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 Progran**

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	Name of Guarantor
Date of Birth	Guarantor DOB
Benefit Holder SS#	Guarantor Address
Benefits Holders Relationship to Client	City, State Zip:

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**

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

☐ Attendance	☐ Absences Monday/Friday's	☐ Tardiness
☐ Decrease in Productivifity	☐ Erratic Behavior	☐ Conflict with supervisors
☐ Discipline	☐ Conflicts with fellow employees	☐ None

CONSEQUENCES OF DETERIORATING PERFORMANCE ON WORK OR SCHOOL:

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

Medical Condition You Have: (If yes check)

☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease
☐ Blood Problems	☐ Bone/Joint Problems	☐ Brain Problems
☐ Skin/Hair/Nail Problems	☐ Liver Disease	☐ Respiratory Problems (Breathing
☐ Genital	☐ Kidney/Bladder	☐ Cancer
☐ Allergies	☐ Eyes	☐ Autoimmune
☐ Chronic Pain	☐ Gastrointestinal	☐ 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

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

If yes what:

PAST TREATMENT INTERVENTIONS:

Date	**Medical & Surgical**	**Provider/Program/Hospital**
Date	**Psychiatric**	**Provider/Program/Hospital**
Date	**Chemical Dependency**	**Provider/Program/Hospital**

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

☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease
☐ Blood Problems	☐ Bone/Joint Problems	☐ Brain Problems
☐ Skin/Hair/Nail Problems	☐ Liver Disease	☐ Respiratory Problems (Breathing
☐ Genital	☐ Kidney/Bladder	☐ Cancer
☐ Alleriges	☐ Eyes	☐ Autoimmune
☐ Chronic pian	☐ Gastrointestinal	

HEALTH HABITS INFORMATION:
For the following questions please base your answers on **the past month** (approximately).

- ☐ Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?
- ☐ Have you been dieting to lose weight?
- ☐ Have you been dieting to lose weight?
- ☐ Have you experienced any increased feelings of sadness or hopelessness?
- ☐ Have you felt more anxious or worried than usual?

How often in the past month did you drink alcohol?:

For the **past month**, please fill in a number for each day of the week indicating the **typical number of alcohol drinks** you usually consume on that day.

Day of Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Number of drinks:							

- ☐ In the past year have you used any illicit or non-prescription drugs?
- ☐ During the past month have you participated in leisure/social/spiritual activities?

Have you ever had a DUI?

Yes: Details:

- ☐ In the past year, have you ever drunk or used drugs more than you meant to?
- ☐ In the past year have you spent more time drinking or using than you intended to?
- ☐ Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?
- ☐ as anyone objected to your drinking or drug use?
- ☐ Have you ever found yourself preoccupied with wanting to use alcohol or drugs?
- ☐ Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?

FAMILY RELATIONSHIPS (Members of the family you are/were close to)

Name	Relationship	Age (or Year of Death)	Quality of Relationship: Excellent, Good, Fair, Bad	Lives with you:

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?	◯ Yes ◯ No	If Yes:
Were you or any family member sexually abused?	◯ Yes ◯ No	If Yes:
Were you or any family member emotionally abused?	◯ Yes ◯ No	If Yes:
Have you or any family member had a problem with drugs or alcohol?	◯ Yes ◯ No	If Yes:
Have you or any family member ever tried to commit suicide?	◯ Yes ◯ No	If Yes:
Is there any history of anxiety, depression or mental illness in your family?	◯ Yes ◯ No	If Yes:

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 disclosed PHI to any other consultant only with your authorization, such as your primary care physician.**

For Payment. **We may use and disclosed 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.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked, unless we have already relied on it.

Your Rights Regarding Your PHI
You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Laura Vail Sage, LISW – 5134 Cedar Village Drive, Mason, OH 45040.

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although e are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have a right to a copy of this notice.

Complaints
If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Laura Vail Sage, LISW, at 5134 Cedar Village Drive, Mason, OH 45040 or with Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601. Voice Phone (312)886-2359; Fax (312) 886-1807; TDD (312) 353-5693.

We will not retaliate against you for filing a complaint.

The effective date of this notice is November 20, 2005.

Mason Family Counseling
5134 Cedar Village Drive
Mason, OH 45040
Phone (513)229-7900
Fax (513)229-0202

NOTICE OF PRIVACY PRACTICES

Mason Family Counseling

I, _____ (Print your name)
hereby acknowledge that I have received the Notice of Privacy Practices from Mason Family Counseling.

_____ _____
Signature of Client or Client's Guardian Date

If client and/or guardian refuse to sign, please note this here:

_____ _____
Counselor Signature Date

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 you 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
50 W. Broad St. Suite 1075
Columbus, OH 43215-5919

Phone 614-466-6462

Ohio Chemical Dependency Professionals Board
Huntington Plaza37 W. Broad Street, Suite 785
Columbus, Ohio 43215

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.***