

Mason Family Counseling

Improving Lives and Relationships

CLIENT DEMOGRAPHIC FORM

Date Last Name First Name Age Mailing Address City State Zip Cell Phone Home Phone Email Client Date of Birth Client's SSN Marital Status Gender Gender Identity

IN ORDER TO FOLLOW UP WITH YOU DURING AND AFTER SERVICES, CHECK EACH APPLICABLE BOX

Permission to use mailing address? Permission to Call Cell? Permission to Leave Message on Cell? Permission to Call Home? Permission to Leave Message on Home? Special Instructions

How would you like to pay for your sessions?

Self Pay Insurance EAP - Employee Assistance Program

Insurance Company Co Pay Insurance ID Number Insurance Group Number Insurance Mailing Address State Zip Insurance Company Phone Does your Insurance Require Pre-Authorization?

EAP Information (Employee Assistance Program)

Authorization Number if EAP Number of Session Approved for EAP EAP Company EAP Start Date EAP Stop Stop Date

Benefit Holder

Guarantor Information

| | |
|--|--|
| Name of Benefit Holder <input type="text"/> | Name of Guarantor <input type="text"/> |
| Date of Birth <input type="text"/> | Guarantor DOB <input type="text"/> |
| Benefit Holder SS# <input type="text"/> | Guarantor Address <input type="text"/> |
| Benefits Holders Relationship to Client <input type="text"/> | City, State Zip: <input type="text"/> |

Who Referred you?

PERMISSION TO TREAT/FEE AGREEMENT

THIS CONSENT TO TREAT/FEE AGREEMENT dated below BETWEEN: [] (Responsible Party) AND Laura Vail Sage, Inc, DBA: Mason Family Counseling, 5134 Cedar Village Dr, Mason, OH 45040.

BACKGROUND:

The Responsible Party (RP) is of the opinion that the Service Provider has the necessary qualifications, experience and abilities to provide services in connection with the Client and hereby gives permission to treat same Client (If not RP _____)

The Service Provider is agreeable to providing such services to the Client, on the terms and conditions as set out in this Agreement.

IN CONSIDERATION OF the matters described above and of the mutual benefits and obligations set forth in this Agreement, the receipt and sufficiency of which consideration is hereby acknowledged, the parties to this Agreement agree as follows:

Engagement: The Client hereby agrees to engage the Service Provider to provide the Client with services consisting of Individual, Group or Family Counseling/Therapy, and such other services as the Client and the Service Provider may agree upon from time to time.

Term of Agreement: The term of this Agreement will begin on the date of this Agreement and will remain in full force and effect until completion of the Services.

Performance: Both parties agree to do everything necessary to ensure that the terms of this Agreement take effect.

Compensation: Co-payments are due at the beginning of each session. A five dollar service charge is added to the account for each session where the co-pay is not paid at time of service. Denied insurance claims are due 10 days after date on client bill.

Late Penalties: The following penalties will be imposed on the RP for failing to pay the Service Provider in a timely fashion. A service fee of 2% of the balance per month will be charged for unpaid charges over 60 days old.

No Show/Late Cancellation Penalties: The appointment time is reserved for the client only. Therefore a charge will be imposed if the client fails to show for a scheduled appointment or does not cancel 24 hours in advance. The charge for the first time is \$40.00. Late cancellations for emergencies can be discussed.

Other Expenses: The Service Provider will be reimbursed for the following expenses incurred by the Service Provider in connection with providing the Services: Paperwork completed outside of session: \$25.00 per 15 minute increment including Written Report for any purpose, Returned Checks: \$25.00 per occurrence. Phone calls over 2 minutes: \$25.00 per fifteen minute increments (Note: phone sessions are not usually covered by your insurance). Court Appearance or Conferences with 3rd parties will be charged at \$150 – \$180 per hour (mileage will not be charged if under 50 miles and hourly billing will begin at the time the provider leaves the office. If mileage is charged it will be at the Federal reimbursement rate).

Confidentiality: The Service Provider acknowledges that a material term of the Agreement with the Client is to keep confidential information belonging to the Client confidential and protect its release to the public. The Service Provider agrees not to divulge, reveal, report or use, for any purpose, any confidential information which the Service Provider has obtained or which was disclosed to the Service Provider by the Client or RP, except as outlined in a., b., or c., below. The obligation to protect the confidentiality of the Client's confidential information will survive the termination of this Agreement and will continue indefinitely.

The Service Provider may disclose the minimum necessary confidential information:

- 1.a. To a third party insurance provider where the Client or RP presents an insurance card/company as a reimbursement source.
1.b. To the extent required by law or by the request or requirement of any judicial, legislative, administrative or other governmental body. However, the Service Provider will first give notice to the Client or RP of any possible or prospective order (or proceeding pursuant to which any order may result), and the Client or RP will have been afforded a reasonable opportunity to prevent or limit any disclosure.
1.c. In the event Client or RP accounts have gone unpaid for 90 days, the Service Provider may release a copy of this agreement, Client or RP contact information and a copy(s) of any billing sent to the client to a third party collection service. No other confidential information will be released.

Modification of Agreement: Any amendment or modification of this Agreement or additional obligation assumed by either party in connection with this Agreement will only be binding if evidenced in writing signed by each party or an authorized representative of each party.

Governing Law: It is the intention of the parties to this Agreement that this Agreement and the performance under this Agreement, and all suits and special proceedings under this Agreement, be construed in accordance with and governed, to the exclusion of the law of any other forum, by the laws of the State of Ohio, without regard to the jurisdiction in which any action or special proceeding may be instituted.

BY THE CLIENT/PARENT/GUARDIAN SIGNATURE BELOW, the client/parent/guardian has duly executed this Fee Agreement/Consent to treat with Laura Vail Sage, Inc.

Client/Parent/Guardian Signature _____

Date _____

Consent to Treat Minor

Mason Family Counseling

I, custodial parent/legal guardian of

, age ,

authorize

to assess and treat my child in this outpatient counseling setting.

I agree to take part in the counseling process as needed, and understand the format of counseling may include any combination of the following: Individual sessions, with minor child, family sessions, and sessions with the parental unit.

Parent #1/Guardian's

Signature _____ Date _____

Relationship _____

Parent #2/Guardian's

Signature _____ Date _____

Relationship _____

(I like to get both parents signatures when it is possible).

Signature of Counselor _____ Date _____

Children under 18 years of age under Ohio law generally have no right to confidentiality where their parent(s)/legal guardian(s) are involved, with the exception, that minors 14 years of age or older may receive certain limited outpatient services without the information being disclosed to the parent(s) or guardian(s) under most circumstances. Other than that specific exception, both parent(s)/legal guardian(s) generally have a right to obtain all information on their minor children, unless specifically blocked from access by a court order.

***Signature of Minor Child/Acknowledging he or she has read the above statement:

_____ Date _____

Client Symptom Self Evaluation

Completed by Client

*Information Remains **Strictly Confidential***

Name

Date

WHAT CONCERNS DO YOU HAVE?

Symptoms (please mark all that apply):

| Emotional: | | Physical: |
|---|---|--|
| <input type="checkbox"/> Feeling of extreme happiness | <input type="checkbox"/> Lack of enjoyment of usual activities | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Feeling of extreme sadness | <input type="checkbox"/> Increased use of alcohol/drugs | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Feeling stressed | <input type="checkbox"/> Avoiding things | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Feeling nervous or anxious | <input type="checkbox"/> Trouble performing your job | <input type="checkbox"/> Chronic weakness |
| <input type="checkbox"/> Feeling fearful | <input type="checkbox"/> Poor interpersonal skills | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Feeling worried | <input type="checkbox"/> Reckless behavior | <input type="checkbox"/> Muscle tension/aches |
| <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Not getting along with friends/family | <input type="checkbox"/> Sweating/Clammy hands |
| <input type="checkbox"/> Easily irritated | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Nerve problems |
| <input type="checkbox"/> Paranoid thoughts | <input type="checkbox"/> Fear of situations where escape is difficult | <input type="checkbox"/> Trembling/twitching |
| <input type="checkbox"/> Self-esteem problem | <input type="checkbox"/> Obsessions or compulsions | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Feeling guilty | <input type="checkbox"/> Thoughts of hurting yourself | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Sudden feeling of panic | <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Thoughts of killing yourself | <input type="checkbox"/> Stomach or bowel problem |
| <input type="checkbox"/> Change of sleeping habits | <input type="checkbox"/> Thoughts of killing others | <input type="checkbox"/> Weight changes |
| <input type="checkbox"/> Procrastination | <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Change in eating habits |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Acting violently | <input type="checkbox"/> Self-starvation |
| <input type="checkbox"/> Problems with anger | <input type="checkbox"/> Intrusive thoughts | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Exaggerated startle response | | <input type="checkbox"/> Shortness of breath |
| | | <input type="checkbox"/> Heart symptoms |
| | | <input type="checkbox"/> Trouble swallowing |
| | | <input type="checkbox"/> Change in sexual interest |

HOW LONG HAVE YOU HAD THE SYMPTOMS CHECKED ABOVE? (APPROXIMATE DATE SYMPTOMS BEGAN)

ANY DETERIORATION IN JOB / SCHOOL PERFORMANCE DUE TO THE PROBLEM?

| | | |
|---|--|--|
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Absences Monday/Friday's | <input type="checkbox"/> Tardiness |
| <input type="checkbox"/> Decrease in Productivity | <input type="checkbox"/> Erratic Behavior | <input type="checkbox"/> Conflict with supervisors |
| <input type="checkbox"/> Discipline | <input type="checkbox"/> Conflicts with fellow employees | <input type="checkbox"/> None |

CONSEQUENCES OF DETERIORATING PERFORMANCE ON WORK OR SCHOOL:

On a Scale of 1-5, how would you rate your distress? (1 is low, 5 is severe distress)

Medical Condition You Have: (If yes check)

| | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Blood Problems | <input type="checkbox"/> Bone/Joint Problems | <input type="checkbox"/> Brain Problems |
| <input type="checkbox"/> Skin/Hair/Nail Problems | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Respiratory Problems (Breathing |
| <input type="checkbox"/> Genital | <input type="checkbox"/> Kidney/Bladder | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eyes | <input type="checkbox"/> Autoimmune |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Head Injury |

Other health problems not listed above:

Sleep Problems:

Appetite Problems:

Past Health Problems (include difficulties with developmental milestones under age 18)

Medication currently using: If NONE, type your initials here

| Medication | Dosage | Time Taken | Prescribing Doctor | Reason Prescribing |
|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Medication Allergies: If **NONE**, type initials here

If yes what:

PAST TREATMENT INTERVENTIONS:

| Date | Medical & Surgical | Provider/Program/Hospital |
|----------------------|----------------------|---------------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date | Psychiatric | Provider/Program/Hospital |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date | Chemical Dependency | Provider/Program/Hospital |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

Medical Conditions that Run in Your Family: (If yes check)

| | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Blood Problems | <input type="checkbox"/> Bone/Joint Problems | <input type="checkbox"/> Brain Problems |
| <input type="checkbox"/> Skin/Hair/Nail Problems | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Respiratory Problems (Breathing |
| <input type="checkbox"/> Genital | <input type="checkbox"/> Kidney/Bladder | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eyes | <input type="checkbox"/> Autoimmune |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Gastrointestinal | <input type="text"/> |

RELATIONSHIP HISTORY: (List all marriages & divorces and/or lived together relationships)

| Partner's First Name | Relationship Type | Length of Relationship | Reason Relationship Ended |
|----------------------|-------------------|------------------------|---------------------------|
| | | | |
| | | | |
| | | | |

WORK HISTORY: (Start with most recent)

| Place | Position | From | To | Reason Ended |
|-------|----------|------|----|--------------|
| | | | | |
| | | | | |
| | | | | |

PERSONAL & FAMILY HISTORY:

| | | |
|---|--|------------------------------|
| Were you or any family member physically abused? | <input type="radio"/> Yes <input type="radio"/> No | If Yes: <input type="text"/> |
| Were you or any family member sexually abused? | <input type="radio"/> Yes <input type="radio"/> No | If Yes: <input type="text"/> |
| Were you or any family member emotionally abused? | <input type="radio"/> Yes <input type="radio"/> No | If Yes: <input type="text"/> |
| Have you or any family member had a problem with drugs or alcohol? | <input type="radio"/> Yes <input type="radio"/> No | If Yes: <input type="text"/> |
| Have you or any family member ever tried to commit suicide? | <input type="radio"/> Yes <input type="radio"/> No | If Yes: <input type="text"/> |
| Is there any history of anxiety, depression or mental illness in your family? | <input type="radio"/> Yes <input type="radio"/> No | If Yes: <input type="text"/> |

Additional Comments:

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization, such as your primary care physician.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility of coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training and teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required or allowed by law, such as, included, but are not necessarily limited to: the reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department), or abuse involving the elderly or the developmentally disabled/mentally retarded.
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, or to other persons as permitted by law, including you.

Registration Information
OFFICE POLICY

1. Your appointment time is reserved for you; I do not double book appointments. Therefore, I have to charge if you fail to show for that appointment or do not cancel twenty-four hours in advance. The charge is \$30.00 the first time, \$60.00 the second time and \$90.00 thereafter. Late cancellations for emergencies can be discussed.
2. Please bring all paperwork including insurance authorizations to my attention at the beginning of your session. I may not be able to complete this work if given to me at the end of a session and the charge for paperwork outside of sessions is \$25.00 per 15 minutes. I prefer that all such work be done in your session so that you are fully aware and participate in what is written.
3. Sessions are 45 minutes long except for the first session, which may be a bit longer. Please help me monitor the time so that I do not keep you or another client waiting.
4. Your insurance company may require that you have your sessions authorized prior to being seen for the first time. You will need to check for and obtain initial authorizations and then help me track the number of sessions allowed or you may be responsible for payment.
5. If you need to have a report written by me for any purpose a charge of \$100.00 per hour, pro-rated to the time your report takes, will be charged and is not reimbursable by insurance. This fee must be paid before the report can be released to you or to any other party.
6. I have a twenty-four hour message service. If you leave a message for me, I am notified shortly of your call. If you are in an emergency situation and do not hear from me immediately then you must call the 24 hour crisis hotline at 281-2273, your primary care physician, your insurance company, or go to the emergency room so that you are safe and can receive the care you need.
7. Termination of treatment: if you miss three scheduled appointments in a row or are not seen for more than three months, then you will no longer be considered an "active" client in my practice. For legal purposes this policy must be defined. If you wish to return for treatment, simply call me and your case will become active again at the time of your first appointment. Please remember to check your insurance authorization needs prior to your first appointment.
8. Please inform me immediately of any change in insurance coverage, personal address or phone numbers as well as employment changes. Failure to update information regarding insurance coverage could result in your sessions not being reimbursed by your insurance company and you would be responsible for the charges. Please make your co-payment by cash or check at each session. There is a \$25.00 charge for any returned checks.
9. Phone calls are welcome but those lasting over 2 minutes may be charged for at a rate of \$25.00 per quarter hour (15 minutes). Please be aware that your insurance may not pay for phone therapy.
10. If after termination of therapy, you have a balance due and have not begun paying on it within 30 days, the account will be charged a service fee of 2% of the balance per month. If regular payment is not occurring, your account may be turned over to collection.

CLIENT RIGHTS

- Clients have the right to be treated with dignity and respect.
- Clients have the right to impartial services and access to treatment, regardless of race, religion, gender, ethnicity, age, disability or source of payment.
- Clients will be assured that all information is kept confidential.
- Information will not be released without their prior consent, except in an emergency, or as required by law.
- Clients have the right to be treated by staff/providers who communicate, or arrange for communication in a language and format they understand.
- Clients have the right to be provided with a complete, easily understood explanation of their condition and treatment.
- Clients have the right to be informed of all treatment options regardless of the cost of benefit coverage.
- Clients have the right to receive information about services and their role in the treatment process.
- Clients have the right to receive information on availability of providers and the clinical guidelines used in providing and/or managing their care.
- Clients have the right to provide input on policies, services and their rights and responsibilities offered by their insurance company(s).
- Clients will be informed of the complaint, grievance and appeal processes should a dispute arise over treatment and/or claims.
- Clients will be afforded all of his/her rights and privileges guaranteed by state and federal laws.
- Clients have the right to be informed of their rights and responsibilities in the treatment process.
- Clients have the right to participate with providers in decision-making regarding their treatment planning.

Limitation in rights:

The main limitation is in the area of confidentiality. In the following situations, confidentiality does not apply:

- (1) An order by the Court, (2) in the case of suspected child, elder or domestic abuse, and (3) for you own welfare (suicide) or that of others (homicide) in serious and imminent life-threatening situations.

For those clients using their insurance to pay for therapy, a consultation with your attending/primary care physician and your insurance company may be needed. Disclosure of your diagnosis, review of your treatment sessions and a review of your treatment plan may be required to access your insurance benefits. You may chose not to authorize the release of this information, however this may prevent you from using your insurance benefits. ***Your signature below indicates your willingness to disclose the needed information to your insurance company so that you may use these benefits.***

THE PROCESS OF COUNSELING/THERAPY:

- 1. Possible benefits derived from therapy include:
 - 1.a. Better ways to deal with social, familial and occupational relationships.
 - 1.b. Better personal adjustment and contentment.
 - 1.c. Better ability to cope with problems and stress.
 - 1.d. Better productivity.
- 2. It is important to note that professional ethic do not permit a guarantee that you will receive these benefits. It is believed that a better life is possible for most people and that an individual’s investment and commitment in therapy can determine the outcome.
- 3. Therapy may also involve some feelings of discomfort. These feelings can occur when you begin to work on changing your beliefs and/or behaviors. This discomfort is viewed as a stepping-stone to a more effective and satisfying life.

I fully understand the above agreement and I freely agree to the above conditions:

Client Signature

Date

My Clinician conforms to the Counselor and Social Worker Board or Psychology Board that regulates the practice of professional counseling and therapy and requires this information be given to clients.

| | |
|---|--|
| State of Ohio Counselor & Social Work Board | Ohio Chemical Dependency Professionals Board |
| 50 W. Broad St. Suite 1075 | Huntington Plaza 37 W. Broad Street, Suite 785 |
| Columbus, OH 43215-5919 | Columbus, Ohio 43215 |
| Phone 614-466-6462 | Phone (614) 387-1110 Fax (614) 387-1109 |

State Board of Psychology
 Vern Riffe Center for Government and the Arts
 77 S. High Street Suite 1830
 Columbus, OH 43215-6108

Phone (614) 466-8808 | fax (614) 728-7081

“Good Faith Estimate”

This form is required only for “Self-Pay” clients i.e., clients not using insurance.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a “Good Faith Estimate” of expected charges.

Mason Family Counseling

5134 Cedar Village Dr. Mason, OH 45040

Contact Person: Laura Sage

Phone: 513-229-7900

Email: Office@MasonFamilyCounseling.com

National Provider Identifier: 1699758250

Taxpayer Identification Number: 043604776

Details of Services

| Service | Diagnosis Code | Service Code | Quantity (Sessions) ** | Cost Per Session ** | Expected Cost * |
|------------------------------|----------------|--------------|------------------------|---------------------|---------------------|
| Initial Session | TBD | 90791 | 1 | \$100.00 | \$100.00 |
| Families/Couples/Marital *** | TBD | 90847 | 6 - 8 | \$80.00 | \$580.00 - \$740.00 |
| Individual Sessions | TBD | 90834 | 6 - 8 | \$75.00 | \$550.00 - \$700.00 |

*Total expected cost is the cost of the initial session and follow up sessions combined.

**In person and telehealth services are the same rate.

***You may not require Family/Couples/marital sessions.

Additional Health Care Provider/Facility Notes:

- Diagnosis Code and Service Code will be determined after the first two sessions.
- The number of sessions is not known at this time. The number of sessions for this Good Faith Estimate is 6-8 as that is the “average” number of sessions our clients utilize for treatment. The number of sessions will be determined by the client and therapist and whether they decide to continue with additional counseling.
- The cost for medication is not included in the Good Faith Estimate as Mason Family Counseling does not provide medication.

Disclaimers:

2. There may be additional services your provider may recommend as part of the course of care and are not reflected in the good faith estimate.
3. The information in this good faith estimate is only an estimate and that actual services or charges may differ from the good faith estimate.
4. You have the right to initiate a patient-provider dispute resolution process if the actual billed charges substantially exceed the expected charges included in the good faith estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises. Your dispute will not adversely affect the quality of health care services furnished to you.
5. This good faith estimate is not a contract and does not require you to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

Type or sign your name in the box below to acknowledge receipt of this Good Faith Estimate:

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises

****Informed Consent For Distance Therapy**

I hereby consent to engaging in telemedicine with Laura Vail Sage, Inc as part of my psychotherapy. I understand that “telemedicine” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to a health care practitioner located in Ohio or outside of Ohio.

I understand that I have the following rights with respect to telemedicine:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

3. I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services have certain benefits and limitations. Care may not be as complete as face-to-face service if using chat or email. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

4. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
5. I understand that I have a right to access my medical information and copies of medical records in accordance with Ohio law. However, Laura Vail Sage, Inc is the legal owner of all written or recorded information. If I have a life threatening clinical emergency I will dial 911 immediately or go to my nearest emergency room. If my crisis is not life threatening and my psychotherapist is unavailable I will contact: <http://www.befrienders.org/> or the National Suicide Hotline at 800-784-2433 for assistance.

If for some reason there is a technology problem and our session does not start on-time or is interrupted I will use an alternative contact given to me by my psychotherapist.

I understand that the time I have scheduled with my psychotherapist is reserved only for me and in compensation for the exclusive reservation of the psychotherapist’s professional time; I will pay in advance for our session and will not obtain a refund if I fail to be available at the appointed time without 24 hours prior notice.

My signature below indicates that I have read and understood the information provided above.

Signature: _____

Name

Date

*****This notice must be signed and received by my clinician, prior to the commencement of treatment.***