

### INFORMED CONSENT

**This document contains important information about my professional services and business policies. When you sign this document, it will represent an agreement between us.**

Welcome to my practice. Your needs are important, and I am committed to you and your personal dignity, and to a high level of service. Today's appointment will take approximately 45 - 50 minutes. I realize that starting counseling is a major decision and you may *have* many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you *have* other questions or concerns at any time, please ask and I will try my best to *give* you all the information you need.

Tamara Smith, L.P.C.C. earned her MA in Counseling from the University of Cincinnati in 1999, and her BS Degree in Occupational Therapy from Colorado State University (1978). She is licensed by the State of Ohio as a Supervising Professional Clinical Counselor (LPCC-S), and she has more than 20 years of clinical experience treating adults and older adolescents in individual therapy. She also engaged in post-graduate study at the Cincinnati Psychoanalytic Institute and graduated as a psychoanalyst in November 2020. She primarily practices psychodynamic psychotherapy and psychoanalysis, although other treatment approaches may be used depending on your needs. Treatment practices, philosophy, plan imitations and risks, and recommendations will be discussed with you today and as needed.

The counseling process is not easily described in general statements. It is a process designed to utilize your strengths to address your unique needs and challenges. It may help you come to a greater understanding and acceptance of yourself and others, to be better able to reach your goals, enhance personal wellbeing, *live* with less anxiety and more hope, and improve relationships. Because counseling involves sharing sensitive or deeply personal information, it may at times feels distressing. There may be periods of increased anxiety, frustration or confusion. The outcome of counseling is generally *very* positive; however, the level of satisfaction for any individual is not predictable.

**CONFIDENTIALITY AND EMERGENCY SITUATIONS:** Your verbal communication and clinical records are strictly confidential except for:

- a) Information (diagnosis and dates of service) necessary to process your insurance claims;
- b) Where you sign a release of information to *have* specific information shared;
- c) Information you and/or your child/children report about physical or sexual abuse; then, by Ohio State Law, I am obligated to report this to the local public children's services agency;
- d) Information you provide that informs me that you are in danger of harming yourself or others;
- e) Information necessary for case supervision or consultation, and
- f) When required by law.
- g) If an emergency situation for which the client (or their guardian) feels immediate attention is necessary, and the call is not returned within 15 minutes, the client (or guardian) understands that they are to contact the emergency services in the community (911) for those services. Tamara Smith will follow those emergency services with standard counseling and support to the client or the client's family.

**Signature(s)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Tamara J. Smith LPCC

**FINANCIAL /INSURANCE INFORMATION:**

- a) **Regarding Insurance:** As a courtesy I will bill your insurance company for you. It is your responsibility to obtain any necessary authorizations prior to treatment. Failure to do so may result in non-payment or reduced benefits, and you would then be responsible for full payment of the charges. I utilize an electronic billing service that is certified HIPAA compliant to safeguard the privacy of your Protected Health Information (PHI).
- b) **Copayments:** I ask that you pay your co-pay each session.
- c) **Missed appointments / Late cancellations:** Unless an appointment is cancelled at least 24 hours in advance, the charge will be \$65 for that session, since insurance companies do not cover missed sessions. If you need to reschedule your appointment, please inform me as soon as possible so that another client might have the opportunity to use your scheduled time.
- d) **Financial Responsibility:** You are financially responsible for all copayments, deductibles, and full and timely payment of services if your insurance company has not paid within 60 days. In the event you have not met your deductible, the agreed upon insurance contract rate is due at each session until the deductible is satisfied.
- e) If your insurance company denies payment or does not cover counseling, I request that you pay the balance due 10 days after the date on the client bill.
- f) If your balance ever exceeds \$300.00, I ask that you pay for services when rendered.

I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances, or payments please feel free to ask

**Signature(s)** \_\_\_\_\_ **Date** \_\_\_\_\_

**COORDINATION OF TREATMENT:**

It is often helpful to coordinate care with other health care providers (e.g., your PCP or psychiatrist). If you would like me to communicate with other doctors involved in your care, please provide the relevant information below. Your consent is valid for one year.

You may inform my physician(s): \_\_\_\_\_ It is not necessary at this time: \_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_

CLINIC: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

**Signature(s)** \_\_\_\_\_ **Date** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:** I/We have received a copy of the Notice of Privacy Practices and Client Rights document.

**Signature(s)** \_\_\_\_\_ **Date** \_\_\_\_\_