

\_\_\_\_\_

**Congruent Counseling Services, LLC**  
**REGISTRATION FORM**

➤ **CLIENT INFORMATION**

Client Name: (First, MI, Last): \_\_\_\_\_ Gender:  M  F \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Email:\*\*\* \_\_\_\_\_  
Social Security No.: \_\_\_\_\_  Single  Married  Other: \_\_\_\_\_ Employed:  Y  N Student:  FT  PT  
Phones:\* Mobile: (\_\_\_\_\_) \_\_\_\_\_ Mobile Carrier: \_\_\_\_\_  
Home: (\_\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_\_) \_\_\_\_\_ OK to leave messages?  Y  N  
*\*Your appointment reminder may be sent by text (if you provide your carrier) or email. Also, please circle preferred number for calls.*  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
How did you choose us?  Physician  Insurance  Internet  Family or Friend  Other: \_\_\_\_\_

➤ **INSURANCE and POLICY HOLDER/SUBSCRIBER INFORMATION**

Relationship to client:  Self  Spouse  Parent/Guardian  Other: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_  M  F  \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Email: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
Subscriber Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phones: Home: (\_\_\_\_\_) \_\_\_\_\_ Mobile: (\_\_\_\_\_) \_\_\_\_\_ Business: (\_\_\_\_\_) \_\_\_\_\_  
Using (*Please circle one*): Primary Insurance EAP Benefits  
Policy/Subscriber ID: \_\_\_\_\_ Insurance Co.: \_\_\_\_\_ Group: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

*Congruent Counseling Services does not bill secondary insurances.  
We will provide a statement at your request that you may submit to a secondary insurance.*

➤ **OTHER PARENT/GUARDIAN INFORMATION**  *Please send the bill to this person (email requested)*

Relationship to client:  Spouse  Parent/Guardian  Other: \_\_\_\_\_ Gender:  M  F  \_\_\_\_\_  
(*Please provide proof of guardianship*)  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_ Email:\*\*\* \_\_\_\_\_  
Address, if different: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phones: Home: (\_\_\_\_\_) \_\_\_\_\_ Mobile: (\_\_\_\_\_) \_\_\_\_\_ Business: (\_\_\_\_\_) \_\_\_\_\_

➤ **IN CASE OF EMERGENCY**

Name of local friend or relative (not at same address): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phones: Home: (\_\_\_\_\_) \_\_\_\_\_ Mobile: (\_\_\_\_\_) \_\_\_\_\_ Business: (\_\_\_\_\_) \_\_\_\_\_

➤ **FINANCIAL POLICY and AUTHORIZING SIGNATURE**

Note that payment of services is considered part of your treatment, and payment is due at the time service is provided. As a courtesy to you we will help you process your insurance claims. Your insurance company and your plan benefits ultimately determine the amount paid by them. All charges you incur are your responsibility regardless of your insurance coverage; our relationship is with you, not with your insurance company. We ask that you pay any deductible and co-payment, which is the estimated amount not covered by your insurance company, at the time we provide service to you.

***Consent:** The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Congruent Counseling Services and the provider. I understand that I am financially responsible for any balance or unpaid claim. I also authorize Congruent Counseling Services or insurance company to release any information required to process my claims. Internet and Email communication carry an inherent risk to privacy; **\*\*\*by providing my email address above, I give permission to receive communication, such as reminders and account statements, through email.** By signing below, I indicate recognition and acceptance of these conditions.*

\_\_\_\_\_  
CLIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
PRINTED NAME (if not client)

\_\_\_\_\_  
DATE

# Congruent Counseling Services, LLC

## Fee Schedule and Policies

Medication Management* \$135	Relationship Counseling* \$125	Psychiatric Interview* \$300
Psychotherapy Interview/Assessment \$175	Brief Phone Session* \$50	Consultation Only* \$175
Assessment w/Mark D. Donovan* \$275	Parental Intervention* \$275	Letter/Forms* \$25
Individual/Family Therapy (Extended) \$125 (\$175)	Unscheduled Refill Request* \$35	Crisis Session/Call (per 15min)* \$45
Intensive Outpatient Program \$220	Insurance/Medication Auth* \$20	Bounced Check Fee* \$25
Family Group/Parent Education* \$45	Disability/Workers Comp Report* \$300	No Show Fee (therapy) \$60
Report/Psychiatric Report* (per half hr) \$50/\$100	Urine Screen* (read Lab Svcs) \$35	No Show Fee (psych) \$100

*\*These services will not be billed to your insurance by our office. This is not a comprehensive list of all possible charges.*

### Cancellation and No Show Policy

*It is office policy to charge for missed appointments not canceled at least 24 hours prior to the scheduled appointment.* This includes groups – unless prior arrangements are made, you will be expected at the next scheduled group meeting. In the event a courtesy reminder is not made, *it does not excuse* a missed appointment.

### Fees and Payment

Fees will be collected at the time service is rendered. Payment may be made by cash, check, or credit card. Checks returned for non-payment will result in a \$25 bounced check charge. ***Statements are regularly e-mailed, and can be mailed upon request.*** Congruent Counseling Services, LLC will only file reimbursable services with the primary insurance. If your insurance has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount. Medicaid clients will not be charged for services rendered by mail, telephone or otherwise not in person; for completion of forms or reports; or for broken or missed appointments.

### Failure to Pay

The client agrees that failure to pay the expected service fee within ten business days of the service date may, at the option of Congruent Counseling Services, be construed as a discharge of services by the client. ***Client accounts sent to collections for non-payment will be charged the amount owed plus any and all associated collection fees.*** The client agrees that information pertinent to the collection of any amount due be released to a third party collection agency or attorney. The client further agrees that in the event that legal action is taken to collect any money under this agreement, the client shall pay the amount due as attorney collection fee as well as any cost of any legal action; and consents to legal action being held in Howard County, Maryland, and waives any right to claim improper jurisdiction and/or venue.

### Court Appearances and Associated Costs

Congruent Counseling Services charges \$400 per hour with a minimum of \$3,200 for any court appearance whether requested or summonsed, regardless of requesting party. Clients will also be charged per hour for any travel time, consultation time, preparation time, and any time spent waiting. Costs incurred by the company for associated legal fees will be passed on to the client. In the case of minors, the signing parent is responsible for this fee unless otherwise pre-arranged with the non-signing parent. A deposit of \$3,200 is due 10 days prior to any court appearance. If a court appearance is canceled or rescheduled, staff must be given ten business days' notice; without this notice, CCS may still charge up to \$3,200 for each day if unable to reschedule appointments and for any preparation time, administration time, and reports completed.

### Understanding of Separate Practices

The client recognizes and understands that although they share space, Congruent Counseling Services, LLC (CCS) and Integrative Counseling, LLC (IC) are separate practices, and as such may require the opening of a separate client chart. The client understands that ***any insurance benefits utilized with CCS cannot be utilized with IC.*** IC accepts no third party payers of any kind and has no insurance contracts. Clients may continue to receive services from either or both programs. Additionally, the client understands that each program may exchange information with the other and the client signature below serves as a release for the programs to exchange such information as needed to ensure appropriate treatment.

### Laboratory Services

CCS works with a private laboratory, Dominion Diagnostics, to perform urine drug screening. Dominion submits to insurance directly and provides screen results to CCS. Please contact Dominion directly at 410.387.3890 for billing questions. If the client prefers not to use insurance or doesn't have insurance, please let the counselor know and CCS will use Friends Lab and charge the \$35 fee as noted above.

### Medication Changes or Refills between Appointments

We understand you may sometimes need a brief refill to get you through to your next appointment. Refills between appointments will be billed at \$35. These refills will be for no longer than two weeks or until you are able to see your psychiatrist in person. You may choose to schedule a Telepsychiatry appointment if the next appointment is too far away.

***Your signature indicates understanding of the fees and policies as delineated above.***

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

# Congruent Counseling Services, LLC

## More Policies and Information

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### **Communication, Reminders, Statements**

We wish to communicate with you in the most efficient way possible. That may be by phone, email, or text message. Telephone, email, and text messaging communications carry an inherent risk to privacy. Please do not use email for an emergency or rapid response request, or for sensitive information. We may use your email, mobile phone text messaging, or home phone for appointment reminders, statement delivery, or general information. By signing below, you acknowledge recognition and acceptance of risk to privacy in the use of email and text message.

### **Client Portal**

We offer you the option to access a portal to your account through which you can communicate with your provider, pay your bill, and verify your schedule. Please note: always follow a payment made online with a system message to Billing to alert us of your payment, so we can apply it in a timely fashion. If at any time you want to opt out of the portal, please let us know.

### **Telephone and Internet Session – Teletherapy or Telepsychiatry**

Teletherapy and telepsychiatry are not covered by our insurance contracts and are therefore billed at our standard rates. Clients regularly seen in the office for sessions under insurance can schedule teletherapy/telepsychiatry appointments. Teletherapy and telepsychiatry clients will be billed via credit card at the time of service. Credit cards must be kept on file with Congruent Counseling Services. Initial sessions must be done in person and are not billable to insurance. In the case of a missed appointment, therapists may opt to conduct a 15-30 minute phone session during your already scheduled individual, family, or couples appointment time. This session will be charged at a rate of \$50, which is less than the full missed appointment charge. The missed appointment phone option may only be used once in a 30-day period. Second missed appointments will be charged at the full rate.

### **Provider Contact Outside of Sessions**

It is our goal to provide you with the best treatment we can provide. If there is an emergency, please call emergency services or 911, or Grassroots at 410-531-6677. If you are calling to make or change your appointment or to address billing issues, please call the office. Your provider has given you personal contact information to help address your needs. If you would like to talk with your provider, and cannot wait until the next appointment, please be respectful of their time. Calls, texts, or emails taking over five minutes will be charged as a crisis session at a rate of \$45 per 15 minutes. Contacts about medication clarification more than a week after your appointment will be charged as a Crisis Session. Crisis Sessions are not billable to insurance and are the responsibility of the client or parent.

### **Client Responsibilities, Rules, Emergency Contact Information, Family Involvement**

As part of this Client Orientation Packet, you will receive a copy of the Client Responsibilities and Rules and contact information for your assigned counselor, contacts for Emergency Services, and our grievance policy. You are encouraged to include your family in therapy and you are given the times for IOP family group sessions.

### **Advance Directive**

If you have an Advance Directive, please provide a copy of the document if you wish to have it on record. If you do not have an advance directive and would like to make one, please notify the front desk staff; they will provide you with the “Maryland Advance Directive for Mental Health Treatment” from the State of Maryland DHMH.

### **Scope of Practice – Description of Services**

The complete description of program services is available on the website: <http://www.congruentcounseling.com>.

### **Statement about Clinical Supervision**

As part of this Client Orientation Packet, you receive a copy of information regarding Clinical Supervision of Services, and have the opportunity to discuss it with your counselor

### **Infectious Disease Education/Risk Reduction**

As part of this Client Orientation Packet, you receive a copy of risk reduction education about TB, STDs, HIV/AIDs and Hepatitis.

*I have reviewed and understand these options and I have received a copy of these Policies.*

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_

**Congruent Counseling Services, LLC**  
**Notice of Privacy Practices (HIPAA),**  
**Client Bill of Rights and Confidentiality of Client Records**

**Client Bill of Rights**

Each Client has the right to:

1. Have self and property be treated with consideration, respect, and full recognition of the client's human dignity and individuality;
2. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;
3. Not be physically or mentally abused by the program staff;
4. Be free from discrimination;
5. Be free from restraints;
6. Privacy and confidentiality; and
7. Refuse participation in any experimental research unless the research complies with 45 CFR Part 46. 45 CFR Part 46 is the Code of Federal Regulations Protection of Human Subjects.
8. Refuse treatment at any time, and request a referral for outside services.

**Confidentiality of Records and Records Request**

Federal Law and Regulations protect the confidentiality of patient records maintained by this program. Generally, the program may not disclose to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug user unless:

1. Clients aged 14 and older receiving substance use services and all other clients aged 16 and older provides consent in writing;
2. The disclosure is allowed by court order;
3. The disclosure is made to medical personnel in an emergency or to qualified personnel for research, audit, or program evaluation.

Violation of Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state and local authorities.

All records requests must be made in writing to the Columbia office; a response will be made within 21 working days. Records copies are charged \$30 to the client prior to preparation.

**Acknowledgment and Consent Regarding Notice of Privacy Practices**

The Notice of Privacy Practices (NPP) of Congruent Counseling Services (CCS) provides information about how CCS may use and disclose your protected health information (PHI). The NPP states that CCS reserves the right to change its terms. Should this happen, understand that CCS will make the changed notice available in its office. You have the right to revoke this consent, in writing, except where CCS has already made disclosures in reliance on your prior consent. Understand that you have the right to request restrictions on how your PHI may be used or disclosed for treatment, payment and health care operations. CCS is not required to agree to your restrictions, but if it does, it is bound by its agreement with you. By signing below, you consent to the use and disclosure of your PHI for treatment, payment and health care operations as described in the NPP. You specifically consent to CCS communicating with you using the contact information you provide, as further described in the NPP.

**Discharge**

Clients who choose to terminate services will be discharged immediately. Clients who have not attended sessions for 30 days or more and who do not have an appointment scheduled will be discharged at the discretion of the doctor or therapist with no prior notice. Discharged clients are no longer under the care of Congruent Counseling Services, Integrative Counseling, a therapist, or a doctor. Discharged clients may be re-admitted at the discretion of the practice upon request.

***I have reviewed and understand these rights and I have received a copy of this Notice.***

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

## Credit Card Recurring Payment Authorization Form

As a courtesy to you, we can now schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started. Once a month, with this authorization, we will charge the balance due on your account to the credit card you list on file.

You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged once each billing period for the total amount due for that period. The charge will appear on your credit card statement.

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### Please complete the information below:

I, \_\_\_\_\_, authorize Congruent Counseling Services, LLC and/or Integrative Counseling, LLC to charge the credit card indicated below once between the 15th and 20th of each month for payment of any balance due for \_\_\_\_\_.  
*(name of client or clients)*

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Account Type:  Visa  MasterCard  Amex  Discover

\*Is this for a(n):  HSA  FSA  Other Consumer Spending Account?

**\*For all consumer spending accounts, be advised that if the card cannot be processed, you will be billed and should seek reimbursement from them directly.**

Cardholder Name \_\_\_\_\_

Account Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ CVV \_\_\_\_\_ (3 digits on back of Visa/MC, 4 digits on front of AMEX)

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

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CARDHOLDER SIGNATURE

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DATE

\_\_\_\_\_

**Congruent Counseling Services, LLC**  
**Primary Care Physician (PCP) Notification**

It is often helpful to notify your doctor of mental health or substance abuse treatment so that your doctor can let us know of any possible medical issues that may affect treatment. In some cases medications or medical issues can cause or worsen mental health or substance use issues. Most insurance companies also request that therapists and psychiatrists notify primary care physicians about mental health or substance abuse treatment.

Please check the appropriate box below. Checking the "Yes" box and signing this form will allow Congruent Counseling Services, LLC to notify your primary care physician.

- No, I would not like Congruent Counseling Services to notify my PCP.
- Yes, I would like Congruent Counseling Services to notify my PCP.  
If you check yes, please fill out the rest of this form to the best of your ability.

I give permission to Congruent Counseling Services to notify my PCP that \_\_\_\_\_ (client name) is being seen by \_\_\_\_\_ (therapist name). I understand that a copy of this letter may be placed in my chart and I encourage my doctor to discuss my treatment with me.

Dr. \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

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***This area is for the office to complete:***

\_\_\_\_\_ is seeing your patient for  
\_\_\_\_\_  
\_\_\_\_\_

If you have any questions, comments, or concerns please contact us by phone in our Columbia office at 410.740.8066. You may also reach us by email at congruentcs@gmail.com.

Sincerely,  
  
Congruent Counseling Services

**Confidentiality Notice**

*PLEASE NOTE:* This document contains information belonging to the sender which is legally privileged and confidential. The information is intended for the use of the individual or entity to whom it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, any disclosure, copying, distribution, or the taking of any action in reliance on the contents of this information is strictly prohibited. If you received this telecopy/facsimile in error, please immediately notify us by telephone at 410-740-8066 to arrange for the return of these documents.

\_\_\_\_\_

**Congruent Counseling Services, LLC**  
**Release of Information**

I, \_\_\_\_\_, hereby authorize Congruent Counseling Services, LLC

to exchange information with: \_\_\_\_\_  
Name of Program, Agency, or Individual

\_\_\_\_\_ Phone

\_\_\_\_\_ Fax

The following information may be exchanged:

- \_\_\_\_\_ Full client record
- \_\_\_\_\_ Progress and attendance reports
- \_\_\_\_\_ Admission and discharge diagnosis and recommendations
- \_\_\_\_\_ Reason for termination of treatment and discharge summary
- \_\_\_\_\_ Urinalysis/Breathalyzer results
- \_\_\_\_\_ Immunization and physical records
- \_\_\_\_\_ Other \_\_\_\_\_

The above information will be exchanged for the following reason(s):

- \_\_\_\_\_ To coordinate treatment
- \_\_\_\_\_ As a condition of probation, parole, or adjudication
- \_\_\_\_\_ As required by my employer or EAP
- \_\_\_\_\_ To assist my attorney
- \_\_\_\_\_ Other \_\_\_\_\_

This consent will expire one year from the date of signature unless otherwise noted  
\_\_\_\_\_.

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that the information has already been disclosed in reliance with this consent.

\_\_\_\_\_  
Client Signature Date

\_\_\_\_\_  
Parent/Guardian Signature Date Witness Signature Date

# **Congruent Counseling Services, LLC**

## **Consent for Treatment**

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### **Counseling**

Services are provided in an individualized person-centered manner primarily through individual and group counseling sessions to include personal growth and awareness. The counseling process is a partnership between you and the counselor to work on areas of concern or dissatisfaction in your life, develop growth and insight, and help you achieve your desired goals and improve your overall well-being. It is expected that you take an active role in this process to ensure the best outcome.

You will be given a clear description from your counselor regarding the problems, diagnosis, personal strengths/limitations and treatment interventions proposed. You will be given a clear recommendation for the types of treatment recommended, such as individual counseling, group counseling, and family counseling. You and your counselor will discuss and agree on dates, times, and session length.

Your counselor cannot guarantee results from services; however, there will be clearly stated reasons, goals, and objectives for services developed with your input.

### **Barriers and Risks**

While counseling is often beneficial for many people there may be some risks. These may include, but are not limited to, addressing painful emotional experiences and/or feelings or being challenged or confronted on a particular issue. The counseling process can also evoke strong feelings and sometimes produce unanticipated changes in one's behaviors, thoughts, and feelings. To maximize your experience, it is helpful to discuss with your counselor any questions or discomfort you may experience during the therapeutic process. Your counselor will work to help you to understand the experience and/or use different methods or techniques and/or provide referrals that may lead you towards the growth you desire.

### **Grievances**

Grievance information has been provided on the client copy of the Telephone, Email and Grievance Policies.

### **Confidentiality**

Any of the team working with you or supervising staff on your team may have access to your record to provide you with the best services and meet all State and Federal regulations. All staff recognizes that confidentiality is essential to effective counseling. In order for counseling to be most effective, you must feel safe about sharing your personal information with your counselor. Your counselor and treatment team will maintain your confidential information. In most cases, information shall not be released to another party without your written consent. However, in certain circumstances, information can be shared legally without your permission. These circumstances include, but are not limited to:

- If you are determined to be in imminent danger of harming yourself or someone else.
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s).
- Disclosure is allowed by a court order.
- Disclosure is made to medical personnel in a medical emergency.
- Disclosure is made to qualified personnel for research, audit or program evaluation.
- Where otherwise legally required.

The above list is considered a summary. If you have questions about specific situations or any aspects of confidentiality, please feel free to discuss your concerns with your counselor. See additional information on the Notice to Privacy Practices.

### **Appointments and Emergencies**

Emergency information has been provided on the client copy of the Client Responsibilities and Rules.

### **Cancellation, Fees and Payments**

Cancellation, Fees and Payments policies have been provided on the client copy of the Fee Schedule and Policies. Medicaid clients will not be charged for services rendered by mail, telephone or otherwise not in person; for completion of forms or reports; or for broken or missed appointments.



## Termination

You may terminate the therapeutic relationship at any time. Your counselor may want to discuss this with you, but you reserve the right to stop treatment. You will be given a list of referrals for counselors in the community and be referred back to your referral source as appropriate. You will be responsible for any outstanding fees for services received.

## Email

Use of Email information has been provided on the client copy of the Telephone, Email and Grievance Policies.

## Legal Information

Please note your counselor is not able to provide legal advice. If you have legal questions and are requesting legal advice, it is recommended you speak with an attorney to act in your best interests.

## Concurrent Services

Your counselor may coordinate with concurrent services within our program and/or the community as needed, such as care coordination, crisis intervention, veteran services, vocational services, medical services, etc.

## Consent for Counseling

The above information is not intended to be “all inclusive” of aspects of your services. It is only intended to provide some useful information before deciding to engage in treatment. I have read the information contained on this form. I voluntarily agree and give my consent to participate in counseling. I have had the opportunity to ask questions about these details.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party signature (if appropriate)

\_\_\_\_\_  
Printed Name, Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**Congruent Counseling Services, LLC**  
**Notice of Privacy Practices (HIPAA),**  
**Client Bill of Rights and Confidentiality of Client Records**

*Client Copy*

**Client Bill of Rights**

Each Client has the right to:

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# Congruent Counseling Services, LLC

## Fee Schedule and Policies

### Client Copy

Medication Management*	\$135	Relationship Counseling*	\$125	Psychiatric Interview*	\$300
Psychotherapy Interview/Assessment	\$175	Brief Phone Session*	\$50	Consultation Only*	\$175
Assessment w/Mark D. Donovan*	\$275	Parental Intervention*	\$275	Letter/Forms*	\$25
Individual/Family Therapy (Extended)	\$125 (\$175)	Unscheduled Refill Request*	\$35	Crisis Session/Call (per 15min)*	\$45
Intensive Outpatient Program	\$220	Insurance/Medication Auth*	\$20	Bounced Check Fee*	\$25
Family Group/Parent Education*	\$45	Disability/Workers Comp Report*	\$300	No Show Fee (therapy)	\$60
Report/Psychiatric Report* (per half hr)	\$50/\$100	Urine Screen* (read Lab Svcs)	\$35	No Show Fee (psych)	\$100

*\*These services will not be billed to your insurance by our office. This is not a comprehensive list of all possible charges.*

### Cancellation and No Show Policy

***It is office policy to charge for missed appointments not canceled at least 24 hours prior to the scheduled appointment.***

This includes groups – unless prior arrangements are made, you will be expected at the next scheduled meeting. In the event a courtesy reminder is not made, it *does not excuse* a missed appointment.

### Fees and Payment

Fees will be collected at the time service is rendered. Payment may be made by cash, check, or credit card. Checks returned for non-payment will result in a \$25 bounced check charge, and revocation of acceptance of checks. Statements are regularly e-mailed, and can be mailed upon request. Congruent Counseling Services, LLC will only file reimbursable services with the primary insurance. If your insurance has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount. Medicaid clients will not be charged for services rendered by mail, telephone or otherwise not in person; for completion of forms or reports; or for broken or missed appointments.

### Failure to Pay

The client agrees that failure to pay the expected service fee within ten business days of the service date may, at the option of Congruent Counseling Services, be construed as a discharge of services by the client. Client accounts sent to collections for non-payment will be charged the amount owed plus any and all associated collection fees. The client agrees that information pertinent to the collection of any amount due be released to a third party collection agency or attorney. The client further agrees that in the event that legal action is taken to collect any money under this agreement, the client shall pay the amount due as attorney collection fee as well as any cost of any legal action; and consents to legal action being held in Howard County, Maryland, and waives any right to claim improper jurisdiction and/or venue.

### Court Appearances and Associated Costs

Congruent Counseling Services charges \$400 per hour with a minimum of \$3,200 for any court appearance whether requested or summonsed, regardless of requesting party. Clients will also be charged per hour for any travel time, consultation time, preparation time, and any time spent waiting. Costs incurred by the company for associated legal fees will be passed on to the client. In the case of minors, the signing parent is responsible for this fee unless otherwise pre-arranged with the non-signing parent. A deposit of \$3,200 is due 10 days prior to any court appearance. If a court appearance is canceled or rescheduled, staff must be given ten business days' notice; without this notice, CCS may still charge up to \$3,200 for each day if unable to reschedule appointments and for any preparation time, administration time, and reports completed.

### Understanding of Separate Practices

The client recognizes and understands that although they share space, Congruent Counseling Services, LLC (CCS) and Integrative Counseling, LLC (IC) are separate practices, and as such require the opening of a separate client chart. The client understands that any insurance benefits utilized with CCS cannot be utilized with IC. IC accepts no third party payers of any kind and has no insurance contracts. Clients may continue to receive services from either or both programs. Additionally, the client understands that each program may exchange information with the other and the client signature below serves as a release for the programs to exchange such information as needed to ensure appropriate treatment.

### Laboratory Services

CCS works with a private laboratory, Dominion Diagnostics, to perform urine drug screening. Dominion submits to insurance directly and provides screen results to CCS. ***Please contact Dominion directly at 410.387.3890 for billing questions.*** If the client prefers not to use insurance or doesn't have insurance, please let the counselor know and CCS will use Friends Lab and charge the \$35 fee as noted above.

### Medication Changes or Refills between Appointments

We understand you may sometimes need a brief refill to get you through to your next appointment. Refills between appointments will be billed at \$35. These refills will be for no longer than two weeks or until you are able to see your psychiatrist in person. You may choose to schedule a Telepsychiatry appointment if the next appointment is too far away.

# Congruent Counseling Services, LLC

## Telephone, Email and Teletherapy Policies

### *Client Copy*

#### **Communication, Reminders, Statements**

We wish to communicate with you in the most efficient way possible. That may be by phone, email, or text message. Telephone, email, and text messaging communications carry an inherent risk to privacy. Please do not use email for an emergency or rapid response request, or for sensitive information. We may use your email, mobile phone text messaging, or home phone for appointment reminders, statement delivery, or general information. By signing below, you acknowledge recognition and acceptance of risk to privacy in the use of email and text message.

#### **Client Portal**

We offer you the option to access a portal to your account through which you can communicate with your provider, pay your bill, and verify your schedule. Please note: always follow a payment made online with a system message to Billing to alert us of your payment, so we can apply it in a timely fashion. If at any time you want to opt out of the portal, please let us know.

#### **Telephone and Internet Session – Teletherapy or Telepsychiatry**

Teletherapy and telepsychiatry are not covered by our insurance contracts and are therefore billed at our standard rates. Clients regularly seen in the office for sessions under insurance can schedule teletherapy/telepsychiatry appointments. Teletherapy and telepsychiatry clients will be billed via credit card at the time of service. Credit cards must be kept on file with Congruent Counseling Services. Initial sessions must be done in person and are not billable to insurance. In the case of a missed appointment, therapists may opt to conduct a 15-30 minute phone session during your already scheduled individual, family, or couples appointment time. This session will be charged at a rate of \$50, which is less than the full missed appointment charge. The missed appointment phone option may only be used once in a 30-day period. Second missed appointments will be charged at the full rate.

#### **Provider Contact Outside of Sessions**

It is our goal to provide you with the best treatment we can provide. If there is an emergency, please call emergency services or 911, or Grassroots at 410-531-6677. If you are calling to make or change your appointment or to address billing issues, please call the office. Your provider has given you personal contact information to help address your needs. If you would like to talk with your provider, and cannot wait until the next appointment, please be respectful of their time. Calls, texts, or emails taking over five minutes will be charged as a crisis session at a rate of \$45 per 15 minutes. Contacts about medication clarification more than a week after your appointment will be charged as a Crisis Session. Crisis Sessions are not billable to insurance and are the responsibility of the client or parent.

#### **Client Grievance Procedures**

Clients have the right to discuss treatment issues, and if necessary to review with the Program Director, disagreements about treatment, discharge, or change in status. No retaliation will be taken against clients who present a grievance. Clients will first be asked to discuss concerns with their counselor. The counselor will attempt to resolve the client's concerns. If the client is unsatisfied, they can write their complaint to the Program Director using the contact information below. The Program Director will communicate with all parties involved to gain a full picture of what occurred. Based on this information, the Program Director will create a resolution which best meets the needs of all involved. The Program Director will then write a response to the client within ten business days.

##### **Adult Program Director:**

Katie Downes  
katie.downes@ccs-ic.com  
443-917-2583  
11:00am – 6:00pm

##### **Adolescent Program Director:**

Lisa Cohen  
lisa.cohen@ccs-ic.com  
443-917-2820  
11:00am – 6:00pm

If the client is dissatisfied with the response from the Program Director, they can contact the following agencies:

##### **DHMH/OHCQ:**

Behavioral Health  
410-402-8198  
8:00am – 5:00pm

##### **ACHC (Accreditation Body):**

919-785-1214  
8:00am – 5:00pm EST

##### **Local Addictions Authorities:**

Roe Rodgers-Bonaccorsy  
LAA, Howard County  
410-313-7316  
9:00am – 3:30pm

Sue Doyle  
LAA, Carroll County  
410-876-4800  
9:00am – 3:30pm

Sandra O'Neill  
LAA, Anne Arundel Cty  
410-222-7164  
9:00am – 3:30pm

Mary Viggiani  
LAA, Baltimore County  
410-887-3828  
9:00am – 3:30pm

# Congruent Counseling Services, LLC

## Infectious Disease Education

### *Client Copy*

#### **Tuberculosis**

Tuberculosis (TB) is an infectious disease that usually infects the lungs, but can attack almost any part of the body. Tuberculosis is spread from person to person through the air. When a person with TB in their lungs or throat coughs, laughs, sneezes, sings, or even talks, the germs that cause TB may spread through the air. If another person breathes in these germs, there is a chance that they will become infected with tuberculosis.

It is not easy to become infected with tuberculosis. Usually a person has to be close to someone with TB disease for a long period of time. TB is usually spread between family members, close friends, and people who work or live together. TB is spread most easily in closed spaces over a long period of time.

If it is not treated, TB can be fatal. But TB can almost always be treated and cured if you take medicine as directed by your healthcare provider. Once you begin treatment, within weeks you will no longer be contagious. That means you can't spread the disease to others. If you take your medicine just as your healthcare provider tells you, all the TB germs should be killed.

**Risk Reduction:** Travelers should avoid close contact or prolonged time with known TB patients in crowded, enclosed environments (for example, clinics, hospitals, prisons, or homeless shelters). If you think you have been exposed to someone with TB disease, contact your healthcare provider or local health department to see if you should be tested for TB. Be sure to tell the doctor or nurse when you spent time with someone who has TB disease.

American Lung Association, <http://www.lung.org/lung-disease/tuberculosis/>

CDC: <http://www.cdc.gov/tb/topic/infectioncontrol/>

#### **Tobacco Smoking**

Cigarette smoking has been identified as the most important source of preventable morbidity (disease and illness) and premature mortality (death) worldwide. Smoking-related diseases claim an estimated 443,000 American lives each year, including those affected indirectly, such as babies born prematurely due to prenatal maternal smoking and victims of "secondhand" exposure to tobacco's carcinogens. Smoking cost the United States over \$193 billion in 2004, including \$97 billion in lost productivity and \$96 billion in direct health care expenditures, or an average of \$4,260 per adult smoker.

**Risk Reduction:** Quitting smoking is the single most important step a smoker can take to improve the length and quality of his or her life. Stopping smoking can be tough but smokers don't have to quit alone. The American Lung Association has lots of options to help adult and teen smokers quit smoking for good.

American Lung Association, <<http://www.lung.org/stop-smoking/how-to-quit/>>

#### **HIV/AIDS**

HIV is the human immunodeficiency virus. It is the virus that can lead to acquired immune deficiency syndrome, or AIDS. HIV damages a person's body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases. Within a few weeks of being infected with HIV, some people develop flu-like symptoms that last for a week or two, but others have no symptoms at all. People living with HIV may appear and feel healthy for several years and can still spread the virus. HIV is spread primarily by not using a condom when having sex with a person who has HIV, sharing needles, and being born to an infected mother. If you believe you may have been exposed you need to see a doctor and get tested. Early treatment can reduce the spread of HIV and allow you to start treatment early to reduce the impact of the disease on your body.

**Risk Reduction:** Use condoms consistently and correctly. Reduce the number of people you have sex with. Talk to your doctor about pre-exposure prophylaxis (PrEP). PrEP should be considered if you are HIV-negative and in an ongoing sexual relationship with an HIV-positive partner. Talk to your doctor right away (within 3 days) about post-exposure prophylaxis (PEP) if you have a possible exposure to HIV. Get tested and treated for other sexually transmitted diseases (STDs) and encourage your partners to do the same. If your partner is HIV-positive, encourage your partner to get and stay on treatment.

CDC: <http://www.cdc.gov/hiv/topics/basic/index.htm>

AIDS.Gov: [www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/sexual-risk-factors/](http://www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/sexual-risk-factors/)

**Congruent Counseling Services, LLC**  
**Infectious Disease Education**

*Client Copy*

**STDs**

Sexually transmitted diseases, or STDs, can be painful and embarrassing. Unfortunately, they are especially common when safe-sex precautions are not taken. Luckily, most STDs are easily treatable by your doctor. If you're afraid you might have an STD, consider these seven warning signs: painful urination; painful intercourse; open sores or bumps near the mouth or genitals; unusual discharge from the genitals/unusual odor; itching or swelling in the genital area; changes in menstruation; high fever, fatigue, or nausea. These can all be symptoms of an STD. If you feel as if you might be coming down with something shortly after having unprotected sex, don't assume that it's just a common cold. If you believe you might have an STD, you should make an appointment with your doctor as soon as possible.

**Risk Reduction:** There are several ways to avoid or reduce your risk of sexually transmitted infections: Abstain from sex; Stay with 1 uninfected partner; Avoid vaginal and anal intercourse with new partners until you have both been tested for STDs; Get vaccinated. Vaccines are available to prevent human papillomavirus (HPV), hepatitis A and hepatitis B. Also, Use condoms and dental dams consistently and correctly; Don't drink alcohol excessively or use drugs. **Communication:** Teach your child that becoming sexually active at a young age tends to increase a person's number of overall partners and, as a result, his or her risk of STDs. Consider male circumcision.

Reference: <http://www.cdc.gov/STD/>

Mayo Clinic: [www.mayoclinic.org/diseases-conditions/sexually-transmitted-diseases-stds/basics/prevention/con-20034128](http://www.mayoclinic.org/diseases-conditions/sexually-transmitted-diseases-stds/basics/prevention/con-20034128)

**Hepatitis**

Hepatitis is an inflammation of the liver. The condition can be self-limiting or can progress to fibrosis (scarring), cirrhosis or liver cancer. Hepatitis viruses are the most common cause of hepatitis in the world but other infections, toxic substances (e.g., alcohol, certain drugs), and autoimmune diseases can also cause hepatitis. There are 5 main hepatitis viruses, referred to as types A, B, C, D and E. These 5 types are of greatest concern because of the burden of illness and death they cause and the potential for outbreaks and epidemic spread. In particular, types B and C lead to chronic disease in hundreds of millions of people and, together, are the most common cause of liver cirrhosis and cancer.

**Risk Reduction:** Good personal habits will help reduce the spread of hepatitis A and hepatitis E. If you're in a place where you're not sure things are clean, boil water. Cook all food well and peel all fruit. If you're a healthcare worker or caregiver for someone who has a contagious form of hepatitis, take extra steps to stay clean. Wash your hands, utensils, bedding, and clothes with soap and hot water. To prevent the spread of hepatitis B, stay away from the blood or body of someone who has it. That means no kissing or sex. Don't share razors, scissors, nail files, toothbrushes, or needles. If you plan to travel to countries where hepatitis is widespread, get protected. You can get vaccinations for hepatitis A and B. In the U.S., all children are advised to receive a series of hepatitis B vaccine before they start school. Kids who live in places with a lot of hepatitis A should get that vaccine. There isn't a vaccine for hepatitis C.

WHO: [www.who.int/features/qa/76/en/](http://www.who.int/features/qa/76/en/)

Web MD: [www.webmd.com/hepatitis/understanding-hepatitis-prevention](http://www.webmd.com/hepatitis/understanding-hepatitis-prevention)

**For Treatment or Testing**

See your doctor, or we recommend Dr. Patel, Family Health Center, 10632 Little Patuxent Pkwy, Suite 111, Columbia, MD 21044. Phone: 410.997.9751.