Firefly
PLAY THERAPY

WELCOME TO CHILDREN'S THERAPY WITH KRISTYN McNALLY.

We are so glad that you have chosen to entrust your child with us, and look forward to serving you and your family. This is going to be a worthwhile experience, and we are excited about what is in store!

Enclosed in this Welcome Packet is information for you regarding all aspects of treatment; consent forms, privacy policies, expectations for therapy, valuable articles, and more. Please take time to review all of the materials and feel free to ask any questions regarding any of the information provided.

It is our goal to provide the best quality services to you by encouraging, empowering, educating, and equipping you and your child to have the family life that you desire. Sometimes this requires a significan commitment of time and resources, and we respect your investment in your family's future.

Allow us to express our gratitude for including us in the process of healing for you and your children. Please know that we highly value you as our client! Please inform us of any way that we can meet your needs throughout the course of treatment,and know how much we believe that great things are in store for you and your family!

Sincerely,

Kristyn McNally, LMHC

Kristyn McNally, LMHC

Firefly Play Therapy, LLC
15123 Ogden Loop, Odessa, FL 33556
(813) 421-5437

FOR SERVICES RENDERED TO OR REGARDING

Name _____

Address

_____

_____

Date of Birth _____

THERAPIST-PATIENT SERVICES AGREEMENT AND INFORMED CONSENT

Welcome to our practice, The Hicks Group, LLC. (THG, LLC). This document (the Agreement) contains important information about professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The law requires that we obtain your signature acknowledging that we have provided you with this information by the end of the first session.

Although these documents are long, it is very important that you read them carefully. We will be happy to discuss any questions you have. When you sign this document, it will also represent an agreement between you and THG, LLC, its employees and contractors. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOTHERAPY SERVICES

There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. In addition your responsibilities are to provide relevant, accurate and complete information as to your history, symptoms, complaints, medication, and current status. Your responsibilities are to make your best efforts on any tests of performance such as

neuropsychological, achievement or ability testing. As appropriate or customary, our assessment procedures may include measures of effort and response bias. Failing to make adequate effort or misrepresenting information may have adverse consequences if you are participating in evaluations for determinations of government or other benefits, or if you are party to a legal suit for claims , or involved in a civil or criminal action.

Psychotherapy can have benefits and risks. Since therapy may involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, better occupational functioning, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

The diagnostic assessment and mental status will involve an evaluation of your needs by reviewing your medical, social, occupational, family and mental health history as well as reviewing current and past symptoms and significant life events. In some cases further formal assessment through psychological or neuropsychological testing may be required or suggested to further assess your abilities, personality or coping skills. We will often request records from other providers that are or have been involved in your care and review these to coordinate care and assist in the assessment phase. Some of these records may not be received for some time, and will be incorporated and reviewed as received. At the end of this assessment phase, unless in certain circumstances where we perform this assessment or consultation for a third party, we will offer you our impressions based upon the information we have gathered. In some cases we will have only a consultative or assessment role. Should you continue beyond an assessment phase, we will present you with a treatment plan to follow.

Where applicable, you should evaluate the assessment and treatment plan information along with your own opinions of whether you feel comfortable working with your psychotherapist. Assessment and therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

The normal psychotherapy intake assessment phase involves gathering history and your presenting complaints as well as assessing your child's mental status. This may take 1 to 2, and sometimes 3 to 4 50 minute sessions. This varies greatly since we assess and treat a wide variety of clients in a wide variety of situations. We will inform you about unusual departures from these expectations early in our meeting(s).

If we mutually agree to begin psychotherapy for your child, we usually schedule one 50 minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may vary as needed. In some cases as you progress, we may also reduce the frequency of visits. Once an appointment hour is

scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation for a therapy session. Repeated missed appointments may result in termination of therapy.

PROFESSIONAL FEES

PsychotherapyServices:

Our usual and customary fee for your first one-hour parent-consultation is provided at no cost to you. Hourly fees for psychotherapy, per 50 minute appointment, are discussed in the initial consultation. In addition to weekly appointments, we charge this amount for other professional services related to psychotherapy you may need, including report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. Fee for court appearances are $300 per hour and includes driving time.

CONTACTING US

Due to our work schedule, your therapist may not be immediately available by telephone. Brief, routine messages may be left on office voicemail and will be reviewed and responded to during normal business hours. Our after-hours voice mail will be responded to the following business day. When you leave messages at the office, we will make efforts to return your call within 24-48 hours, with the exception of weekends, holidays, or if we are out of town. In some cases, we may arrange for coverage with another therapist if we are out of town. If you are difficult to reach, please inform us of times when you will be available.

If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. In case of medical emergencies, overdoses of medication, or situations where your physical health or safety is in immediate danger, call 911.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a therapist, but some situations are excluded by law. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or other Federal or State law.

There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for the following activities and those provided in the attached Notice:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patients. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that we share offices with and practice with other mental health professionals and that we may employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, returning messages to you, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality.All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- We have contracts with a number of independent practices, government and state agencies, municipalities,employee assistance programs, billing program vendors, and hardware and software vendors/maintenance individuals and companies and entities which are considered "Business Associates". As required by HIPAA, we have formal Business Associate contracts with these businesses, in which they promise to maintain the confidentiality of any data they are disclosed or come into contact with except as specifically allowed in the contract or otherwise required by law.
- Protected health information may by used or disclosed in supervised training within our office where interns or trainees learn to practice psychotherapy or assessment.
- We may use personal health information to conduct or participate in research studies based upon clinical and health records (archival research) .In such cases any personal identifying information shall be removed from any data sets created. Any such planned research shall be contingent upon a review of the research plan by us to ensure that privacy and other ethical requirements are met. For example, we may collect outcome data on group treatment approaches or we may use limited data from your record to conductastudyoftestpatternsinheadinjury.Of course,we will not conduct any experimental research without a separate informed consent.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychotherapist-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if we receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. However, if ordered by a court of law to disclose protected

information, we will comply with this demand. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a patient files a worker's compensation claim, and we are providing necessary treatment related to that claim, we must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider. HIPAA rules also do not protect your information when applying for governmental or private disability, or when you are covered by automobile insurance.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment.

- If we know, or have reason to suspect, that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that we file a report with the Department of Child and Family Services. Once such are port is filed, we may be required to provide additional information.
- If we believe that there is a clear and immediate probability of physical harm to the child, to other individuals, or to society, we may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or seeking hospitalization of the child.

If such situations arise, we will make a reasonable effort to fully discuss it with you before taking any action and we will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that we keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (other than a health care provider) and we believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical

Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. In the case of psychological/neuropsychological assessment, copyright laws prohibit distribution of copied test protocols. If you request a copy of your neuropsychological assessment records, you will receive a copy of your report. If you request the testing data, your report and a list of test scores will be provided to an appropriate mental health professional of your choice. In most circumstances, we are allowed to charge a copying fee of $1.00 per page for the first 25 pages and 25 cents per page thereafter as well as postage or other costs associated with furnishing you these records. We may withhold copies of your records until payment of the copying fees has been made. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Receipt of Privacy Notice form, and my privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, we may request an agreement with minors [over 12] and their parents about access to information. This agreement provides that during treatment, we will provide parents only with general information about the progress of the treatment, and the patient's attendance at scheduled sessions. We may also provide parents with a summary of their child's treatment when it is complete. In these cases, we may require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concerns. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

It is our understanding that Federal laws are more stringent in protecting release of Drug and Alcohol information regarding adults as well as minor children. While we recognize the serious parental concerns in this regard, we cannot release such information without your child's informed consent.

By presenting your minor child for treatment, you are representing and affirming that you have legal parental authority to do so. Unless parental rights have been terminated, or there have been other specific restrictions imposed by the court or law, you are affirming that both parents have equal rights to information about diagnosis and treatment under the law.

COMPLAINTS ABOUT SERVICES

We strive to provide quality services in a caring and professional manner. However, we understand that sometimes disagreements or complaints regarding services can occur. We encourage you to first discuss these directly with the individual involved in order to directly solve any problem.

If you wish, or if this does not provide adequate remedy, you may contact our President, Brenna M. Hicks, PhD, RPT*, LMHC (License #: MH9748). * Registered Play Therapist

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested.

If you carry a balance, client statements are usually sent the last week of each month. The portion marked client responsibility is due upon receipt.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, personal identifying information, payment history, information about any agreements or authorizations made regarding payment or responsibility for services, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included by us or our attorney in the claim.

By signing this agreement you understand that you are responsible for reasonable attorney and legal fees for accounts that go to collections. We will also release information necessary to file an adverse credit report with Equifax or other such agency.

SPECIAL ACCOMMODATIONS

If you require any special accommodations for purposes of evaluation or treatment, you agree that you will provide a written statement of what you require such that it may be discussed at your first visit.

INSURANCE REIMBURSEMENT

In order for us to provide you with the best standards of care, we are a Managed Care-Free practice. That means that we do not bill insurance carriers or providers for psychotherapeutic services rendered. We are solely a fee-for-service practice, with the implication that by agreeing to therapy, you agree to fulfill your financial obligations to Firefly Play Therapy, LLC through your own means, and not through an insurance provider or third-party payer.

PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

Your signature below indicates that you have read the information in this document, that it has been presented to you in a manner you understand, you have had an opportunity to ask any questions, and you agree to abide by its terms during our professional relationship.

Please initial below:

_____ I will private pay for services. I will be responsible for all fees at the time of service unless otherwise agreed to by Firefly Play Therapy, LLC. I agree that I will not subsequently bill my insurance carrier for services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND CONDITIONS AND ALSO SERVES AS INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES.

Printed name of Patient (or Legal Guardian/Parent)

_____

Date

_____

Signature of Patient (or Legal Guardian/Parent)

_____

I, the psychotherapist, have discussed the issues above with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Signature of Psychotherapist

_____

Date

_____