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INFORMED CONSENT TO TREATMENT

Welcome to Healthy Minds Therapy. This document contains important information about our professional services and business policies. Please read it carefully and let us know if you have any questions, as we our happy to discuss further. When you sign this document, it will represent an agreement between us.

24-HOUR CANCELLATION POLICY

We reserve a limited number of sessions each week so we can devote a certain amount of time and attention to each of you that is required to provide excellent service and outcomes. Therapy is most successful when sessions are regular and consistent. If you need to cancel an appointment, please contact me us soon as possible so we may reschedule. It is extremely difficult to schedule another client on short notice, which is why **we charge $50 for a missed appointment or an appointment cancelled in less than 24 hours**. If you know you will not be able to make your appointment the following week during your session, please let us know and we are happy to reschedule for you. Insurance companies will not reimburse for missed appointments.

PSYCHOTHERAPY

THE INTAKE CONSULTATION

The initial consultation will last 75 minutes, but can extend to additional sessions. During the first session, we will discuss your reasons for seeking treatment and basic background information about you. Policies, fees, and scheduling will also be discussed in this meeting. To the extent possible, we will offer you some first impressions of what our work will include. You should evaluate this information along with your own opinions to determine whether you feel comfortable working with us. Therapy involves a noteworthy commitment of time, money, and energy. You should be very thoughtful about the therapist you select. If you have questions or doubts about participating in therapy at the present time or specifically with your therapist, please talk to us about your concerns. We will be more than happy to help you set up a meeting with another mental health professional for a second opinion.

BENEFITS & RISKS

Engaging in therapy often involves discussing unpleasant aspects of your life. Therefore, you may experience uncomfortable feelings like frustration, sadness, guilt, anger, loneliness, and helplessness. On the other hand, psychotherapy may help you change your unhealthy or maladaptive thoughts and behaviors. Consequently, you may benefit by minimizing your overall distress, learning more effective problem-solving strategies, and experiencing more rewarding interpersonal relationships.

COUNSELING SESSIONS
Frequency of counseling sessions will be determined by the severity of your presenting symptoms, your treatment goals, and agreed upon treatment plan. Frequency of counseling sessions a week are based on the needs of the client, however, they are generally scheduled once a week, and may be reduced in frequency as you progress in treatment. A given hour is considered blocked for a particular client; this hour is comprised of 50 minutes of psychotherapy and 10 minutes of administrative procedures (i.e., note-taking, phone calls, insurance claim submissions).

LATENESS
If you arrive late for a scheduled appointment, only the remainder of the 50-minute session will be available. If we run late with a prior appointment for some reason, you will still receive the full 50 minutes. **If you arrive more than 15 minutes late to your scheduled appointment, without notice, it will be considered a no-show and you will be responsible for the missed appointment fee.**

INCLEMENT WEATHER AND CLOSURES
If there is inclement weather and/or if local schools are closed due to weather conditions, we will do our best to contact you via phone or email if we will not be in the office and may need to reschedule the appointment. The same protocol will apply for any personal emergencies that may arise causing us to reschedule or cancel scheduled appointments.

PSYCHOTHERAPY FEES
Our rate for the 75-minute intake session is $125. Fees for weekly services are $90 to $100 per 45 to 50 minute session.

OTHER PROFESSIONAL SERVICES & FEES
In addition to weekly appointments, we charge the same hourly rate for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include 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.

FORENSIC AND LITIGATIVE SERVICES
It is the stated philosophy of this practice that we do not participate in lawsuits of any type on a plaintiff's behalf, unless compelled to do so by subpoena or court order. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation, deposition, telephone time, transportation costs, court appearance, report writing, consultation and supervision, even if we are called to testify by another party. Because of the complexity of legal involvement, any court appearance or telephone contact with the court during a court case regarding the client or the client's family members in a civil or criminal matter will be charged at $2500.00 per day, paid two weeks in advance and non-refundable. Travel time will be billed at an hourly rate of $185.00 per hour, plus mileage portal to portal. Depositions will be charged at $175.00 per hour plus travel time, wait time, and transportation costs portal to portal.

INSURANCE
We participate and are in-network for certain insurance providers. For other insurance companies, we are considered "out-of-network" and you may receive full or partial reimbursement according to guidelines they have been established for out-of-network providers. The client (not the insurance company) is responsible for full payment of our fees. It

is very important that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administration.

BILLING AND PAYMENTS
Payment is due at the time of service. Cash, check, or credit cards are acceptable forms of payment. A credit card is required to be kept on file to hold all scheduled appointment times. **Missed sessions (including sessions cancelled within 24 hours) will be charged to the credit card on file.**

CREDIT CARD AUTHORIZATION. Your signature authorizes Healthy Minds Therapy, PLLC to charge your credit card for late cancellations, missed appointments, and outstanding balances (over 60 days):
Payment method MASTERCARD VISA AMERICAN EXPRESS DISCOVER
Credit card number_____
Print name as it appears on credit card
_____
Zip code_____ Security code_____
Expiration date _____/_____
Email address for receipts _____
Authorization signature _____
Date_____

By signing this agreement, you are confirming that you understand that it is your responsibility for full payment of my fees. Further you understand that I may submit your claims to your insurance company (ies), if applicable, for direct payment to Healthy Minds Therapy and that if your insurance company does not cover 100% of your bills for services provided that it is your responsibility for full payment of my fees, not your insurance company's. Further, you confirm that you understand that it is your responsibility to:

- Pay, at the time services are rendered, the agreed upon session fee, co-pay, co-insurance, deductible, or any other fees relating to services rendered that are denied or not fully covered by your insurance company (ies);
- Provide current mailing address and phone numbers, as well as notification when there are any changes to this information.
- Confirm with your insurance company that the therapist is a participating provider under your specific insurance plan;
- Provide appropriate and current insurance information and updates to ensure efficient billing and payment;
- Obtain all necessary referrals or authorizations required prior to treatment

ASSIGNMENT OF BENEFITS
By signing this agreement, you authorize payment of all medical insurance benefits, which are payable under the terms of your insurance policy to be paid directly to Healthy Minds Therapy, PLLC for services rendered. You further authorize the release of any information needed for the purposes of treatment, payment and health care operations, including, but not limited to the processing of these insurance claims. A copy of this authorization may be used in place of the original. **You understand that you are financially responsible for charges not paid by your insurance company.**

DELINQUENT ACCOUNTS AND COLLECTIONS
You are responsible for payment of your therapy fees, regardless of whether or not they are covered by your insurance carrier. **Outstanding balances of more than 60 days will be charged to the credit card on file.** 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, and this could affect credit. You agree to the costs of any action necessary to collect your portion of the fee due, including court and attorney fees that might accrue. You will receive appropriate notice of efforts to obtain this debt. There will be a $30 charge for the return of a check from the bank.

CONTACTING US
Because this is a limited private practice, we are often not immediately available by telephone. When we are unavailable, please leave a message on our voicemail. We monitor our voicemail frequently during the day on weekdays, and at least daily on weekends and holidays. We will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If we will be unavailable for an extended time, such as for a scheduled vacation, we will provide you with the name of a colleague to contact if necessary. Email is usually best for the quickest response. Please do not leave emergent or personal information in an email or text message, as they are not secure.

EMERGENCIES
In the event of a psychiatric emergency, and you are unable to reach us, please call a local Mental Health Hotline or CALL 911 or go to the nearest Emergency Room of your nearest hospital and ask to be evaluated by the psychologist or psychiatrist on call. After Hours Crisis Hotline 540-373-6876 and National Suicide Prevention Lifeline 1-800-273-8255. For less urgent matters or for scheduling issues, please leave a message on our voicemail or by email. Email is not a secure, confidential form of communication and should not be used for discussion of clinical issues or for urgent communications.

PROFESSIONAL RECORDS
The laws and standards of our profession require that we keep treatment records. You are entitled to receive a copy of your records unless we believe that you seeing them would be emotionally damaging, in which case we will be happy to send them to a mental health professional of your choice. Alternatively, we can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, we recommend you review them in our presence so that we can discuss the contents. Clients will be charged a fee for any professional time spent in responding to information requests. We charge a $10 processing fee to obtain a copy of your records and then an additional .10 per page.

MINORS
If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request that we will provide parents only with general information about our work together, unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of our concerns. We will also provide them with a summary of your treatment when it is complete. Before giving them any information, we will discuss the matter with you, if possible, and do our best to handle any objections you may have about it.

CONFIDENTIALITY
In general, the law protects the privacy of all communications between a client and a therapist and we can release information about our work to others only with your written permission. All aspects of your treatment are confidential, and we will need your written permission if you wish us to discuss your treatment with anyone else, including your insurance company. Even the fact that you are a client in our practice is protected by confidentiality. However, there are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a client's treatment. For example, if we believe that a child, elderly, or disabled person is being abused, we are required to file a report with the appropriate state agency. If we believe that a client is threatening serious bodily harm

to another, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself or herself, we may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection. We will make every effort to fully discuss it with you before taking any action.

In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony if he or she determines that the issues demand it. We may occasionally find it helpful to engage in professional consultation with another professional regarding some aspect of a client's treatment. During a consultation, we make every effort to avoid revealing any identifying information about my client. The consultant is also legally bound to keep the information confidential. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential issues, it is important that we discuss any questions or concerns you have. We will be happy to discuss these issues with you, but if you need formal legal advice please consult an attorney.

ENDING THERAPY
Our goal is to provide a quality service in the shortest period of time that is necessary for you to derive benefit from the therapy. You have the right to withdraw from treatment for any reason at any time. We ask that you agree to have a final session after you notify us of your voluntary termination of treatment, so that we may responsibly review and evaluate your reasons, and make recommendations related to the termination of treatment.

SEVERABILITY
If any of the provisions of the Agreement shall be held to be invalid or unenforceable, all other provisions shall nevertheless continue in full force and effect. The Agreement shall be interpreted in accordance with and controlled by the laws of the State of Virginia in effect at the time of the execution of this Agreement.

(Continue to final page for acknowledgement and signature)

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT:

_____ (Initial) I HAVE REVIEWED AND BEEN PROVIDED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT THESE POLICIES, AND I UNDERSTAND THAT I MAY ASK QUESTIONS ABOUT THEM AT ANY TIME IN THE FUTURE. I CONSENT TO ACCEPT THESE POLICIES AS A CONDITION OF RECEIVING MENTAL HEALTH SERVICES.

INFORMED CONSENT TO TREATMENT:
I HAVE READ, UNDERSTOOD, AND HAD OPPORTUNITY TO QUESTION, AND I AGREE TO THE ABOVE CONDITIONS AND POLICIES. I AGREE AND CONSENT TO PARTICIPATE IN BEHAVIORAL HEALTH CARE SERVICES OFFERED AND PROVIDED AT REYNOLDS & RUBINO PSYCHOLOGY GROUP. IF THE PATIENT IS UNDER THE AGE OF EIGHTEEN OR UNABLE TO CONSENT TO TREATMENT, I ATTEST THAT I HAVE LEGAL CUSTODY OF THIS INDIVIDUAL AND AM AUTHORIZED TO INITIATE AND CONSENT FOR TREATMENT AND/OR LEGALLY AUTHORIZED TO INITIATE AND CONSENT TO TREATMENT ON BEHALF OF THIS INDIVIDUAL. I ALSO PERMIT THE USE OF A COPY OF THIS SIGNED AUTHORIZATION IN PLACE OF THE ORIGINAL.

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Signature of Client / Legal Representative Print Name of Client / Legal Representative Date Signed

_____ _____

Client's Date of Birth Relationship to Client

_____

Signature of Therapist Print Name of Therapist Date Signed