Welcome to Integrity Psychological Services

Thank you for choosing to be part of the Counseling program provided by Integrity Psychological Services. Our focus is on enhancing the mental health and emotional well-being of older adults and the families who care for them, all in the comfort and privacy of your own home. This letter explains what to expect from the sessions by our Counselors.

Regular Sessions are the Key

The Counselor will do their best to work within your own current schedule of appointments and commitments to set up a good schedule for counseling sessions. Our goal is that, working within reasonable expectations, the counseling sessions will be set up on a regular weekly basis. Consistency in sessions provides the surest foundation for achieving the best results. Counseling sessions run 45-60 minutes in length.

Cancellations

If a scheduled counseling appointment needs to be cancelled, please speak to the Counselor to inform them about the situation. Every effort will be made to re-schedule a cancelled appointment when possible.

Please feel free to call our office at 888-223-6650 should you have any questions. Any one of our friendly and professional office staff will be happy to help with any concerns that may arise. Our goal is to help you find renewed enjoyment in life and greater health and emotional well-being.

Consent for Treatment and Notice of Privacy Practices Forms

The Counselor has gone over in detail the Consent for Services and Notice of Privacy Practices for the agency. Attached you will find a copy of both forms for your records.

Integrity Psychological Services

Please note: Patients have the right to treatment without discrimination as to race, age, religion, sex, national origin, socioeconomic status, sexual orientation, gender identity or expression, disability, veteran status, or source of payment. You will be treated with dignity, compassion, and respect as an individual.

Staten Island
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Consent for Treatment

Thank you for choosing to be part of the mental health counseling program provided by Integrity Psychological Services ("IPS"). Our focus is on enhancing the mental health and emotional well-being of adults and the families who care for them, all in the comfort and privacy of their own homes. This letter explains what to expect from the sessions by our Counselors. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between you and Integrity Psychological Services. Please feel free to call our office at 888-223-6650 should you have any questions.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights of which you should be aware. Your Counselor/Therapist also has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first session will involve a comprehensive evaluation of your needs. By the end of the evaluation, the Counselor will be able to offer you some initial impressions of what your work might include. You and the Counselor will begin to discuss your treatment goals and create an initial Treatment Plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with the Counselor. If you have questions about procedures, or any questions at all, you should discuss them with your Counselor 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.

Note: All Counselors working for IPS are licensed professionals. We use Licensed Clinical Social Workers (LCSW), Licensed Mental Health Counselors (LMHC), and Licensed Master Social

Workers (LMSW). If your Counselor is an LMSW, he or she is only authorized to practice clinical social work under supervision. All our LMSW Counselors are under the supervision of a PhD with whom the LMSW shares information about the diagnosis and treatment of each client. The supervisor is professionally responsible for the services provided by the LMSW. Please contact our office if you have any concerns or questions.

APPOINTMENTS

Appointments will ordinarily be 45-60 minutes in duration, once per week at an agreed upon time. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide the Counselor with 24 hours' notice. If it is possible, the Counselor will try to find another time to reschedule the appointment.

INSURANCE

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, our billing service will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting our office know if/when your coverage changes, or you will be responsible for unpaid claims. You are also responsible for any deductibles, coinsurance and copayments required by your insurance carrier.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed care plans will not allow services to be provided to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems.) Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report submitted, if you request it. By signing this Agreement, you agree that IPS can provide requested information to your carrier if you plan to pay with insurance.

PROFESSIONAL RECORDS

IPS is required to keep appropriate records of the services that are provided. Your records are maintained in a secure location in the office or, in the case of electronic health records, in password-protected encrypted files in a HIPAA-compliant document storage. The Counselor keeps brief records noting that the session took place, your reasons for seeking therapy, the goals and progress set for treatment, your diagnosis, topics discussed, your medical, social, and treatment history, records received from other providers, copies of records sent to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and /or upsetting to untrained readers. For this reason, we recommend that you initially review them with the Counselor or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right to have the decision reviewed. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

IPS policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been or will soon be provided with a copy of that document and with the Counselor you have discussed those issues. Please remember that you may reopen the conversation at any time during your work together with the Counselor.

CONSENT TO PSYCHOTHERAPY DELIVERED THROUGH TELEMENTAL HEALTH

Telemental health is the practice of delivering clinical mental health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. Below are the rights, responsibilities and protocols as it relates to telemental health:

1. You have the right to withdraw consent at any time without affecting your rights to future care, or program benefits to which you are entitled.
2. There are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. The privacy laws that protect confidentiality of protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; you raise mental/emotional health as an issue in a legal proceeding).
5. If you are having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6. During a telemental health session, there could be technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If the session cannot be restarted within ten minutes, the counselor will call you to discuss rescheduling.
7. The counselor may need to contact emergency contacts and/or appropriate authorities in the case of an emergency.

EMERGENY PROTOCOLS

You agree to provide a contact person who may be contacted on your behalf in the event of a life-threatening emergency only. This person will be contacted to go to your location or take you to the hospital in the event of an emergency.

CONSENT TO MENTAL HEALTH SERVICES

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

COPY FOR YOUR RECORDS
(NO SIGNATURE REQUIRED)

Client Name (Print)	**Client Signature**	**Date**
Legally Authorized Representative Name	**Legally Authorized Representative Signature**	**Date**

HIPAA Notice of Privacy Practices

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, we will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, we do not routinely disclose information in such circumstances, so we will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting us.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by our own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from us, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

We may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

Emergency: If you are involved in in a life-threatening emergency and we cannot ask your permission, we will share information if we believe you would have wanted me to do so, or if we believe it will be helpful to you.

Child Abuse Reporting: If we have reason to suspect that a child is abused or neglected, we are required by New York State law to report the matter immediately to the Department of Social Services.

Adult Abuse Reporting: If we have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, we are required by law to immediately make a report and provide relevant information.

Health Oversight: The New York State law requires that licensed psychologists [social workers; counselors] report misconduct by a health care provider of their own profession. By policy, we also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, we are required to explain to you how to make such a report. If you are yourself a health care provider, we are required by law to report to your licensing board that you are in treatment with me if we believe your condition places the public at risk.

Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under New York State law, and we will not release information unless you provide written authorization, or a judge issues a court order. If we receive a subpoena for records or testimony, we will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, we are required to place said records in a sealed envelope and provide them to the Clerk of Court.

Serious Threat to Health or Safety: Under New York State law, if we are engaged in my professional duties and you communicate to us a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we are legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By our own policy, we may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. If you ask us to disclose information to another party, you may request that we limit the information we disclose. However, we are not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me.

Upon your request, we will send your bills to another address. You may also request that we contact you only at work, or that we do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, we will discuss with you the details of the accounting process

Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, we may charge a fee for costs of copying and mailing. We may deny your request to inspect and copy in some circumstances. We may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

Right to Amend – If you feel that protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing, and submitted to us. In addition, you must provide a reason that supports your request. We may deny your request if you ask us to amend information that: 1) was not created by us; we will add your request to the information record; 2) is not part of the medical information kept by we; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Changes to this notice: We reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information we already have about you as well as any information we receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. We will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

STATEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Integrity Psychological Services for your mental healthcare needs. We are committed to providing you with the highest quality mental healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.

- The patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles, and all other treatment not overed by their insurance plan.
- Copays, coinsurances and deductibles are due within 30 days of billing.
- A fee may apply for returned checks or late payments.
- If the insurance plan denies coverage for any reason, the patient is responsible for any amount owed for the session.
- I authorize direct payment from my insurance to the provider (assignment of benefits).

By signing below, I understand that I am financially responsible for any and all charges not covered by my healthcare insurance for services provided by Integrity Psychological Services.

_____ _____

Signature Date

_____

Print Name

☐ **Optional Credit Card Authorization for Autopay**

I authorize Integrity Social Work Services to securely store my credit card and charge it for any patient- responsible balances not paid by the insurance, including copays, deductibles and coinsurances.

Card Type: _____Visa _____Mastercard _____AmEx _____Discover

Name on Card: _____

Card #: _____Expiration Date: _____/_____

Authorization Signature: _____ Date: _____

This autopay authorization may be revoked at any time in writing

Client Responsibility for Disclosure of Hospice, Hospitalization, Nursing Home, Rehabilitation Facility, or Change of Insurance Status

I, the undersigned patient (or legal representative), understand and agree that it is my responsibility to inform my counselor or the IPS Office at 855-812-46770, prior to receiving counseling services if I am currently:

- **On hospice**
- **Admitted to a hospital**
- **Residing in a nursing home or Rehab facility**
- **If residency is establishe outside the State of NY**
- **Change of insurance**

I acknowledge that failure to disclose this information will result in my financial responsibility for any counseling sessions that occur during the time period I am in any of the above.

By signing below, I acknowledge that I have read, understood, and agree to the terms outlined above.

Patient (or Legal Representative) Name: _____

Signature: _____ Date: _____