PALMETTO COUNSELING ASSOCIATES, L.L.C.
1911 Gadsden St., Suite 204, Columbia, SC 29201
Phone (803) 254-9740
Website: palmettocounseling.com
Email: info@palmettocounseling.com

# Palmetto Counseling Associates, LLC Professional Disclosure Statement and Consent for Treatment with Gina Rogers, M.A.

The majority of this document is mandated by both South Carolina State Law and Public Law 104-91; it is provided for your protection. Palmetto Counseling Associates, LLC has tried to anticipate the risks you may face as a result of being in counseling. If you have any questions regarding any documents you have received, please feel free to discuss them with Gina Rogers, M.A.

## Contact Information:

- Address/Mailing Address: 1911 Gadsden Street, Suite 204, Columbia, SC 29201
- Office Hours: 8:30 a.m. - 5:00 p.m. Monday - Thursday, and 8:30 a.m - 12:00 p.m. on Friday.
    - Clients are seen by appointment only and special arrangements for evenings, weekends, and other selected times can be considered.
- Phone Number: 803-254-9767
- Fax Number: 803-254-9740
- Emergency phone line for after hours: 803-397-6739
- Email address: info@palmettocounseling.com and is checked daily on work days.

## Personal Qualifications:

- Gina Rogers is a Licensed Counselor and a Board Certified Coach. She has a Bachelor of Science in Chemistry from the University of Bucharest in Romania and a Masters of Arts in Clinical Counseling from Columbia International University. Gina has worked with Christian ministries for over 19 years, offering spiritual direction and guidance to individuals, couples, and families. Together with her husband she enjoys opportunities to help other couples experience growth and to build stronger marriages. She also likes helping engaged c couples prepare for marriage and is comfortable working with people who don't have everything figured out yet. Having children of her own, her heart connects with children and teens, helping them navigate through life's challenges.

## Services:

- Gina Rogers, M.A. provides a number of services in the area of professional counseling which include:
    - Individual counseling for emotional, relational, or spiritual issues
    - Child/Adolescent counseling for behavioral and/or emotional issues
    - Crisis. Trauma and Abuse
    - Mood disorders (Depression, Anxiety)
    - Marital Counseling

- Post-Traumatic Stress Disorder
- Grief and Loss
- Cross-Cultural Transitions / Adjustment Issues

## Fees:

- It is customary to pay for professional services at the time they are rendered. The fee for individual, marital or family counseling is $145.00 per forty-five-minute session. Each session includes the time necessary to make payment and schedule your next appointment. Checks should be made payable to Gina Rogers.

## Confidentiality:

- The information you share in counseling is protected health information and is generally considered confidential by both South Carolina Statute Law and Federal Regulations. Your counseling file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system. Gina Rogers, M.A. is mandated by state and federal regulations through duties to warn-to breach confidentiality if he discovers
  - 1) You are threatening self-harm of suicide
  - 2) You are threatening to harm another or homicide
  - 3) A child has been or is being abused or neglected
  - 4) A vulnerable adult has been or is being abused or neglected
  - 5) You have broken or intend to break a law or laws
- Finally, if you wish to have your protected health information released to someone else (e.g. an attorney, a physician, another mental health agency, etc.), you must sign a specific Release of Information.
- Palmetto Counseling Associates will no longer release psychotherapy notes because PCA is considered a "covered entity" under Public Law 104-191, commonly known as the Health Insurance Portability and Accountability Act (HIPAA) passed August 8, 1996. Under this law, psychotherapy notes are afforded specifical privacy protection. Your psychotherapy notes would be released through your individual provider to your desired entity.
- Should you request remuneration from your insurance for part of your entire bill, then we will give you a receipt with dates of your sessions and a diagnostic code which identifies the major problem (s) being addressed in therapy. If other information is required by your insurance, which is infrequent, your therapist will only do so after obtaining your consent. Confidentiality must also be broken if a government court orders the information.

## Ethics:

- Gina Rogers, M.A. follows the Code of Ethics of the following organizations:
  - The South Carolina Board of Examiners for the Licensure of Professional Counselors, Marriage and Family Therapists, and the Psycho-educational Specialists
- Any type of sexual behavior between counselor and client is unethical. It is never appropriate and will not be condoned.

## Informed Consent:

- You will be asked to sign the last page of this document. Your signature verifies you have been given this document and the HIPAA document; that you have read and understand these documents, and that you consent to treatment. Further you need to be aware:
    - Treatment isn't always successful and may open unexpected emotionally sensitive areas
    - Gina Rogers, M.A. is not a physician and cannot prescribe medications
    - Gina Rogers, M.A. may need to consult with your physician, attorney or other counselor
    - Gina Rogers, M.A. is not available 24 hours a day
    - The Practice Manager for Palmetto Counseling Associates is Debbie Russell. She is a confidential administrator under state and federal law. She will be your major contact for appointments, problems, complaints, and commendations.

## Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available upon request.

All information revealed by you in a counseling or therapy session and most information placed in your counseling/therapy life (all medical records or other individually identifiable health information held or discled in any form (electronic, paper, or oral) is considered "protected health information" by HIPAA). As such, your protected health information **cannot be distributed to anyone else without your expressed informed and voluntary written consent or authorization**. The exceptions to this are defined below. Additional information regarding your rights as a client can be found in your therapist's/counselor's Professional Disclosure Statement and Consent for Treatment.

**Use or disclosure of the following protected health information <u>does not require</u> your consent of authorization.**

1) Uses and disclosures required by law-like files court-ordered by a Judge
2) Uses and disclosures about victims of abuse, neglect, or domestic violence-like the duties to warn explained in your therapists/ counselor's Disclosure Statement
3) Uses and disclosures for health and oversight activities-like correcting records or correcting records already disclosed
4) Uses and disclosures for judicial and administrative proceedings-like a case where you are claiming malpractice or breach of ethics
5) Uses and disclosures of law enforcement purposes-like if you intend to harm someone else
    a) See Duties to Warn in your provider's Disclosure Statement
6) Uses and disclosures for research purposes-like using client information in research; always maintaining client confidentiality
7) Uses and disclosures to avert a serious threat to health or safety-like calling Probate Court for a commitment hearing

8.Uses and disclosures for Workers Compensation-like the basic information obtained in therapy/counseling as a result of your Worker's Compensation Claim

## Your Rights as a Counseling/Therapy Client under HIPAA

**As a client, you have the right to:**

- see your counseling/therapy file.
- request amendments to your counseling/therapy file.
- **Psychotherapy notes are afforded special privacy protection under HIPAA regulations and are excluded from this right.**
- receive a history of all disclosures of protected health information.
- You will be required to pay copying fees at a $25.00 "handling" charge, a $0.65 per page "duplication charge" for the first 30 pages, and a $0.50 per page "duplication charge" for the additional pages.
- restrict the use and disclosure of your protected health information for the purpose of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.
- register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

Prior to your counseling or therapy, you will receive:

1) An exact duplicate of these two pages and your Therapist/Counselors Professional Disclosure Statement and Consent of Treatment for your personal records

It will be necessary for you to sign a certificate indicating that you have received, read and understood the documents. This certificate will be placed in your counseling/therapy file. Please do not sign the certificate if you do not understand any part of the HIPAA Client's Rights of the Professional Disclosure Statement and Consent for Treatment. Your counselor or therapist will be happy to explain these documents further.

Page 5 is the signature certificate.

**Thank you!**

# Palmetto Counseling Associates, LLC Professional Disclosure Statement and Consent for Treatment with Gina Rogers, M.A.

I acknowledge that I have received and read the **Palmetto Counseling Associates Professional Disclosure Statement and Consent for Treatment** and the **HIPAA Client's Rights**. I further acknowledge that I seek and consent to treatment with Gina Rogers, M.A.. My signature below confirms that I understand and accept all the information contained in the **Palmetto Counseling Associates Professional Disclosure Statement and Consent for Treatment and the HIPAA Client's Rights.**

_____
Printed Client's Name

_____
Signature of Client

_____
Date

If more than one individual (e.g. spouse or family member) is seeking counseling, please have each of the others sign below. Signatures below confirm that each understands and accepts all the information contained in the **Palmetto Counseling Associates Professional Disclosure Statement and Consent for Treatment** and the **HIPAA Client's Rights,** and that each seeks and consents to treatment. We will provide additional copies of the **Palmetto Counseling Associates Professional Disclosure Statement and Consent for Treatment** and the **HIPAA Client's Rights** upon request.

_____
Signature of Client #2

_____
Signature of Client #3

_____
Signature of Client #4

_____
Signature of Client #5

_____
Signature of Client #6

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# Client Financial Policy

We are dedicated to providing you with the best possible care and service; and believe understanding our financial policies is an essential element of your care and treatment.

**Please read carefully, initial or sign where requested, and sign at the bottom of the second page indicating your understanding and acceptance of our policies and procedures.**

We accept cash, checks, Visa, MasterCard, and debit cards. At the time of scheduling, we put the card given to us over the phone on file to use for future appointments. If you would like to change payment, let the office know and we will update your account. Payment is due at the time of service. Payment not made at the time of the appointment needs to be made later the same day. When possible, clients are asked to pay their fees at the beginning of each session. If major services result in a large balance, an installment plan can be arranged prior to treatment. Minimum payment amounts begin at $25.00, or 10% of the balance per month, whichever is greater. Installment pay back periods can not exceed one year (12 months).

## Regarding Insurance _____ (initial here)

By providing your insurance information, you have asked, and promised to pay for the services we provide you. We can provide you with a receipt for you to submit to your insurance company (superbill) or as a courtesy, submit your claim for you. We will have you pay for any deductibles and copay required at the time of service.

Please realize that:

1. Your insurance is a contract between you, your employer, and the insurance company and we are not a party to that contract.
2. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover.
3. The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.
4. **Please note: insurance will not pay for missed appointments or cancellations. If you cancel late or miss an appointment you will be responsible for the entire session fee, not just the amount of your copay.**

Please know your benefits, limitations, and responsibilities of your plan. While filing insurance claims for our clients is a courtesy that is extended; **all charges are your responsibility from the date service is rendered.** Clients who wish to file their claims may be asked to pay for the 1st session in full until we receive written confirmation from their

insurance company as to benefits and eligibility. If you accrue a credit balance, we will apply it to your next visit(s) or refund it to you. If you have insurance with a plan that we do not have a contract with, or, if you are using a HSA/HRA, we require full payment at the time of service. We make every effort to code and file claims accurately according to the services rendered and your counselor's physician's documentation. Annually, or whenever there are insurance changes, you are required to complete and update our insurance information form.

**Circle one below:**

Yes, please file my claims for me (if yes, please sign below)

No, I plan to file my own claims

**I authorize payment of medical benefits to Palmetto Counseling Associates, my counselor and/or physician for services rendered.**

_____

**Client Signature**

_____

**Date**

**I authorize the release of any medical or other information necessary to process claims for services rendered.**

_____

**Client Signature**

_____

**Date**

## Client Financial Policy Continued

**_____ Overdue Payments**
(initial here)
Payment is due at the time of service. A billing fee of $5.00 will be added to your account each time we have to send you a bill. If we have not heard from your insurance after 30 days, we will contact you for assistance and/or to make payment arrangements. **Accounts with no payments after 30 days may be subject to a 10% late fee. Accounts with no payments after 90 days may be turned over to a collection agency and reported to the credit bureaus.** A collection agency which follows HIPAA privacy policies will be used to collect debts not paid promptly. If your account is sent to a collection agency, the collection agency's fees, and any associated legal fees, will be added to your account and you may be discharged as a client from the practice.

**We do realize that there are times that a temporary financial problem may affect your payment of your account. In that case, PLEASE, contact our practice manager for assistance so that we may be able to set up payment options for you.**

**_____ Canceled and Missed Appointments**
(initial here)
In order to provide the best possible service and availability to ALL of our clients, **we reserve the right to charge the full session fee for any appointments not canceled at least 24 hours in advance, regardless of the reason for the cancellation/missed visit. We will immediately charge the credit card on file for any late cancellations or no shows that were not canceled in advance.** In some cases, telephone appointments may be substituted for face-to-face appointments for individuals who are not able to cancel on time. Please call us as early as possible if you will need to reschedule your appointment. Monday appointments must be canceled by 9:30 a.m. the previous Friday to avoid a late cancellation charge.

**_____ Other Financial Guidelines**
(initial here)

Clients who use a third party payer such as a non-client responsible party, family trust or financial account, public assistance or any other payer for the payment of our charges, must coordinate with your third party payer to provide payment at the time of your appointment. A receipt will be provided.

All checks returned for non-sufficient funds or otherwise not paid will be subject to a $35.00 fee plus the amount of the check.

In addition, a $25.00 fee to Palmetto Counseling Associates may apply for each of the following: 1. If we obtain prior authorization for office visits when we are out of network

with your insurance provider 2. If prior authorization is needed for a prescription drug to be filled at your local or mail order pharmacy 3. If you request new prescriptions or refills for your medications between appointments

Paperwork for court documents, school related papers, employment absence, and/or disability or insurance summaries will be completed and billed on a pro-rated basis for time required to complete outside of a normal office visit. Additional fees may apply for copies, required meetings and/or court appearances on behalf of our clients, and related mileage/travel expenses.

**I have read and understand the financial policy of the practice and I agree to be bound by its terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree that such terms may be amended from time to time by the practice.**

_____

Patient/Responsible Party Signature

_____

Date

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# Policy Regarding Administrative Services Fee

**Effective January 1, 2019**

Palmetto Counseling Associates is committed to providing the best compassionate care to our community. We continually strive to increase our level of care to our clients and make their experience a more excellent one. However, over the last several years there has been a continued deterioration in the economics of managing an office-based counseling and psychiatric care practice. You may or may not know that third-party payors (insurance companies) have not significantly increased the fees paid to providers in well over a decade. During that same time period, the office overhead for a practice such as ours has risen over 100%. Many practices across the nation have either significantly raised their session fees to non-insurance clients, dropped insurance coverage altogether, or cut staff and services offered. None of these options fit with our goals of compassionate care and an excellent experience for clients.

We have been looking for another option for quite a while and believe we have finally found one that aligns with our goals and values here at PCA. Several medical practices across the country have been moving to a model where they charge an administrative service fee to their patients that covers the significant amount of time spent on providing administrative services which are not covered by any federal, state or private health insurance coverage. This fee allows the practices to continue to provide all the features and services that their patients have come to expect while keeping overall session fees as fair as they can be. We believe this is the best path forward for PCA.

Therefore, beginning January 1, 2019, all current and future clients at Palmetto Counseling Associates will be assessed this Administrative Services Fee. This fee will not impact your current session fees, copayments or deductibles. It does not affect anything regarding your insurance (if you are using insurance) or your relationship with your counselor or psychiatrist. It only applies to PCA which is an LLC offering management services for each individual practitioner. This fee will be paid to PCA and not to your clinician.

The only exceptions to this policy are if you are a new patient as we will not require you to pay the fee prior to your first appointment. Once you have decided that you will become an ongoing patient of our practice, then the fee will apply to all future sessions.

**$10.00 per session**

If you have any questions on this policy, please let us know.

_____ _____

Client Signature Date

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# Policy Regarding Credit Card Fee

Beginning January 2019, the individual therapists at Palmetto Counseling Associates have decided to institute a credit card fee for those clients who use credit cards.

This fee will be 3.5% of your total amount paid.

This fee will only apply to credit card charges to help offset the increasing fees for security compliance and processing of credit cards by the merchant card processors.

You may avoid this additional fee by choosing to pay your entire fee with a check or with cash.

_____
Client Signature

_____
Date

# Palmetto Counseling Associates Intake Form

## Section I: Patient Information

First Name _____ MI ___ Last Name _____ Today's Date _____/_____/_____ Home Address _____ City _____ State _____ Zip _____

Home E-Mail _____ Gender Male Female Other

Home Phone (___)_____ Home Fax (___)_____ Cell Phone (___)_____

Date of Birth _____/_____/_____ Social Security___/___/____ Referred by _____

Employer _____ Address _____ City _____

State ___ Zip _____ Occupation _____ Title _____

Work Email _____ Work Phone (___)_____ ext.___

Work _____ Fax (___)_____

Spouses Name: First _____ MI _____ Last _____

Cell Phone (___)_____ Spouse's Employer _____

Work Phone (___)_____

Emergency Contact _____ Phone (___)_____

Relationship _____ Church Affiliation _____

Pastor _____

## Section II: Medical History

Physician's Name(s): _____

Current Medication(s): _____

Significant illnesses and hospitalizations: _____

Reason for Consultation: _____

Comments:

## Section III: Insurance Information

Insurance Company: _____

Insurance Policy Number: _____

Client's Relationship to Insured: Self Spouse Child Other

Insured/Subscribers Name: _____

Insured/Subscribers Phone Number: _____

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## Email Consent

I give consent to receive emails that describe new services provided by Palmetto Counseling Associates and Future Psych Solutions.

_____ _____

Client Signature Date

_____

Email

## Written/Video Testimonials

In order to provide opportunity for others to become aware of the services offered by Palmetto Counseling Associates and Future Psych Solutions, I give consent to provide written or video testimonials for the excellent service I received at Palmetto Counseling Associates or Future Psych Solutions. No personal identification will be given away.

_____ _____

Client Signature Date

## Good Faith Estimate

In an effort to provide a Good Faith Estimate on the cost of therapy, I request four sessions at the cost of $125 per session in order to fully understand the extent of the situation. During the fourth session, we will discuss the progress of work and conjointly plan for future appointments accordingly. Payment for sessions is required on the day of your session.

_____ _____

Client Signature Date

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# Telehealth Consent Form

1. I understand that I am agreeing to engage in telehealth services with my provider.

2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider can discontinue the telehealth consult/visit if it is felt that the video conferencing connections are not adequate for the situation.

5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

# Consent To Use Telehealth by Doxy.Me

Telehealth by Doxy.me (or other similar platform) is the technology service we will use to conduct telehealth video conferencing appointments. It is simple to use and there are no passwords required to log in.

By signing this document, I acknowledge:

1. Telehealth by Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Tele health Service, neither Doxy.me nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

3. The Telehealth by Doxy.me service facilitates video conferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by Doxy.me Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by Doxy.me Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

<u>By signing this form, I certify:</u>

1. That I have read or had this form read and/or had this form explained to me. • That I fully understand its contents including the risks and benefits of the procedure(s).
2. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
3. That I am agreeing to be within the state of South Carolina at time of services.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Client Signature Date