Bowman Counseling & Consulting Services

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THERAPIST-CLIENT SERVICES AGREEMENT

This document contains important information about the professional services and business policies of Bowman Counseling & Consulting Services, Inc. ("BCCS"). It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA) with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that you be provided with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care. This Notice can be found at http://www.bowmancounseling.com/notice-of-privacy-practices. A written copy will be provided to you upon request.

The Agreement you are reading applies to you and your specific therapist and is not an agreement between you and The Indianapolis Gestalt Institute nor is it between you and any other therapist that may work for BCCS. The law requires that I obtain your signature acknowledging that you have been provided with this information. It is very important that you read these documents and we discuss any questions you have. This signed document represents an agreement between us which you may revoke in writing at any time. That revocation will be binding unless there are obligations imposed by your health insurer or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Our first few sessions will involve an evaluation of your needs, goals, and circumstances and we will discuss this evaluation. You should evaluate this information and decide if you feel comfortable working with me since therapy involves a large commitment of time, money, and energy. If you have questions about my procedures, we should discuss them whenever they arise.

THERAPY SESSIONS / MISSED APPOINTMENTS

Sessions will be scheduled at a frequency that is mutually agreed upon. ***Once an appointment is scheduled, you will be expected to pay for the full fee unless you provide 24-hours [1 day] advance notice of cancellation.*** Illnesses, accidents, and other beyond-our-control situations occur and with these events, there will be no charge for missed or cancelled appointments. ***It is important to note that insurance companies do not provide reimbursement for cancelled or missed sessions.***

EMERGENCY PROCEDURES

I am not available 24-hours or during weekends/holidays. If an emergency occurs, please dial 911 or safely proceed to the nearest emergency room. Call me and leave a message so that I know what is happening and can get in touch with you as soon as possible.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written release of information that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

1. Professional consultation with other health professionals. I will not reveal your identity and they, too, are legally bound to keep the information confidential. I will not tell you about these consultations unless it is important to our work together or if you inquire.
2. There are some situations where I am permitted or required to disclose information without either your consent or authorization. These situations include, but are not limited to, the following:
3. Court proceedings requesting information. I cannot provide it without your (or your legal representative's)

written authorization or a court order.

4. Complaints or lawsuits requiring me to defend myself.
5. If you threaten serious harm to yourself or others, I may seek hospitalization, contact family members, law enforcement or take other steps necessary to provide protection.
6. If I have reason to believe that a child or vulnerable adult has been or is likely to be subjected physical abuse, neglect, sexual exploitation abuse, the law requires that I immediately notify the Division of Child Services, Adult Protective Services, or an appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.

If one of these situations arises, I will make every effort to fully discuss my actions with you before proceeding and I will limit my disclosure to what is necessary. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required you may wish to seek formal legal advice.

PROFESSIONAL RECORDS

You should be aware that the Protected Health Information (PHI) I keep includes progress notes, your diagnosis, goals, your medical, social, and treatment history, and past treatment records. Your PHI also includes your billing records and any reports that have been sent to anyone.

Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Generally, I respond to requests for Clinical Records only with a treatment summary. If you do want to see your Clinical Records, I recommend that you review them in my presence I would conduct any review meeting with our normal fee charge. HIPAA provides you with rights to your Clinical Record and disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; and having any complaints you make, and about my policies and procedures recorded in your records.

MINORS & PARENTS

If you are under eighteen years of age, please be aware that while the specific content of our communications is confidential, your parents have a right to receive general information on the progress of the treatment. Under current Indiana law, in group and family therapy and in marital therapy all participants are required to consent to the release of information. One marital partner may not waive privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privilege or release of the record is court ordered.

PROFESSIONAL FEES

My fee for individual psychotherapy begins at $125 per hour. Longer sessions are prorated from this basic fee. The same fee applies for other professional services you may require, such as reading or writing reports, or off-site travel. My fee for group therapy varies. Contact me to discuss the appropriateness of group therapy and the cost.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENTS

Payment is due at the time services are rendered unless we make other arrangements. I "accept assignment," that is, collect co-payments and bill insurance companies for the balance due. Check with your carrier about coverage before starting therapy. I accept cash, check or credit card payment at the time of service.

You will be expected to pay for each session in full unless we agree otherwise or unless your insurance coverage requires another arrangement. An annual finance charge of 17.5% will accrue on all unpaid accounts unless specific payment arrangements have been set up between us. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment.

This may involve hiring an attorney, collections agency, and/or going through small claims court, which will involve disclosing otherwise confidential information. If such legal action is necessary, you are responsible for the costs I incur, including attorney's fees.

INSURANCE REIMBURSEMENT

Health insurance policies generally provide some coverage for mental health treatment whether I am a member of your insurance panel or an "out of network provider." I will forms or provide you with whatever assistance I can in helping you receive the benefits to which you are entitled, but you (not your insurance company) are responsible for payment of my fees. Insurance benefits are complex and it is often difficult to determine coverage. If you have questions about your insurance coverage, call your plan administrator.

If you decide to seek third-party reimbursement, I will provide your insurance company relevant information in order for them to process the claim. ***If you choose to use your insurance, then some of the potential consequences to consider is that this use and diagnosis may affect applying for health, life, or disability insurance in the future.*** I will make every effort to release only the minimum information about you that is necessary for the purpose requested. Although HIPAA provides a general framework to protect client confidentiality, there are many ways in which you relinquish many of your rights to privacy when you participate in third party reimbursement and I have no control over the information once it is released

By signing this Agreement, you agree that I can provide requested information to your carrier if you are using third party reimbursement. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above. If your therapy is self-pay you maintain maximum control over your record.

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPPA notice described above or know where to obtain it on my website.

HIPAA PRIVACY POLICY DISCUSSED AND RECEIVED IF REQUESTED:

_____ _____

Signature (Parent or Guardian if Minor) Date

_____ _____

Signature (Parent or Guardian if Minor) Date

AGREEMENT READ & UNDERSTOOD:

_____ _____

Signature (Parent or Guardian if Minor) Date

_____ _____

Signature (Parent or Guardian if Minor) Date

Charles Bowman, MS, LCSW, LMFT, LCAC

OR

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