Many clients elect to use their health insurance which typically provides coverage for mental health services. While we may be able to negotiate professional fees to a limited extent, unless you waive your right to use health insurance for services, we must honor whatever contractual obligations exist with that organization. Should you wish to avoid certain complexities involved in using your insurance for clinical services, you and your therapist can discuss and agree to other fee arrangements. Under this condition it is important to know that you, not your insurance company, are responsible for full payment of that fee.

Your health insurance will only reimburse for "medically necessary" services. We are often requested to provide other forms of professional services, such as reports, letters, consultations with other professionals (with your authorization) and extended telephone discussions (greater than 10 minutes). These types of services will be billed to the client on a prorated basis at the same hourly rate for psychotherapy ($140/ hour).

If you are unable to attend or cancel a scheduled appointment your are expected to provide the therapist with at least a 24-hour (business hours) notification, including Fridays for Monday appointments; and will be expected to pay for that session in full unless other arrangements are made with your therapist. This charge is not reimbursable by insurance and due at the time of your next appointment. Please speak with your clinician as to how such charges will be implemented.

Please make every effort to discuss any financial concerns with your therapist and/ or our billing department (Extension *21). We, in turn, will make every effort to address and resolve these issues. Unless other arrangements are made, overdue accounts (90+ days) will be considered excessive and our billing department will contact you to develop a payment plan. Accounts greater than 120+ days which have not responded to our request for payment arrangements may be referred to a local collection agency. Should that circumstance occur, we are required to provide the agency with limited information: Your name/ contact data, the nature of services provided and amount due.

Using Medical Insurance

If you plan to use your health insurance for clinical services it is important that you contact your plan to determine if there are prior authorization requirements and/ or limits of coverage for clinical services. Any changes to your health care plan may require a new authorization which you, the client, are responsible for obtaining prior to your next session.

Once you have obtained this information you should discuss with your clinician what types and length of treatment are realistic to expect within the limits of coverage available, and/ or what will happen should those insurance benefits end prior to reaching your treatment goals. Please remember that you always have the right to pay for services yourself and avoid these complexities.

Please be aware that in order to reimburse for clinical services, insurance companies require your authorization such that your therapist can provide a clinical diagnosis, and sometimes additional information such as a treatment plan or summary; or in rare cases, a copy of the entire record. Your therapist will make every effort to release only the minimum information that is necessary for the purpose requested. This information will become part of the insurance company's file; once in their possession your therapist has no control over how that information is managed or protected.

Client Rights, Records, Practices, and HIPAA

Consistent with state law, the Mental Health Bill of Rights is posted in the waiting room for your review. Please direct any related questions to your therapist.

Federal law (HIPAA) and the standards of our profession require that your therapist maintain Protected Health Information (PHI) about you in your Clinical Record. This record contains information regarding your reasons for seeking treatment and the ways this problem impacts your life, diagnosis, treatment goals/ progress, medical, social and treatment history, including past treatment records received from other providers. Additionally, this record may contain a record of professional consultations, your billing records and reports that may have been sent to anyone with your authorization.

HIPAA also addresses the use of Psychotherapy Notes, those which are designated to assist the clinician in providing you with quality treatment. These notes may contain contents of discussions with your therapist, some of which may include sensitive information. While insurance companies can request and receive a copy of the Clinical Record, they cannot receive these Psychotherapy Notes without your written consent.

You may examine and/ or receive a copy of your record if you make that request in writing. Because these are professional records and are subject to misinterpretation or may be upsetting to untrained readers, we recommend that you initially review them with your therapist, or have them forwarded to another mental health professional with whom you can discuss their contents.

You may also revoke this agreement in writing at any time. That revocation will be binding on your therapist and the Green House Group unless your therapist has already taken action in reliance on it; if there are obligations imposed on the therapist by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations incurred. We must obtain your signed authorization before we can release your PHI for any use and disclosure not described above or in the attached HIPAA Privacy Notice.

You have the right to restrict disclosures of your PHI at Green house Group to a health plan if you pay out-of-pocket for services.

Your therapist will make every effort to provide quality and effective psychological services. If you are dissatisfied with your treatment it is strongly encouraged that you first contact your therapist directly to discuss and hopefully resolve these concerns together. Should you decide to pursue such concerns further and initiate a professional ethics complaint, you should contact either the New Hampshire Board of Mental Health Practice (BMHP) or the New Hampshire Board of Psychologists, as appropriate to the clinician's licensure; both are located in Concord, New Hampshire.

You should also be aware that the presence of a mental health diagnosis and/ or sensitive clinical information within the Clinical Record could potentially impact services you might seek to obtain in the future. For example, applications for life insurance, military service, national security clearance may all be affected.

Privacy Practices and Confidentiality

The relationship and communications between a licensed mental health professional and client are privileged and confidential in the state of New Hampshire and in accordance with HIPAA regulations. However, state law and the ethics of our profession indicate there are certain exceptions to such privileged confidentiality. Under specific conditions, listed below, the mental health professional cannot be held legally liable for violating the privacy of confidential therapist-client communications. In each instance, every effort will be made to fully discuss these circumstances with the client before taking action.

1) We are required to report to state authorities any instances of reported, observed, and or suspected abuse/ exploitation of children, the elderly, or handicapped adults;

2) Should a client communicate and/ or present a serious threat for self-harm, every reasonable attempt will be made to address that concern, i.e. contacting family, arranging for protective hospitalization. If these efforts are unsuccessful, we are ultimately mandated to contact law enforcement in order to protect the life and well being of our client;

3) Should a client communicate and/ or present a serious threat of harm against an identified victim(s) and/ or substantial damage to real property, we have a legal duty to take reasonable precautions by either notifying that individual and/ or the appropriate authorities;

4) Were a client to make a formal complaint of professional misconduct to the regulatory board which licenses mental health clinicians, and/ or filing of a lawsuit, the therapist is expected to provide records and otherwise Protected Health Information (PHI) to the appropriate agency in order to respond to a complaint or lawsuit;

5) We will comply with a valid Court's Order to the clinician requiring therapeutic disclosure (e.g. child custody proceedings, cases in which the client's psychological condition is an important element);

6) In the case of group therapy, issues of confidentiality among the participants are discussed and emphasized. However, absolute confidentiality within that setting cannot be guaranteed.

7) Records of Deceased Individuals. In the case of married individuals where one or both are clients of the Green House Group, the surviving spouse is legally entitled to access the decedent's medical record irrespective of whether the surviving spouse is the decedent's executor - unless the decedent objected to such release prior to his or her death.

Treatment of Minors (Please Refer to the attached Informed Consent For Treatment of Minors)

Couple's Treatment (Please Refer to the attached Informed Consent for Treatment of Couples)

Psychiatric Services

The Green House Group does not provide psychiatric medication services. Should you and your clinician determine that a psychiatric consultation could be a helpful adjunct to your treatment, we have good relationships with and often refer to qualified providers in the surrounding community; your own medical doctor/ PCP may also be able to assist towards that goal.

Peer Consultation

In the interests of maintaining best practices and quality treatment, our clinicians sometimes find it helpful to discuss a case with other professionals in or outside the practice, typically through regularly scheduled peer consultation meetings. Under these conditions neither the clinician or consultant ever disclose the client's identity and are equally bound to maintaining client confidentiality. Your signature on this document indicates your understanding and consent that your therapist may discuss your case in such consultation.

CONSENT FOR TREATMENT

Your signature below indicates that you have read and understood information in this document, discussed its contents with your therapist as necessary, and agree to abide by its terms over the course of your treatment relationship with the Green House Group, PA. Your signature also indicates that you have given formal consent for your therapist to provide treatment.

_____	_____
Client Name/ DOB (Printed)	Client Name/ DOB (Printed)
_____	_____
Client Signature	Client Signature
_____	_____
Date	Date
_____	_____
Therapist Signature	Date

Green House Group, PA

Psychotherapy and Consultation

250 Commercial Street, Suite 3004 * Manchester, NH 03101 * (603) 668-3050 * Fax (603) 668-8666

INFORMED CONSENT: TREATMENT OF MINORS

The following information assumes that the parent(s) have already read, understood and agreed to the overall informed consent document entitled Treatment Services Agreement which accompanies this section pertaining to Treatment of Minors.

If the individual receiving treatment is under the age of 18 their parents and/ or legal Guardian must authorize services. It is our policy to undertake treatment of minors only with the consent of both parents; unless, at our discretion, it is reasonable to proceed with authorization by one parent; or under legal conditions which otherwise allow such authorization, i.e. Sole Decision-Making Responsibility and/ or a Court's Order.

Under conditions where only one parent authorizes treatment for their minor child, that parent should be aware that the non-authorizing parent may have the legal right to access the child's record. In contested custody disputes involving the records of minor children, the release of such records may require an independent determination by the Court if its disclosure is not deemed in the child's best interest (Berg v. Berg).

Should there be extenuating legal circumstances related to the minor's treatment, i.e. ongoing custody/ visitation litigation/ divorced parents - and it appears reasonable to accept the case given that context - we require that a separate document be completed by the parent(s) which addresses specific parameters under which we can provide assistance.

In general, we limit treatment solely to that which will benefit your child; thus, anything that is shared in session is treated as confidential. We ask that neither parent attempt to use any aspect of their child's treatment to obtain an advantage in any legal proceeding.

Under these conditions, and unless other arrangements are agreed to in writing, the parent(s)/ Guardian must agree that they would never support, or seek via subpoena, any legal effort to have the clinician deposed or testify in Court; nor would the parent(s) or Guardian ever authorize the child's clinical record to be used for legal or other non-clinical purposes.

If the client is under the age of 18 and not considered emancipated by the Court, state law provides the parents with the right to examine treatment records. Depending on the adolescent's age, maturity, and goals for treatment, we make every attempt to honor the minor's confidentiality as appropriate to the goals of treatment. It is thus our general policy to request that the parents agree to limited access to records and to accept summary information regarding their son/ daughter's treatment and progress.

An exception to this policy could occur should the therapist believe that a significant risk exists that the minor individual may seriously harm them self or another, in which case we must immediately notify the parent of these concerns. Before providing any such information to a parent the therapist would make every effort to discuss the matter thoroughly with the minor client.

Should there be a disclosure during treatment through which the therapist learns of sexual activity between one or both underage (16) adolescents, we are legally obligated to inform our client's parent - and under certain conditions child welfare authorities.

In the case of treatment for substance-related concerns, Federal Confidentiality Law indicates that parents have the right to examine the records of children under the age of 12. A child 12 years of age and older has the same rights to confidentiality as an adult when seeking treatment for substance use issues.

CONSENT FOR TREATMENT OF A MINOR

I/ We _____ ,
(Printed)

Parents/ legal Guardians of _____(DOB:_____)
(Printed)

authorize the provision of therapeutic services as explained for my son/ daughter from

_____
Clinician (Printed)

_____ _____
Parent/ Guardian's Signature and Date Parent/ Guardian's Signature and Date

_____
Clinician's Signature and Date

Green House Group, PA

CLIENT FIRST NAME _____ PRIMARY PHONE _____
Ok to leave message? Y N

CLIENT LAST NAME _____ SECONDARY PHONE _____
Ok to leave message? Y N

STREET ADDRESS _____ EMAIL _____
Ok to send non-clinical email? Y N

CITY, STATE, ZIP _____ DATE OF BIRTH _____
(Required)

Male_____ Female_____ Other_____ Married_____ Single_____ SOC SEC #_____-_____ -_____

PARENT NAME (if minor client)_____ PARENT PHONE _____
Ok to leave message? Y N

EMERGENCY CONTACT (name) _____ PHONE _____

IS CLIENT RESPONSIBLE FOR BILL? Y N If NO, list responsible party (parent or guardian) below:

RESPONSIBLE PARTY # 1 BILLING ADDRESS (If different from above)

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

RESPONSIBLE FOR _____ % OF BILL

RESPONSIBLE PARTY # 2 BILLING ADDRESS

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

RESPONSIBLE FOR _____ % OF BILL

INSURANCE INFORMATION

Must be completed in addition to copy of insurance card(s)

PRIMARY INSURANCE COMPANY NAME _____

I.D. # _____ POLICY # _____ GROUP # _____

CLIENT'S RELATION TO INSURED SELF_____ SPOUSE_____ CHILD_____ OTHER_____

POLICY HOLDER NAME _____ DATE OF BIRTH _____
(**Required**, if different from client)

ADDRESS _____ WORK TELEPHONE _____

CITY, STATE, ZIP _____ HOME TELEPHONE _____

EMPLOYER _____ SS # OF POLICY HOLDER _____

CLARIFY THE FOLLOWING INFORMATION WITH THE *PRIMARY* INSURANCE COMPANY:

IS CLINICIAN COVERED BY PLAN? Y N

IS A REFERRAL, NOTIFICATION, OR AUTHORIZATION REQUIRED? Y N AUTHORIZATION #_____

WHAT IS THE COPAY/COINSURANCE FOR THIS SERVICE? _____

SECONDARY INSURANCE COMPANY NAME _____

I.D. # _____ POLICY # _____ GROUP # _____

CLIENT'S RELATION TO INSURED _____ SELF _____ SPOUSE _____ CHILD _____ OTHER

POLICY HOLDER NAME _____ DATE OF BIRTH _____
(If different from client)

ADDRESS _____ WORK TELEPHONE _____

CITY, STATE, ZIP _____ HOME TELEPHONE _____

EMPLOYER _____ SS # OF POLICY HOLDER _____

CLIENT NAME/DOB: _____

OTHER INFORMATION

WHO REFERRED YOU TO GREEN HOUSE GROUP PA? _____

FAMILY MEMBERS IN YOUR HOME:

NAME	**AGE/DOB**	**RELATIONSHIP**

PRIMARY CARE PHYSICIAN _____ PHONE # _____

PSYCHIATRIC PROVIDER _____ PHONE # _____

LIST ANY HEALTH PROBLEMS FOR WHICH YOU CURRENTLY RECEIVE TREATMENT

_____

MEDICATIONS _____

HAVE YOU HAD PREVIOUS THERAPY? IF SO, WITH WHOM AND WHEN?

_____

I understand that I am responsible for FULL payment for the services rendered; GHG will submit claims to my insurance company as a service to me. I also understand that I am responsible for obtaining pre-authorization from my insurer, billing fees which I might incur, and any late charges on outstanding balances. I am also responsible for collection fees and/or legal fees incurred in settling any outstanding accounts I might have. If I am unable to keep a scheduled appointment and do not give 24 hours notice, I understand that I will be charged directly for that visit; GHG cannot bill insurance for missed appointments. My signature below authorizes the release of any medical information necessary to the insurer of record so to pay insurance claims for services rendered.

I authorize payment of benefits by my insurer to Green House Group, PA for services described on the health insurance claim form.

_____ _____
Signature Date

If I choose to pay for services on my own and without insurance, I agree to pay $ _____ per session as discussed with my provider. If I choose not to use my insurance and pay privately for services, I agree to waive any right to reimbursement from my insurance company.

_____ _____
Signature Date

I am requesting psychological or neuropsychological testing. I understand that I am financially responsible for any remaining balance related to this service after my provider has fulfilled all contractual requirements with the insurer and exhausted all authorized benefits. This remaining balance may include deductibles, co-pays for authorized sessions, and the billed cost for service hours either beyond or not covered by limits of insurance coverage. The evaluator will provide an estimate of these additional costs, if any, before the assessment has begun.

_____ _____
Signature Date

TO BE COMPLETED BY CLINICIAN:

INTAKE DATE _____ PROVIDER _____ DIAGNOSIS _____ Usual CPT CODE _____ FEE _____

AUTH # _____ # VISITS _____ DATE RANGE _____ to _____ COPAY _____

Green House Group, PA

Psychotherapy and Consultation

CREDIT CARD INFORMATION FORM

Client Name: _____

Cardholder Name: _____

Billing Zip Code: _____

Card Type: Visa_____ MasterCard_____ Discover_____ AmEx_____

Is this an HSA/FSA card? Yes_____ No_____

Credit Card #: _____

Expiration Date: _____ 3 digit code_____ (on back)

Payment amount:_____ (USD)

Note: Once information is entered into our credit card processing system, this document will be shredded.

Signature: _____ Date: _____