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PRACTICE POLICIES AND CONSENT TO TREATMENT

INTRODUCTION:

Welcome and thank you for scheduling an appointment. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

CONFIDENTIALITY:

Below is a description of confidentiality as it applies to discussions between medical or mental health provider and client. The limits placed on the confidentiality of disclosures made to a provider by Tennessee State Law are also explained. Additional information is provided in the attached "Patient Notification of Privacy Rights". This information is important, so please read it carefully.

Your identity as a client as well as the disclosures that you make to your provider are private and protected. This means that your provider will not reveal to others that you are her client, and will not share anything that you say during your treatment with anyone else. If you would ever like your provider to reveal your status as a client, or you would like your provider to share information with a third party, you will be asked to sign a release of information. Our policy is to provide a written summary of the treatment information contained in your file if you would like information from your file released to a third party other than another mental health professional.

For those under the age of 18:

Be aware that if you are under the age of 18 the law provides your parents the right to examine your records and to be informed about your treatment. It is our policy for you to be aware if your provider meets with your parents. If your provider believes there is a high risk that you may threaten the safety of yourself or someone else, your parents will be notified.

Limits of Confidentiality

There are certain situations which can arise in which disclosures you make to your provider cannot be kept private due to Tennessee State Law. They are as follows:

1. If you indicate that you are in serious and immediate risk of harming yourself or someone else. The most typical situation would be when the threat of suicide is such that your provider cannot be assured of your safety once you leave the session. It is important to note that this does not apply to talking about thoughts of harming yourself that you may be experiencing. Many people who are feeling discouraged and hopeless think about harming themselves, and it is very important to openly talk about this with your provider. Talking about suicide or other thoughts of self-harm would not automatically require your provider to breach confidentiality. However, in the event you intended to act on any thoughts to kill or harm yourself, your provider would be required to act to protect you even if that involved breaching confidentiality. If you



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reveal a serious intention to harm someone else, your provider would be required to take action to protect that person.

2. If you indicate that you are involved in the abuse of a child, minor, elderly adult, or a disabled person, your provider is required by law to report these activities to the appropriate office. Your provider is also required to report cases of domestic abuse. Once filed, your provider is unable to safeguard the privacy of the information released.

3. If you become involved in a court proceeding, the court may use the power of subpoena to gain access to information that you have shared with your provider. Although it is our policy to limit our involvement in legal proceedings as much as possible, under court order your provider may be required by law to provide written or verbal testimony to the court.

4. If a government agency is requesting information for health oversight activities, your provider may be required to provide it for them. 5. If a client files a complaint against your provider, she may disclose relevant information regarding that client in order to defend him/herself. 6. If your fees are being reimbursed by an insurance or managed Care Company, you should know that such companies often ask that treatment information be shared with them as part of their review of services. Typically, these companies have their own policies and procedures for safeguarding your privacy. However, once your provider has released the required information to any such company, your provider can no longer assume responsibility for preventing the dissemination of the information that has been released.

Be assured that your right to confidentiality is very important to us. In the unlikely event that your provider must breach confidentiality, your provider will make every effort to use care and discretion while meeting legal and ethical obligations.

_____ I have read and accept the terms of the confidentiality and disclosure policies.
(Initials)

OFFICE HOURS:

Office hours are by appointment only.

CONTACTING YOUR PROVIDER:

If you need to speak with me between office visits please call the office # between 8 am and 4pm. You may leave a message and I will call you back. Phone conversations longer than 15 minutes are to be billed at the provider's hourly rate and will be prorated based on the duration of the conversation. You will be informed of such costs if relevant. If, for any number of unforeseen reasons, you do not hear from your provider and you feel unable to keep yourself safe, please 1) contact the Crisis Intervention Center at 615-244-7444, 2) go to your Local Hospital Emergency Room; or, 3) call 911.

EMERGENCIES:

Monday – Friday from 8am – 4 pm, call the office number at 615-696-4450. In the event of a life-threatening emergency or a situation that presents imminent risk or harm, call 911 or the Crisis Line at 1-855-274-7471, or go to the nearest emergency room. **DO NOT DELAY TREATMENT!**



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PAYMENT INFORMATION:

Payment is expected at the time of service. Payment may be made by cash, check or credit card (Visa, Master Card, Discover, and American Express). Any balances will be due upon receipt of the monthly statement. Accounts over 30 days are subject to a late fee.

I am currently out of network with insurance companies. You may choose to seek reimbursement from your insurance company using your out of network benefits if desired. I can print a bill and receipt that you will then submit to your insurance provider for reimbursement.

To save an initial appointment time, credit card information will be required. In the event you do not come to your initial appointment and do not give at least 48 hours' notice, the full appointment fee will be charged to your credit card. If you cannot come to your initial appointment, please call to cancel or reschedule as soon as possible. At the time of your appointment, you may choose another payment method if you do not wish your credit card to be charged.

_____ I have read and accept the payment information terms.
(Initials)

CANCELLATIONS:

Appointments are scheduled individually. With the exception of unforeseen emergencies, notification of cancellation is expected 48 hours (two business days) in advance; otherwise you will be billed for your missed appointment. Monday appointments would need to be cancelled by the previous Friday to avoid a charge. Requests for changing appointment times should be discussed in advance.

_____ I have read and accept the cancellation terms. (Initials)

ELECTRONIC MAIL (EMAIL) Policy:

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to-face). We cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we will save email correspondence with you and these communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature and please contact the office if you have not received a reply within 24 hours. Please be aware that a fee will be incurred if consultation is obtained via email and will be calculated in accordance with the provider's hourly billing rate.

_____ I have read and accept the email communication terms and policies.
(Initials)

Email address for communications: _____



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TERMINATION OF TREATMENT:

Patients are not obligated to continue treatment. If you decide to terminate at any time, you are encouraged to discuss your decision to terminate care with your provider.

CONSENT TO TREATMENT AND PATIENT/GUARANTOR PAYMENT RESPONSIBILITY:

I have read the policies listed above and I understand and agree to them. I agree that I am responsible for all charges for services rendered and I agree to adhere to the payment policies outline above. I understand that if I do not pay for my treatment, the therapist may stop treatment.

I do hereby seek and consent to take part in treatment by Stephanie Upchurch with Like You Counseling Services. I understand that developing a treatment plan with this therapist and regularly reviewing our k toward meeting my treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will be responsible for is paying for services already received.

I hereby authorize my individual provider to release to my insurance company or other third party payer any and all information they may require concerning patient care.

Your signature below indicates that you have read this Agreement, the Patient Payment Agreement, and the Notice of Privacy Practices and agree to their terms.

Patient Full Name (please print)

Relationship to client

Patient Signature

Date

If patient is a minor:

Parent / Legal Guardian Full Name (please print)

Relationship to client

Parent/ Legal Guardian Signature

Date