

**Intake/Demographics Form**

**Client Information:** (Please Print)

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

 (Last) (First) (MI) (DOB)

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

 (Street Address/P.O. Box) (Apt #)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (City) (State) (Zip Code)

Cell Phone #: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ Other Phone #: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

Sex: [ ]  Male [ ]  Female [ ]  Identify as Other Social Security #: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

Marital Status: [ ]  Single [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Widowed [ ]  Partner

Name of Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Mental Health Treatment (Check all that apply): [ ]  Psychiatrist [ ]  Psychologist [ ]  LCSW [ ]  LPC [ ]  Other

Briefly describe who saw you, what treatment was for, and what parts you found helpful:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Provider Contact # (Optional): \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Past Provider Contact # (Optional): \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Employment: [ ]  Full-Time [ ]  Part-Time [ ]  Unemployed [ ]  Retired [ ]  FT Student [ ]  PT Student

Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (First) (Last) (MD, DO, Other)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

 (Street Address) (Suite #)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (City) (State) (Zip Code)

Phone: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ Consent to Discuss Care w/ PCP: [ ]  Yes [ ]  No Initial: \_\_\_\_\_\_



**Insurance Information/Authorization to Bill Insurance**

**Insurance Information:**

Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid # (If Applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claims Phone #: (Reverse of Card): \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

 (Last) (First) (MI) (DOB)

Social Security #: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Phone #: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Client Relationship to Insured: [ ]  Self [ ]  Spouse [ ]  Child [ ]  Other

Person Responsible for the Account: [ ]  Client [ ]  Parent [ ]  Other

Name: (if not client) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

 (Last) (First) (MI)

Secondary Insurance Company: (If Applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid # (If Applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claims Phone #: (Reverse of Card): \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_

Name of Primary Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

 (Last) (First) (MI) (DOB)

**Authorization to Bill Insurance: (Signed by Client and Primary Insurance Holder (if different than client.)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Derik S. Berkebile, LCSW Outpatient Counseling Services and its employees to submit claims to my insurance on my behalf. I authorize the release of medical or other information needed to process these claims. I attest that the above information is true and correct to the best of my knowledge.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_



334 Budfield St., Suite 152

Johnstown, PA 15904

(814)254-4588 dberkebilelcsw@outlook.com

**Outpatient Therapy Services Contract**

**& Informed Consent**

**Introduction**

 Thank you for your interest in utilizing our practice to assist you in meeting your mental health needs! The following information is designed to make sure you fully understand your rights in therapy, the policies in place regarding this practice, billing procedures, treatment protocols, etc. You will be offered a copy of this contract upon request. There is also a frequently updated version on my website at [www.dsbcounseling.com](http://www.dsbcounseling.com) to review at any time. It is your decision whether to sign this form until you arrive at your intake appointment. You can print and bring the forms here or we can print them at the time of intake. During the course of treatment, you may refer back to this form or ask your therapist in person if there is anything you are uncertain about.

**Therapeutic Services**

**General Information About Therapy:** Therapy is not easily described in any “one size fits all” description. There are numerous factors to how therapy will work based on the therapist’s training and personality traits as well as with what each individual client is dealing with and the coping skills (both negative and positive) that have developed over time. Our therapists are well versed in several treatment methods but it does sometimes require time and patience to find the right fit for a client. Unlike going to a doctor’s appointment, psychotherapy requires a great deal of effort on the part of the client. We will often ask for you to be doing your own therapeutic work in between scheduled sessions.

 Many clients have reported coming to therapy to have the therapist tell them what to do and to “fix” their problems. Not only is telling you what to do counterproductive to empowering clients, it also has the potential to create a rift between the therapist and client if we provide direct instruction and it fails. The goal in therapy should always be to develop the tools necessary for client to resolve their own problems.

 During treatment, we will attempt to establish a therapeutic relationship. The therapist will work to establish total confidence and complete trust so that the client does not feel there is anything to hide. This is the path to long lasting healing from whatever has occurred to cause you to seek out help. Therapy often entails exploring parts of you that have been repressed or unexplored due to the painful emotions they cause. It is not uncommon for symptoms to worsen during this time because old, counterproductive coping patterns are being removed. Research has shown, however, that when people stick to psychotherapy and make it a priority in their lives, they often report drastically reduced symptoms. In psychotherapy, as with all things in life, there are no guarantees. As always, if you would ever be unsatisfied with our services, you have the right to request seeing another mental health professional and we will do our best to refer you to someone if you desire. Therapy is a very serious undertaking and if there is no connection with your current therapist, you owe it to yourself to seek help elsewhere.

**What to Expect:** In the first session, we will be reviewing the forms you have completed in advance and will also review the consent portion. Your therapist will address any questions you have up front. You will sign in at every session you attend. If the intake forms have not been completed, we will ask you to complete them as the therapist begins collecting information from you about why you are seeking therapy services. Gathering this information and enrolling you in the electronic health record (EHR) will likely conclude session one. As a reminder, please remember to bring your insurance card with you to your intake appointment. In session two, your therapist will work with you to begin the formation of a treatment plan based on the information you have provided the them. This may, or may not, be completed in session two. Ultimately, once the treatment plan is in place, we will then begin routine therapy sessions.

 We typically start clients at weekly sessions but this can be modified based on possible financial constraints, session availability, work requirements, transportation needs, etc. The minimum we will see clients is on a monthly basis. The goal will be to monitor improvement and gradually scale back treatment from weekly, to bi-weekly, to monthly. If progress has continued or goals have been maintained, we will then look to discharge. When clients discharge, you will be asked to do a general review of treatment and reinforce those interventions that worked well and will be provided contact information for the future if needed. Of course, you have the right to terminate therapy at any time and are not required to follow this plan if you so choose, however, we would like the opportunity to discuss termination with you for feedback on how to improve the practice. We will utilize therapeutic homework as well and will assign these to you as stated in the treatment plan. The expectation is that these are completed between sessions and brought with you for review.

**Treatment Models:** Our predominant model of choice for psychotherapy is called cognitive-behavioral therapy (CBT). You may feel free to research this model in advance to assure that you feel it will be helpful. Research has shown it to be one of the most effective models in psychotherapy, hence the reason many practitioners are using it. Our staff are also supervised in the use of mindfulness-based treatment, systems-based interventions, interpersonal therapy, and Dialectical Behavioral Therapy (DBT). If you have any questions about these models, you may feel free to ask your therapist at intake.

**Finances/Billing**

**Session Fees:** In most cases, insurance is available to cover some, if not all, of the expense for therapy. However, any charges for services received are ultimately **YOUR** responsibility. If you receive charges that you believe are not correct, you must contact either your insurance company or the business owner for assistance. **Employed therapists will not be able to assist with billing issues.** Until claims are processed and payment received, you will be held responsible for any outstanding balances. Below is a breakdown of fees for different therapeutic services rendered:

|  |  |
| --- | --- |
| Psychotherapy Intake | $170.00 |
| Psychotherapy: 53-60 Minutes | $160.00 |
| Psychotherapy: 37-52 Minutes | $130.00 |
| Family Psychotherapy w/ Patient Present | $120.00 |
| Family Psychotherapy w/o Patient Present | $128.00 |
| Group Psychotherapy | $40.00 |

**Sliding Scale Fees:** For those who do not have insurance or the practice is not “in-network” with the insurance, there is a sliding scale fee schedule based on either an unmarried individual’s net income or a married couple’s joint net income. The formula is to take what you clear annually x 2% to figure out the session fee. This bottoms at $70.00 per session and caps at the above private pay amounts. These amounts will need verified via a completed tax return from the prior year or the final pay stub of the prior year.

**Cancellation Policy and Fees:** Unfortunately, we do not receive compensation for sessions that clients cancel. Once you have been given an appointment slot it becomes very difficult to fill that slot without proper notice. Therefore, it is the practice policy to charge a $40.00 cancellation fee for no-shows or those not providing 24 hr. notice prior to your scheduled appointment. This fee is NOT covered by insurance and will typically be deducted from the card on file at fifteen minutes past your scheduled appointment time. Our electronic medical record software automatically generates appointment reminders sent to your e-mail to help you remember when your appointments are.

 There are exceptions to these policies; if there is inclimate weather and it would pose an undue risk to come to therapy (which the practice will determine) and if the client (and/or family member) is ill. In the case of illness, we request an excuse from a physician stating only that you were there the day of session. If these circumstances are met all cancellation fees will be waived. We cannot bill no-show or cancellation fees to Medicare or Medical Assistance clients but we will strictly enforce the cancellation policy on termination, the same as all other clients.

There are separate fees associated with non-therapeutic services that we provide as well. The following is a breakdown of charges for these ancillary services:

|  |  |
| --- | --- |
| Letters of Attestation, Treatment Summaries, Preparing Release of Records to Another Professional | $100.00/hr. prorated for < 1 hr. |
| Telephone Conversations < 30 mins. | $25.00 Flat Rate |
| Meetings with Other Professionals/Consultation | $100.00/hr. prorated for < 1 hr. Includes Drive Time |
| Legal Preparation, Litigation, Court Appearances, Expert Testimony | $250.00/hr. prorated for < 1 hr. Includes Drive Time, Preparation Time |
| Copies of Records | Paper = $0.50/page Digital = $50.00 plus you provide storage device |
| Returned Check/Insufficient Funds Fee | $50.00 |
| Cancellation/No-Show Fee | $40.00 |

**\*\*NONE OF THE ANCILLARY SERVICES LISTED ABOVE OR OTHERWISE WILL BE PROVIDED IF THERE IS AN OUTSTANDING BALANCE ON YOUR ACCOUNT\*\***

**Court Involvement:**

As you can see, bringing our staff to court can be quite costly. Also, we will report on exactly what our professional opinion is on all topics questioned with complete honesty. Knowing this, our testimony could be more detrimental than helpful to your cause depending on the circumstances. You do have the right to consult with your therapist about this before legal counsel would issue a subpoena.

**Due to the difficult nature of how confidentiality laws are determined in court-ordered treatment and in custody cases, we will no longer be seeing these clients.**

**Methods of Payment:** In many cases, insurances may require a co-pay. Co-pays will be collected at the beginning of each session. The practice reserves the right to refuse treating a client when they have a remaining balance or do not pay their co-pay. Any other, non-therapy fees are also due at the beginning of the next session attended. We can accept cash, check, money order, debit/credit cards, and HSA/FSA cards. All private pay clients will also need to pay the full session fee prior to starting sessions. Before performing any ancillary services, we will be sure to inform you of prices.

 For deductible and coinsurance payments we must first submit the claim to the insurance and they will let me know if you are in deductible or have a coinsurance. If so, you will receive a monthly invoice sent out at the end of each month. These fees will need to be paid at the beginning of the next session after the invoice was mailed. The owner, Derik Berkebile, handles billing for the practice and can often answer questions you may have but it is suggested that clients start with their insurance company first.

The practice does the billing and invoicing at the end of each month. The practice owner will attempt to reach you to see whether you simply want to make a payment prior to mailing invoices out.

**Delinquent Accounts:** In the event a balance is owed past 90 days and a payment option has not been agreed upon, the practice reserves the right to terminate treatment, bill the card on file, utilize a collection agency to recover fees for services rendered, and/or seek legal action if the balance is substantial. All fees attached to utilization of a collection agency and/or attorney will be added to the overall balance and will also be your responsibility. When utilizing collections or taking legal action, we will only release information necessary for the agency/attorney to attempt to recover funds (i.e., service codes, demographics, employer, balances owed, social security number, etc.) and no treatment information will be shared. The business owner will also attempt to contact you directly prior to taking any of the above actions.

**Medical Records Policy**

 All paper records are kept under lock and key in a filing cabinet. The office, as well as the main entrance, are locked when we leave. We also keep cloud-based records through the online EHR (which is password protected and HIPAA compliant). Physical records will be kept for up to seven years from the completion of therapy and then will be shredded. Digital copies are cloud based and will be stored for ten years as well before being deleted. The practice contracts with TherapyNotes, LLC as a provider of both electronic medical records (EMR) and for claims submission. TherapyNotes utilizes a clearinghouse named Change Healthcare that scrubs our claims for better return and fewer denials. These two agencies receive only the basic information needed to process a claim such as: name, insurance plan, authorization numbers, ID numbers, date of birth, date of service, length of service (CPT code), diagnosis, any co-pays that have been paid and method of payment. Any pertinent clinical information will continue to be kept private.

The office manager, Kristie Berkebile, will be assisting with scheduling and billing and will only have access to the basic information listed above for these purposes and will not have access to clinical information. As new therapists are brought on board, basic clinical information will be shared between therapists as part of their training and supervision requirements.

**Contacting Employees**

You may contact your therapist with appointment changes or minor issues or concerns between sessions at the number listed on their business card. It is our policy to NOT provide clients with personal cell phone numbers so texting your therapist is not an option. If you have an emergency or you are suicidal, **DO NOT CALL YOUR THERAPIST!** Instead contact your county crisis intervention hotline or call 911. Your safety is of the utmost importance to us and we are not in the clinic often enough to be able to address these issues immediately and when we are at the clinic, we are likely in session and unable to answer the phone. You may also contact Derik Berkebile via e-mail at dberkebilelcsw@outlook.com and Lisa Zayac at lzayac90@outlook.com with questions, concerns, or minor issues but not for crisis or emergency situations. Below is a list of the appropriate crisis intervention hotlines for a few of the local counties.

Cambria County Crisis Intervention: 877-268-9463

Somerset/Bedford County Crisis Intervention: 866-611-6467

Blair County Crisis Intervention: 814-889-2141

Indiana County Crisis Intervention: 877-333-2470

988 – National Crisis Hotline

**Client Engagement Outside of Therapy:** It is our policy to not accept “friend” requests or other similar online connections from clients. Much of what social media consists of is personal and could impact the therapeutic relationship. We also do not wish for clients to inadvertently breach their own confidentiality. The practice does have a Facebook business page under the business name, Derik S. Berkebile, LCSW Outpatient Counseling Services and a website at [www.dsbcounseling.com](http://www.dsbcounseling.com). Clients are encouraged to follow these for helpful articles, business announcements, blogs on various topics, and inspirational quotes. If you comment on these posts, the practice cannot be held liable for you breaching your own confidentiality.

 In the event providers see a client in public we will try to avoid contact, if possible, again, to protect client confidentiality. We may greet a client with a simple salutation and no further conversation.

**Termination Policy**

It is obviously our preference for therapy to end successfully. There are times where termination may occur prior to successful completion. The practice reserves the right to terminate therapy early for any of the following reasons:

1. Therapy has not been effective
2. Client threatens or harms the therapist
3. If the client makes sexual advances towards the therapist or makes sexually inappropriate comments
4. After three cancellations without 24-hour notice or no-shows
5. After 90 days of no scheduled sessions
6. Client lacks motivation or routinely does not follow the treatment plan
7. If a client breaches the confidentiality of another client
8. If there are previous unpaid balances and arrangements have not been made prior for payment
9. If the client files a lawsuit against the therapist
10. If an unknown pre-existing relationship is uncovered

In most cases, we will allow for a thirty-day transition period where you may still see your therapist if there is absolute need for a session until you can schedule with another therapist. Prior to discontinuing treatment, we will make every reasonable effort to resolve situations that could result in termination before taking that action.

**Change of Information**

If you change your address, phone number, e-mail, place of employment, or insurance coverage, it is your responsibility to inform the practice of that change. You will be responsible for any charges that result from not sharing this information.

**Addendums:**

In the event there are any addendums to these policies set forth in this contract we will notify you prior to enforcing changes and will give a summary of changes in writing as well.

Please take a moment to let us know how you heard of my practice:

[ ]  Online Profile (Psychology Today, Good Therapy) [ ]  My Website [ ]  Current or Former Client

[ ]  Another Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Doctor/Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Insurance Website [ ]  Social Media [ ]  Employer [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices**

**Notice of Policies and Practices to Protect the Privacy of Your Health Information**

*This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

1. **Uses and Disclosures for Treatment, Payment, and Health Care Options**
2. The practice may use or disclose your protected health information *(PHI), for treatment, payment, and health care operations* purposes with your *written authorization*. To help clarify these terms, here are some definitions:
3. *“PHI”* refers to information in your health record that could identify you.
4. *“Treatment,” “Payment”, and “Health Care Operations”*
	1. *“Treatment”* is when a therapist provides, coordinates, or manages your health care and other services related to your healthcare. An example of treatment would be when we consult with another healthcare provider such as a primary care physician, other therapists, psychologists, and psychiatrists.
	2. *“Payment”* is when the practice obtains reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage.
	3. *“Healthcare Operations”* are activities that relate to the performance and operation of the practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and/or care coordination.
	4. *“Use”* applies only to activities within the practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
	5. *“Disclosure”* applies to activities outside of my practice such as releasing, transferring, or providing access to information about you to other parties.
	6. *“Authorization”* is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.
5. **Other uses and Disclosures Requiring Authorization**
6. The practice may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances, when a clinician/manager is asked for information for purposes outside of treatment, payment, or health care operations, an authorization from you will be obtained before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *“Psychotherapy Notes”* are notes your therapist has made about our conversation during a private, joint, or group counseling session. These notes are given a greater deal of protection than other PHI.
7. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage; law provides the insurer the right to contest the claim under the policy.
8. **Use and Disclosure Without Authorization**

The practice may use or disclose PHI without your consent or authorization in the following circumstances:

1. Child Neglect or Abuse – If we have reason to suspect that a child has been subjected to abuse or neglect, we must report this to the appropriate authorities.
2. Neglect or Abuse of the Elderly or Disabled – If we have reason to suspect that an elderly or disabled individual has been subjected to abuse or neglect, we must report this to the appropriate authorities.
3. Adult or Domestic Abuse – If we have reason to believe you are a victim of abuse, neglect, self-neglect, or exploitation, the practice reserves the right to disclose though this not required by law and is determined on a case-by-case basis.
4. Health Oversight Activities – If we receive a subpoena from the Association of Social Work Boards (my licensing board) because they are investigating my practice, we must disclose any PHI to the board. This would also include any oversight department at the federal, state, and local levels.
5. Judicial and Administrative Proceedings – If you are involved in court proceedings and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law and we will not release information without your written authorization or a court order to release them. The privilege does not apply when you are being evaluated by a third party, or where evaluation is court ordered. You will be informed in advance if this is the case.
6. Serious Threat to Health and Safety – If you communicate to us, a specific threat of imminent harm against another individual or if we believe there is clear, imminent risk of physical or mental injury being inflicted upon another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we will make disclosures we consider necessary to protect you from harm.
7. **Client Rights and Therapist’s Duties**
8. Patient Rights:
9. *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
10. *Right to Receive Confidential Communications by Alternative Means and Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know you are seeing a therapist. Upon your request, we will send bills or other correspondence to an alternate address.
11. *Right to Inspect and Copy* – You have the right to inspect and/or obtain a copy of PHI in the practice’s mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. You have the right to inspect and/or obtain a copy of psychotherapy notes unless we believe the disclosure of the record will be injurious to your health. Upon your request, we will discuss the details of the request and denial process for both PHI and psychotherapy notes.
12. *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. Upon your request, we will discuss with you the details of the amendment process.
13. *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
14. *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to the notice electronically.
15. Therapist Duties:
16. We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
17. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
18. If we revise our policies and procedures, you will be notified in person at the beginning of your next session.
19. **Questions and Complaints**
20. If you have questions about this notice, disagree with a decision made about access to your records, or have other concerns about your privacy rights, you may contact Derik S. Berkebile, LCSW at 814-254-4588, request to meet in person, or-e-mail at dberkebilelcsw@outlook.com.
21. If you believe that your privacy rights have been violated and wish to file a complaint with the practice, you may send your written complaint to:

Derik S. Berkebile, LCSW, CMH, C-DBT

334 Budfield St., Suite 152

Johnstown, PA 15904

1. You may also send a written complaint to:

Centralized Case Management Operations

The US Department of Health and Human Services

200 Independence Ave., S.W.

Room 509F HHH Bldg.

Washington, D.C. 20201

1. You have specific rights under the Privacy Rule. No one at the practice will not retaliate against you for exercising your right to file a complaint.
2. **Effective Date, Restrictions, and Changes to the Privacy Policy**

This notice will go into effect December 1st, 2022. We reserve the right to change the terms of this notice and to make the notice provisions effective for all PHI that the practice maintains. You will be notified of and sign for revisions in person unless this is not feasible and notice will be sent via mail or e-mail.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Non-Discrimination Policy**

 It is the policy and commitment of this practice to not discriminate against clients based on race, age, color, sex, national origin, physical or mental disability, religion, creed, birth gender, gender identity, marital status, sexual orientation, or military status in any of its activities or operations. If you feel that the practice has, in any way, discriminated against you, you may certainly bring this to the attention of the practice owner, Derik S. Berkebile, without fear of retaliation. You may also file a complaint to the licensing board that assures the practice follows the NASW Code of Ethics requirements for licensure in the state of Pennsylvania. The licensing board contact is as follows:

State Board of Social Workers, Marriage, and Family Therapists

and Professional Counselors

Physical Address: Mailing Address:

One Penn Center P.O. Box 2649

2601 N. 3rd St. Harrisburg, PA 17105-2649

Harrisburg, PA 17110

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Financial Agreement**

Please understand that you are financially responsible for your treatment and that payment is expected when services are rendered. Therefore, at your intake appointment, you will be asked to provide a credit or debit card that will be stored digitally in our EMR/Billing software. In the event we charge the card on file and you will be owed reimbursement from your insurance company, we will provide a receipt or invoice for services rendered and the amount paid to you in order to secure reimbursement.

I authorize Derik S. Berkebile, LCSW Outpatient Counseling Services to use my credit/debit card stored digitally for payment of any fees owed that have not been collected in session, including cancellation/no-show fees and other unpaid balances, beyond termination of treatment until my balance is paid or I explicitly request to stop billing. I understand that this is a requirement of treatment and that I can opt out of treatment and choose not to allow a card to be kept on file.

**\*\*IF NO PAYMENTS HAVE BEEN MADE AFTER 90 DAYS FROM THE DATE OF SERVICE AND THE BALANCE IS HAS NOT BEEN PAID, THE FULL AMOUNT WILL BE DEDUCTED FROM THE CARD ON FILE. IF, FOR ANY REASON, I CANNOT BILL THE CARD ON FILE, THEN THE BALANCE WILL BE SENT TO COLLECTIONS\*\***

**Informed Consent for Telehealth/Virtual Therapy Services**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to engage in Telehealth/Virtual Therapy services with Derik S. Berkebile, LCSW Outpatient Counseling Services. I understand that Telehealth/Virtual Therapy 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 these Telehealth services meet the requirements of both Commonwealth of Pennsylvania as well as the Federal Government guidelines for HIPAA compliance and other privacy regulations.

It is our policy to only provide Telehealth/Virtual Therapy services in circumstances where clients cannot make their regular appointments but still wish to maintain continuity in their treatment. Once regular “face to face” appointments can resume, this would be the expectation, as our preference is in-person interaction. However, research has suggested that Telehealth/Virtual Therapy can be just as effective as in-person treatment when needed. It is important to understand that therapists rely heavily on non-verbal cues in session to read how a client is reacting to therapy, therefore, progress may be slowed to some degree. If Telehealth/Virtual Therapy continues for an extended period, we will be evaluating the effectiveness regularly to assure this form of treatment is meeting your needs.

We use TherapyNotes as the vendor for Telehealth/Virtual Therapy Services. This is a HIPAA compliant software that will allow for both audio and visual sessions. You will need to have a therapy portal account set up to use this service. This consent will need to be completed prior to initiating Telehealth/Virtual Therapy sessions. We will be conducting most of our Telehealth sessions from the office locations at 334 Budfield St., Suite 151-152, Johnstown, PA 15904. There will be times where we provide services from home for these sessions as well. We will notify you if the location is anywhere other than the offices and you may refuse those sessions without fee if they are conducted at our homes and this makes you uncomfortable.

Your privacy follows all the same restrictions as laid out in the original consent form and your notice of privacy practices. You may feel free to ask any questions regarding the Telehealth/Virtual Therapy service delivery model at any time.

 I understand that I have the following rights with respect to Telehealth/Virtual Therapy:

1. I have the right to withhold or withdraw consent to Telehealth/Virtual Therapy at any time without affecting my right to future treatment.
2. I understand that the privacy laws that apply to traditional, face-to-face, psychotherapy also apply to Telehealth/Virtual Therapy and that all reporting requirements and legal inquiries remain as exceptions to these rules.
3. I understand that any use of images in regards to my Telehealth/Virtual Therapy for any purpose without my written consent is strictly prohibited.
4. I understand that there are risks with Telehealth/Virtual Therapy, including but not limited to:
	1. The possibility that the transmission could be disrupted by factors outside of my control such as power outages, poor internet connectivity on either end, or other technical failures.
	2. The transmission could be interrupted by unauthorized persons.
	3. Telehealth may simply not be as effective as therapy in-person.
5. I understand that, just like in traditional psychotherapy, results are not guaranteed or assured.
6. I understand that if, I am in need of emergency mental health services, I should contact my local crisis intervention hotline or dial 911 for emergency care.
7. I understand that I have the same rights to my records as laid out in the original psychotherapy consent form in accordance with Pennsylvania law.
8. I understand that the location where I choose to participate in Telehealth/Virtual Therapy is my choice and that my therapist may not be held liable for any breeches of confidentiality that occur as a result of my chosen location.
9. I understand that the cancellation policy of providing 24-hour notice is still in effect if I cannot participate in a scheduled Telehealth/Virtual Session and that any fees as a result of not providing notice are still my responsibility.

**Client Rights and Responsibilities**

This is a brief outline of both your rights and responsibilities while you receive services at Derik S. Berkebile, Outpatient Counseling Services or any of its facilities. It will help you better understand the need for cooperation between yourself, your therapist, or other care provider. You have certain rights that must be respected. The health care providers also have rights and it is only through a mutual understanding of both sets of needs that you can receive the most effective health care. We promote that understanding through the following information. As a client, you have the right:

1. To receive prompt evaluation, care, and treatment regardless of your race, gender, sexual orientation, gender identity, ethnicity, disability, religion, age and to be treated with dignity and respect and addressed in a respectful, age-appropriate manner, and regardless of ability to pay.
2. To have services explained to me in a language and in a way I can understand. If language becomes a barrier to treatment, we will assist you in finding a therapist that can accommodate your needs better.
3. To receive information about the qualifications of the staff that provide services to me and to have any change in the professional staff responsible for your care or for any transfer from one caregiver to another within or outside the business.
4. To receive psychiatric treatment that is within the accepted standards of medical practice and to an explanation of the risks, effects and benefits of all medications and treatment provided.
5. To refuse specific treatment procedures to the extent permitted by law or to terminate therapy.
6. To participate in the planning of your and care, including discharge planning and follow up care. This includes active participation of patients over 12 years of age and their parents, relatives, or guardians in planning for treatment.
7. To have your records kept confidential to the extent permitted by law and to know where and to whom your records have been disclosed. I understand that Derik S. Berkebile, Outpatient Counseling Services may coordinate with outside providers who have an established treatment relationship with you. We may use or disclose your information with these other providers, and we may access your information from other providers with your written consent. See your notice of privacy practices in your intake packet for more information.
8. To have access to and an explanation of your health records, unless deemed therapeutically inadvisable.
9. To receive, at admission, a written description of services, costs and rules and a written statement and explanation of patient rights and responsibilities and grievance procedures without fear of recrimination.

**CLIENT RESPONSIBILITIES**

1. Take time to read, understand and sign the Application for Services and other forms necessary for treatment.
2. Give complete and accurate information to the professional staff and participate actively in the treatment planning and review process.
3. Discuss and ask questions regarding any aspects of treatment, which are unclear.
4. Keep scheduled appointments, cancel only when absolutely necessary and give at least 24-hour’s notice.
5. Respect other clients and staff and their right to privacy and dignity.
6. Support the efforts of staff to keep the facilities clean and attractive.
7. Voice any concerns through the proper channels.
* Try to resolve your concern with your primary service provider.
* Or you can talk to the business owner, Derik S. Berkebile, LCSW at 814-254-4588.
* Or you may file a complaint with the State at:

Professional Compliance Office

Department of State, Professional Compliance Office

PO Box 69522, 2601 North Third Street, Harrisburg, PA 17106-9522.

* If that fails contact the Department of Health and Human Services at:

Centralized Case Management Operations

The US Department of Health and Human Services

200 Independence Ave., S.W.

Room 509F HHH Bldg.

Washington, D.C. 20201

* Derik S. Berkebile, Outpatient Counseling Services operates out of one location:

334 Budfield St., Suite 152

Johnstown, PA 15904

Ph: 814-254-4588

Fax: 814-254-4215

E-Mail: dberkebilelcsw@outlook.com

**Consent for Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the intake, consents, and policies set forth in this document and I agree with all contained therein. My assigned therapist has reviewed these documents with me and I am in complete and full understanding. I have been made aware and agree to the following: use of my private information, exceptions to confidentiality, the authorization for the practice to bill my insurance for services rendered, the disclosure of billing practices, fees, and to keep a card on file to bill for services rendered, consent and disclosures to engage in telehealth sessions, how to contact my therapist and instructions for crisis situations, the rights and responsibilities of both myself and my therapist, the non-discrimination policy of the practice, the procedures for filing a complaint/grievance, causes for early termination of services and, in understanding this fully, do hereby consent to receive treatment through Derik S. Berkebile, LCSW Outpatient counseling Services and its therapists under its employ.

Also, I have been made aware of my right to receive a copy of this document.

* I have requested and received a copy of this document at my request.

Or

* I have opted to not receive a copy of this document and understand that this is available for review on the practice website.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

 (additional if under 18)

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_