CONSENT FOR EVALUATION/TREATMENT/CPST/TBS/PSYCHIATRY SERVICES
FEE AGREEMENT AND INSURANCE AUTHORIZATION

THE COUNSELING SOURCE, INC.
10921 Reed Hartman Highway, Suite 133, Cincinnati, Ohio 45242
Phone: (513) 984-9838 or 800-618-0688 Fax: (513) 984-8075 or 800-738-9854

Client Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Telephone: (_____)_____ E-Mail:_____
Area Code

I, the above-named individual (or legal representative of this individual), acknowledge and agree to the following:

General Consents/Acknowledgments:

1. I consent to receive mental health services as provided by The Counseling Source, Inc. (TCS). These services may include evaluation, individual or group counseling, Community Psychiatric Support Treatment (CPST), Therapeutic Behavioral Services (TBS), or psychotropic medication management (Med Mgt) as recommended. Services will be provided consistent with an Individual Service Plan developed with my input.

   I consent to receive these services either face-to-face or via telehealth (video conferencing, phone, email, or texting) as appropriate. I acknowledge receipt of the Telehealth Standards of Care (attached) and have reviewed and agree to abide by them. I also understand that some forms of electronic communication may not be compliant with the Health Insurance Portability and Accountability Act (HIPAA), and I consent to these modes of communication.

2. I acknowledge that I have been provided with access to information regarding the risks and benefits of treatment and my right to refuse or withdraw consent for treatment. I also acknowledge that I have been made aware of the availability of the Client Handbook and HIPAA information on TCS's website at www.thecounselingsource.com on the "Useful Documents" tab.

3. I authorize a review of my records for quality assurance purposes.

4. Should I be transferred to an inpatient hospital, I authorize TCS to exchange verbal and written information with the hospital regarding clinical services provided to me in order to assure continuity of care.

5. I acknowledge that repeated cancellation of sessions without 24-hour prior notice may result in termination of services by TCS.

6. I understand that, consistent with HIPAA, TCS can contact and exchange information about my care with my physician and other involved health care professionals.

7. I acknowledge that I have been informed that the Client Rights and Grievances Policy and Procedures are available to me on the TCS website at www.thecounselingsource.com on the "Useful Documents" tab and that the Client's Rights information is contained within the Client Handbook.

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8. Should I be acting as a guardian, I authorize TCS to use the preferred pronouns and name of the client. Furthermore, should the client present in a manner consistent with a Gender Identity related disorder, I authorize TCS to accurately diagnose, develop a treatment plan, and treat such diagnoses. Furthermore, I consent to TCS evaluating the minor-client for other comorbidities, abuse, and trauma during the course of treatment.

9. If I am typically served and physically present in either a nursing home or school setting, I acknowledge that in a mental health crisis, my best course of action is to inform the nursing home or school staff. If I am at home or in the broader community, I should call 911 and provide the dispatcher with my location and the nature of my crisis. For less emergent needs, TCS has a clinician on call at 1-800-618-0688. Furthermore, I acknowledge that I understand that it is not appropriate to communicate urgent concerns to a TCS therapist through email, texting, or clinician specific voicemail, as the clinician will not receive or review these messages in real time.

10. I acknowledge that I have been informed that while interactions between a client and mental health provider are confidential, there are exceptions that dictate the mental health provider, as a mandated reporter, must report instances of elder abuse, child abuse, or imminent harm when disclosed by the client.

Fee Agreement/Insurance Authorization:

1. I authorize TCS to act as my agent in obtaining payment from all third-party payers and authorize third-party payers to make payment directly to TCS. Based on the payer information TCS has at this time, my costs for services will be as follows **(check only one):**

____ a. I have Ohio Medicaid, and as a result, while I have Medicaid, I will not have any financial responsibility to pay for services.

____ b. I have commercial insurance, and I will be personally responsible for paying for whatever my insurance does not pay. I will be required to submit a deposit of _____before the start of services.

____ c. I have Medicare, and I will be personally responsible for paying for whatever services Medicare (and any supplemental insurance, if applicable) does not pay.

____ d. I have elected to pay for one or more of TCS's services out of pocket based on a Sliding Fee Schedule (SFS) as detailed below. A deposit of _____will be required prior to delivery of SFS services.

$_____/hr. of evaluation. $_____/hr. of treatment. $_____/hr. of CPST/TBS. $_____ / hr. of Med Mgt

Treatment and CPST/TBS services may be provided in individual or group sessions. Treatment formats and/or duration of sessions may vary and will ultimately determine fees billed.

2. I understand that by signing this document, I authorize the release of sufficient information to the Ohio Department of Medicaid (ODM) and any related Managed Care Organizations (MCO's) or insurance companies to determine my eligibility for third-party funded services.

3. I understand that I am liable for the full cost of services not covered by third-party payers.

4. Third-party payers (Medicare, Medicaid, private insurance, etc.) will be billed for any covered services, to the extent that I am eligible. I understand that telehealth services may be treated differently by payers.

5. I authorize the release of information from my clinical records as necessary to process claims for third party payers.

6. I agree that if I choose to receive services based on a SFS that I will provide the requested information to TCS to verify household size and income. I also agree to provide a deposit before the initiation of services on a SFS or commercial insurance basis.

7. I acknowledge that I am responsible for notifying TCS of changes in my insurance coverage or financial status that might affect my billing rate for TCS services.

8. I acknowledge that with appropriate prior warning, TCS may terminate services due to non-payment of my bill.

_____

Signature of Client or Legal Representative_____ Date_____

If not signed by the client, please provide the following information :

Client Name_____ Date_____

Name of Legal Representative: _____

Legal Representation Type: Guardian, Durable Power of Attorney, Other (specify):_____

Address of Legal Representative_____

Phone of Legal Representative_____ Email _____

Witness to Verbal Consent (if applicable) _____

If this document was signed by the client or legal representative in the presence of the undersigned TCS representative, the TCS representative acknowledges that they have reviewed the above information with the client and/or legal representative. Additionally, the TCS representative has provided access to orientation materials: which include Client Handbook and TCS Notice of Privacy Practices to the (client/guardian name)_____, (Client SS#)_____and if there were any questions, the TCS representative answered the questions to the client's or guardian's satisfaction. If this document was signed electronically, the TCS representative commits to reviewing the information contained herein during their first interaction with the client/legal representative and will endeavor to answer any questions posed by the client/legal representative to the best of their ability.

_____ _____

Signature - Representative - The Counseling Source, Inc. Date of First Billable Contact

Telehealth Standards of Care

By engaging in telehealth services with a clinician from The Counseling Source, Inc. (TCS), you are providing informed consent for receiving care remotely. You have the right to decline telehealth services and request in-person care at any time, if available, without affecting your right to future care.

Privacy: It is the client's responsibility to be in a private and confidential location for the session, where interruptions and being overheard are avoided. Using headphones can enhance privacy. It is the client's right to conduct a session with third parties present; however, the clinician cannot guarantee confidentiality when third parties are present during telehealth sessions.

Identity and Location Verification: To maintain confidentiality and ensure appropriate care, your identity and location will be confirmed at the beginning of each session. Passwords and/or other identifying information may be required in the event there is a need for additional verification of the client's identity. A “safe” word or phrase will also be agreed upon and used to indicate when a client does not feel they have sufficient privacy to proceed with the session.

Conduct: Treat the telehealth session with the same professionalism as an in-person appointment. Avoid driving or being in a public place during the session.

Questions: Feel free to ask any questions about care or the telehealth process during the session.

Boundaries in the Professional Counseling Relationship: It is important to note that while TCS has a 24-hour on-call clinician available, your individual TCS clinician does not provide 24-hour services. Sessions are conducted on the day and time established between the clinician and client. If a client or clinician needs to reschedule a session, contact can be made via phone call or text message. Clinician will respond to client's request as soon as possible -- typically by the close of the next business day. Both the client’s and the clinician's time is valuable. If a client is more than 15 minutes late for a session, they will be considered a "no show". Please text or call the clinician to reschedule.

Clients will not send sensitive information via text message to the clinician. Text messages should be utilized strictly for administrative information (i.e., session cancellations, rescheduling, or confirmations).

Emergency Procedures & Immediate Danger: If in immediate danger, experiencing a medical emergency, or concerned about safety, including suicidal thoughts, call 911 for emergency services immediately. Telehealth is not suitable for emergencies. Clients who feel suicidal can also call the Suicide and Crisis Hotline (988). For non-life-threatening crises, clients should call the 24-hour TCS Emergency Hotline by dialing (1-800-618-0688).

Disconnections: In the event of a technical disconnection during a session, an attempt to reconnect will be made via the telehealth platform. If unsuccessful, contact will be made at the phone number provided by the client.

Emergency Contact: It is preferred that the client provide a local emergency contact person and their contact information. This person will only be contacted if there concern over the safety and/or welfare of the client.