PROFESSIONAL SERVICE AGREEMENT

Informed Consent for Psychotherapy Services

HISTORY

Shannon Leigh Rowell, LLC is the private practice of Shannon Leigh Rowell, LMHC. Shannon has over 6 years of clinical experience treating children, adolescents, adults and families using individual and family therapy. Shannon treats a variety of mental health conditions but especially specializes in self-injurious behaviors and trauma recovery. She earned her Master's Degree in Mental Health Counseling from Nova Southeastern University in 2010.

Shannon has been in private practice in Central Florida for four years. She is licensed by the State of Florida as a Licensed Mental Health Counselor (license #11468) and is a Qualified Supervisor for the State of Florida for Registered Mental Health Counselor Intern.

TREATMENT APPROACH

Shannon Leigh Rowell believes in the power of collaboration between client and therapist with the client being the expert on his/her own life and path to healing. This important work is something that we will partner on, and requires input and involvement from both parties. While there are many different therapeutic approaches to utilize and all have various strengths and advantages depending on the person or condition, in our practice, we emphasize evidence-based treatment strategies such as Cognitive Behavioral Therapy (CBT) and mindfulness-based therapy because studies have shown that they are most effective.

SESSIONS

Your intake appointment will last approximately 50-60 minutes and will cover treatment practices, philosophy, insurance plan limitations and risks, assessment and an individualized plan for treatment. You and your therapist will develop a treatment plan aimed at reaching your personal goals. There is no one prescription for therapy that works for everyone. Therapy may last two months to two years. It is typically a commitment involving weekly sessions initially while your situation is assessed and goals are developed. We will review your progress toward treatment goals regularly.

This document is intended to inform you of our policies, state and federal laws, and your rights as a client, but may not be comprehensive. If you have questions or concerns, please ask! Psychotherapy is a professional service involving personal needs and a therapeutic relationship. It is your responsibility to fully understand what it is and is not, and to clarify your goals and needs in regards to our services, to ensure a good fit and a successful course of treatment.

1100 Town Plaza Court, Suite 2020, Winter Springs, FL 32708 Ph: 407.415.4464
Web: www.ShannonLeighRowellCounseling.com

WELCOME

Thank you for choosing Shannon Leigh Rowell, LLC for your psychotherapy needs. We look forward to serving you! While you await your appointment, please fill out the following identifying information, if you have not done so already (via email or telephone).

Then, please move on to reviewing the Professional Service Agreement packet. We will go over this at the start of the session before moving into the details of what brings you in today.

Client Name: _____

Address: _____

Phone: _____ **Email:** _____

Home **Cell** **Work**

Emergency Contact: _____ _____ _____

Name **Relationship** **Phone Number**

Client Date of Birth/Age: __/__/____ _____

Parent/Guardian Name (if under 18): _____

Reason for seeking counseling:

FOR IN-NETWORK INSURANCE CLIENTS ONLY:

Insurance Provider: Cigna/Health Choice/ValueOptions

_____ _____ _____ __/__/_____

Insured's ID **Name of Insurer** **Relationship** **Date of Birth**

_____

Address

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Congratulations on choosing this investment in yourself!

CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for:

a) Information (diagnosis and dates of service) shared with your insurance company to process your claims, if applicable,

b) Information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Florida state law, we are obligated to report this to the Department of Children and Family Services,

c) Where you sign a release of information to have specific information shared with treatment team members, such a doctor or psychiatrist,

d) If you provide information that informs one of our staff that you are in danger of harming yourself or others,

e) Information necessary for case supervision or consultation, or

f) When required by law.

Shannon Leigh Rowell, LLC is not a crisis facility and does not provide emergency services or services outside of normal business hours (Tuesday-Thursday 9am-5pm). If a client or a client's guardian believes that a client is in danger of immediate harm to self or others, they should call 911, or bring the client to the nearest Mental Health facility where a psychological evaluation can be performed. Shannon Leigh Rowell, LLC does not provide such services; however, in case of hospitalization the therapist should be notified in order to coordinate aftercare services.

E-mail and text messages are not confidential and your therapist may not be able to respond in a timely manner. Please reserve clinical or personal discussions for sessions. Social networking sites are not an appropriate place to exchange information as they may violate your confidentiality and lead to potential ethical dilemmas. Please do not seek connections with your therapist on these sites, as those requests will be denied.

Signature(s)_____Date:_____

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FINANCIAL and INSURANCE POLICIES

This section covers the business aspect of the therapeutic relationship. While therapy is inherently personal, and you may develop a close connection and trust with your therapist (that is our goal!), therapy is also a service just like any other you may receive which requires fair payment for services provided. In addition, the licensed professionals employed by Shannon Leigh Rowell, LLC have many years of professional experience as well as advanced degrees. Please promptly pay for services provided. **It is your responsibility to review and understand the fee schedule, and to ask any questions that you may have at your initial session.**

FEES

Individual counseling sessions are **$125 for 45-50 minutes**. The initial session/intake assessment fee is **$185**. Other fees for services provided are listed on the **Fee Schedule**, which is provided for you to keep. Payment is due at the time of service rendered. If you need to cancel/reschedule an appointment, please give 24 business hours advanced notice, otherwise you will be billed at the hourly rate with the credit card you have authorized us to have on file.

INSURANCE

Shannon Leigh Rowell, LMHC is an in-network provider with the following insurance providers only:

Cigna

Health Choice

ValueOptions

It is the patient's responsibility to verify insurance benefits and co-pays. *Please review the Insurance release document (page 9) for more information.*

OUT OF NETWORK BENEFITS

If you would like to use different insurance benefits, it is your responsibility to verify with your insurance plan that you have Out of Network (OON) benefits *prior to your first session*. If you have, and choose to use these benefits, you are responsible for payment in full **at the time of service, including the Intake**. Shannon Leigh Rowell, LLC does not assist with identifying or recovering any OON benefits you may have. However, we will provide a detailed receipt called a "super bill" for you to submit to your insurance company after the session is completed. This document may contain Personal Health Information (PHI) related to your mental health condition requiring treatment. In many cases, clients

can receive up to 60-70% of fees paid, but this is not a guarantee and is dependent upon your individual insurance provider. Confirmations of such benefits are the patient's responsibility, as is the payment in full at the time of service. Requests for records/receipts for insurance or tax purposes must be made in a timely manner, allowing 2-3 business days for completion. Additional fees may apply.

EMAIL DISCLAIMER

To expedite the Insurance/OON benefits process for your convenience, email may be used for such purposes as sending superbills and other receipts for insurance documentation. As noted, email is not fully private and your health information may be jeopardized by using this transmission of medical data.

RELEASE FOR EMAIL

_____ I agree to have my superbills or other insurance documentation emailed to the

Initial following email address: _____.

Email address

_____ I agree to have appointment reminders emailed to me at the following email

Initial address: _____ .

Email address

_____ I do not wish to use email for correspondence that includes PHI

Initial (protected health information).

CREDIT CARD POLICIES

Payment is due at the time of service. Cash and checks are welcome! However, if you choose to use a credit card, you may place a card on file for ease of weekly payment. Additionally, this form requests authorization for us to maintain a credit card on file for missed appointments.

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CANCELLATION POLICY

24 hour's notice is required to cancel or reschedule an appointment. In the event of a missed appointment without 24 hour's notice, you will be billed at the hourly rate with the credit card you have authorized us to have on file.

CREDIT CARD AUTHORIZATION

I, _____, give Shannon Leigh Rowell, LLC, the authorization to charge my credit card $_____for each missed counseling session where 24 hours notice is not given.

_____I would like Shannon Leigh Rowell, LLC to place the following credit card on file for my regular counseling sessions. I understand that my card will be charged at the time of service unless I have requested an alternate form of payment be utilized.

_____I do not wish to have a card on file for regular use. I will pay cash or check.

I am also aware that when services rendered at Shannon Leigh Rowell, LLC have ended, this form shall be returned to me for my disposal.

_____ _____

Client Signature **Date Signed**

Credit Card Number: _____

_____ _____

Expiration Date **Security Code**

Name on card: _____

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If you would like your receipt emailed to you, please provide an email address where you would like the receipt sent, if different from your primary email address: _____

COLLECTION OF FEES

In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed.

I have received a copy of my fee schedule (page 13) **_____.**

Client Signature

We sincerely appreciate your cooperation and at any time you have any questions regarding fees, balances or payments please feel free to ask.

I agree to the terms set aside in the above section entitled "Financial and Insurance Policies, " and I understand that I may request a review of this document and the policies contained herein at any time during the course of treatment.

Signature(s)_____Date_____

COORDINATION OF TREAMENT

It is important that your health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please note, you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization**. If you prefer to decline consent no information will be shared.

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME:_____

CLINIC:_____

ADDRESS:_____

PHONE:_____

Signature(s)_____Date_____

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NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I/We have read and received a copy of the Notice of Privacy Practices and Client Rights (page 10,11).

Signature(s)_____Date_____

May we contact you at home (circle one) **yes no**?

May we contact you at work **yes no?**

May we contact you by cell phone **yes no?**

Where may we contact you _____?

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS

I/We consent that _____ be treated as a therapy client by Shannon Leigh Rowell, LLC. Parent involvement is a necessary component of the treatment of children. Parents must agree to attend sessions as requested by the therapist, and to follow through on treatment plans recommended by the clinician to the extent that they are able.

It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours, and we ask for your cooperation to provide timely treatment for you and your children. This consent to treat my child expires at the end of treatment or if revoked in writing.

Signature(s)_____Date_____

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INSURANCE RELEASE

By signing this form I am voluntarily authorizing the release of any information, including Personal Health Information (PHI) relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further agree and acknowledge that my signature on this document authorizes Shannon Leigh Rowell, LLC to submit claims for benefits for services rendered without having to obtain my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though I had personally signed each individual claim.

I,_____hearby authorize_____

(Name of Insured) **(Name of Insurance Company)**

To pay and hearby assign directly to Shannon Leigh Rowell, LLC all benefits, if any, otherwise payable to me and for services rendered. I understand I am financially responsible for all charges incurred, including services not covered by insurance and cancellation fees not covered by insurance. I further acknowledge that any insurance benefits, when received by and paid to Shannon Leigh Rowell, LLC, will be credited to my account in accordance with the above said assignment.

I understand that a no show/ late cancellation fee of your total billed session will be assessed for cancellation less than 24 hours notice before my appointment and will be due **before my next appointment**. This is not billable to the insurance company. I also acknowledge that if I am late for an appointment, I will still be charged for a session in full and am not entitled to additional time.

If requesting out-of-network insurance to be filed, you are responsible for **full payment for each session ($125)** until the first claim is filed and your deductible/co-insurance information has been confirmed. If it is determined that your deductible has been met, any fees paid in excess of what is owed will be credited toward co-payment fees for future sessions, or refunded if applicable. Every effort will be made to receive authorizations if necessary, however please note that authorizations do not guarantee claims payment and you will be responsible for any claims not paid by your insurance carrier. It is your responsibility to verify coverage, deductibles, and format for submitting claims.

Insured's Signature:_____ **Date:_____**

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HIPPA NOTICE OF PRIVACY PRACTICES

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

EFFECTIVE DATE: January 2016

Shannon Leigh Rowell, LLC, is committed to maintaining client confidentiality. We will only release health care information about you in accordance with federal and state laws and the ethics of the social work profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services: Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT: We may need to use or disclose health information about you to provide, manage or coordinate your care or related services, which could include consultants and potential referral sources.

PAYMENT: Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS: We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent: There are some instances where we may be required to use and disclose information without your consent. This includes, but is not limited to:

- Information you and/or your child or children report about physical or sexual abuse. By Florida State Law, we are obligated to report child and elder abuse to the Department of Children and Family Services.
- Information that informs us that you are in danger of harming yourself or others, we must also report this information to the proper authorities.
- Information to remind you of, or to reschedule, appointments, or treatment alternatives.
- Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

CLIENT RIGHTS

- **Right to request how we contact you**
- It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

- **Right to release your medical records**
- You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

- **Right to inspect and copy your medical and billing records.**
- You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request or offer to provide a treatment summary instead of full records. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

- **Right to add information or amend your medical records**.

- If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

- **Right to an accounting of disclosures.**
- You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

- **Right to request restrictions on uses and disclosures of your health information.**
- You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

- **Right to complain.**
- If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

- **Right to receive changes in policy.**
- You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

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FEE SCHEDULE
Effective 1/1/16

CPT Code		
90791	Initial Consultation	$185.00
90834	Individual therapy (50 minutes)	$125.00
90847	Family or Couples counseling	$150.00
90853	Group Therapy	$55.00
Online	30-minute session	$45.00
	45-minute session	$75.00
	60-minute session	$125.00

Reduced Fee Opportunities for

Prepayment of 4 sessions full fee……. 15% discount

Scholarship application* …… per application

Limited number of slots, will be reassessed after 6 months

Divorce Mediation—Court-ordered 3 hours $300.00

Intern/Supervision Rate $75.00 per hour

Review of Records* $45 per 30 minutes

Includes tax receipt preparation, insurance "superbill" preparation exceeding 15 min. Restrictions apply.

Minimal phone consultation, texting, or email* No charge if under 15 min.

Please review privacy practices and see above as Review of Records and/or session rate may apply depending upon the content of the communication. Communication of a clinical is charged at the contracted hourly rate while business/financial communication is at the Review of Records rate.

Extensive Phone Consultation* $125 per hour

Correspondence of any kind, including texting, email, online, or telephone, of more than 15 minutes.

Missed appointment—hourly rate* Per Rate

Late payments or returned checks $25.00

*Insurance may not reimburse for mediation, review of records, extensive phone consultation or missed appointments.

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