Acme Counseling and Consulting Services * Valerie Peckham, LCP

Clinic Policies

Welcome to Acme Counseling and Consulting Services! We want to help make your experience with us pleasant and comfortable. Please read the following documents carefully and feel free to ask questions about anything you do not understand.

Business and Billing Policies

• Co-pays are due at the time of service and can be made through cash, check, or card.
• Personal accounts must be up to date for appointments to be scheduled (except in the event of emergency).
• Payment Options are available for clients not using insurance—Please ask.
• As a courtesy to you, the clinic may submit claims to your insurance company. Clients are responsible for any unpaid balance that may be due. Benefits quoted to Acme Counseling and Consulting Services by insurance companies are not a guarantee of payment. You are strongly encouraged to contact your insurance company to verify information about your benefits.
• You will be asked to provide a debit or credit card and to authorize payment for fees that may not be covered by insurance to ensure that a debt is not created on any account.
• When submitting claims to your insurance provider claims are submitted through electronic data interchange (web-based), fax, and/or mail-in processing.
• The Clinic is not a Medicare Provider. In the event you have Medicare as your primary insurance, you will be responsible for payment at time of services if you do not have secondary insurance coverage for the services.
• If your therapist is not contracted with your insurance company or is not an eligible provider, you will be responsible for payment at time of service. In some situations there are Managed Care Organizations involved that your therapist will not be contracted with and this will not initially be known. It is strongly recommended that you investigate coverage for services as you will be responsible for any services not covered by insurance.
• All clients should notify the clinic of any insurance change during the course of treatment and should provide a copy of new insurance card and information.
• Any balance is due upon receiving a statement or as otherwise expressly agreed. We currently are able to receive checks, cash, and credit cards for payment.
• A $35 fee and/or any fees applied by the bank for the returned check will be assessed for checks returned to us by the bank.
• A fee for returned or denied ACH or debit/credit debits will also be applied and will be the patient's responsibility.
• If it is necessary to use a collection service or small claims court to receive payment from you, you will be assessed the amount owed to the Clinic plus the amount charged by the collection service or court process. Please also note the limits of confidentiality in regards to non-payment and collections.
• **You are required to give a 24 hour notice for cancellation or change of appointments not due to illness or emergency. Insurance companies do not pay for appointments cancelled or missed. Late cancelations and No Shows will be charged a $75 fee unless other arrangements have been made ahead of time.**
• *The Clinic may decide to terminate services for clients who do not show for appointments or who make numerous cancellations. Please be aware that all future scheduled appointments will be cancelled if a client no-shows and does not respond to or communicate with the clinic about missing the appointment.*

Client/Guardian Initials _____

This document is continued on the following page…

Acme Counseling and Consulting Services * Valerie Peckham, LCP

Acme Counseling and Consulting Clinic Policies and Information

• Your therapist will use the first session as the initial assessment session and this session is usually 55 minutes but may last up to 90 minutes.
• After the initial session your therapist will work with you on setting goals and determining a treatment plan.
• Your therapist may recommend additional testing or assessment as warranted for diagnostic or treatment needs. You may also be asked to sign a release of information to obtain prior records that will allow the clinic to facilitate more comprehensive services for you. This type of release is specific and time-limited.
• The length of time in treatment will be determined by client progress and needs as well as by insurance company authorization.
• Session lengths are determined by the provider with consideration to needs and time available. Individual therapy session lengths will either be 45-50 minutes or 55 minutes for individual therapy.
• General hours of clinic operation are 9:00 am to 5:30 pm Monday - Thursday. Appointments outside of these hours may be available if necessary and/or recommended by your therapist.
• Your therapist will attempt to return calls within 2 business days with the exception of weekends, vacations, and holidays. When leaving messages please indicate date, time, and where you would like to be reached. You may also e-mail your therapist at valerie@acmeccs.com.
• If an emergency occurs after hours or on weekends/vacations/holidays, please call the after-hours line at 785-393-9809 (for calls that cannot wait until the next business day). Please be aware that this is a cell-phone so there are limitations as to the availability of access. This number should only to be used for emergent needs. Valerie will not be available by text and will not respond to such in order to maintain confidentiality. If you experience a life-threatening emergency please dial 911 or report to your local emergency room.
• All intake forms must be completed upon initial visit.
• The information we gather about you will be kept confidential, with some limited exceptions. For further information about privacy, please review the Notice of Privacy Practices and Informed Consent that you receive at the time of your intake.
• Session notes are completed to document all services provided. These records are maintained in paper form and through a web-based service provider that is HIPPA compliant.
• Children under age 12 are not allowed to wait in the lobby while you attend your session.
• If you have questions at any time about these or any other aspects of the clinic's services you have been provided, please discuss this with your therapist. Please also refer to the section on Client Bill of Rights and Informed Consent that you were given at the time of intake.
• General Rates of Service are as follows:

- Initial Admission Evaluation: 55-85 minute session is $150
- Individual Psychotherapy: 45 minute session is $135
- Individual Psychotherapy: 55 minute session is $150
- Interactive add-on (Including family or other agencies in therapy): $15 per session
- Couples and Family Therapy (more than 1 client): 55 minute session is $150
- Couples and Family Therapy (more than 1 client): 75-85 minutes is $210
- General Psychological testing battery: Pricing is determined by instruments used and extent of referral question.
- Crisis Rates: $175, First 60 minutes then $85 every 30 minutes

** Rates for any other services will be determined on a case by case basis.**

• Neglect on the part of Acme CCS to enforce any policy does not equate dismissal of that policy for future application or negate potential for later enforcement.
• I understand and agree to follow the above clinic policies. I understand that my signature will serve as my informed consent to comply with the above described policies.

Client/Guardian Signature_____ Date: _____

Acme Counseling and Consulting Services * Valerie Peckham, LCP

Patient Confidentiality and Informed Consent

Licensure Details

Valerie Peckham is a Licensed Clinical Psychotherapist. She has earned a Master's Degree in Psychology with an emphasis in Clinical Skills and completed post-graduate supervised work in order to attain a clinical level license to practice Masters Level Psychology. Valerie Peckham is not a doctor of Psychology and is also not a Psychiatrist. This means that Valerie Peckham does not prescribe medications. You are encouraged to seek medication services through your primary care physician or a licensed Psychiatrist.

Confidentiality and Limits

By legal and ethical guidelines, the contents of all Therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and or/legal authorities

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records

Insurance Providers (when applicable)

Insurance Companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of services, diagnosis, treatment plan, description of symptoms, progress of therapy, case notes and summaries

Court Orders

Mental health professionals may (very rarely) be required to furnish client treatment records if so mandated by court order.

Lifesaving Measures

In the event of an emergency medical situation, mental health professionals may need to give basic personal information about you to first responders in order to save your life.

Legal Involvement

If you pursue legal action against me for alleged negligence or malpractice, I will share your treatment records and other information with my attorney and my insurer. If I have to take legal action against you for fees owed by you, the fact of our professional relationship may be disclosed in the lawsuit. Likewise, if you allege a complaint against me with my licensing board your records will be released to my attorney, the licensing board, and my insurer.

Professional Consultations

In some cases I may determine it necessary to consult with another health care provider for purposes of your diagnosis or treatment. If this is determined necessary your treatment records and communications with me may be revealed.

Informed Consent—Risks and Benefits

Therapy is a powerful tool which can provide a forum for clients to evaluate their emotions, choices, relationships, and life path and make significant and lasting changes in behavior and relationships with the ultimate goal being improving quality of life. However, therapy has some risks and is not appropriate for everyone and all situations. Therapists often discuss sensitive emotional issues with clients that can tend to elicit uncomfortable feelings and emotions. There is a real possibility that, while working through some of these challenging issues, clients may feel poorly and, possibly, worse than they felt before starting therapy. These feelings usually subside once clients develop different understandings and coping skills and begin to make real progress toward achieving treatment plan goals. However, no therapist is able to guarantee a client will get better. By signing this informed consent, you acknowledge and accept the above described risks.

I have read and understand the above Limits of Confidentiality and Informed Consent

Client/Guardian Signature_____ Date: _____

Acme Counseling and Consulting Services * Valerie Peckham, LCP

Authorization of Benefits and Authorization for Release

Assignment of Benefits and Authorization for Release

Private Insurance companies and government insurance programs such as Medicare and Medicaid require you to sign an assignment of benefits in order for us to bill your insurance company directly. For this reason, the clinic requires your consent to release medical information to your insurance company and any other parties cooperating in the delivery of your care.

Assignment of Insurance Information:

I hereby authorize assignment of benefits and payment of medical/mental health benefits to Acme Counseling and Services-Valerie Peckham, LCP for services rendered to myself and/or other dependents. I agree to be responsible for payment of any co-pay charges and any balance due for charges not covered by my insurance policy. I understand that co-pays are due at the time of service and any additional charges are due in full upon receipt of my first statement. I authorize my insurance company to credit me for any overpaid benefits. These credits will be applied toward my sessions or to me directly at the end of treatment. By signing this form I recognize that my protected health care information (PHI) may be released for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made by my prior consent. I recognize that if I do not consent to release my PHI for the above purposes I will not be denied treatment, but the provider may not be able to utilize my insurance for payment.

Authorization for Release of Insurance Information

I hereby authorize Valerie Peckham or authorized staff of Acme Counseling and Consulting Services to contact my insurance company directly to obtain coverage and payment information regarding my policy.
This consent is given freely with the understanding that:

- Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as provided by law.
- A photocopy or fax of this consent is as valid as the original.

Client/Guardian Signature_____ Date: _____

Please Provide Insurance Information Below:

Name of Insurance Company:_____ (please provide a copy of Insurance Card)
ID #:_____Group #:_____
Name of Insurance Policy Holder:_____DOB:_____
Relationship to client: _____Phone Number:_____
Does your policy require preauthorization? ____YES____NO
Did you contact your insurance company prior to today's visit? ____YES____NO

Do you have additional/secondary insurance coverage? ____YES____NO (If yes, please complete information below)
Name of Insurance Company:_____ (please provide a copy of Insurance Card)
ID #:_____Group #:_____

Explanation of Client Rights

- To be free from discrimination due to race, religion, gender, sexual or political orientation, disability or any other unlawful category while receiving services
- To be informed of the cost of professional services before receiving the services
- To be informed of how your personal healthcare information will be shared with and utilized by any third party
- To revoke a signed disclosure in writing to your Therapist
- To obtain a copy of your mental health records as requested
- To be free of exploitation for the benefit or advantage of a Therapist
- To expect that your Therapist has met the minimal qualifications of training and experience required by state law
- To receive information regarding the Limits of Confidentiality before beginning treatment services
- To report complaints to the Kansas Behavioral Sciences Regulatory Board
- To privacy as defined by APA ethics and the law
- To request and receive a referral for any needed supplementary services
- To terminate treatment upon request

Client/Guardian Signature_____ Date: _____

Acme Counseling and Consulting Services * Valerie Peckham, LCP

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and the limits of confidentiality in relation to such.

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care and respect. Our clinic employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. This is referred to as using your Protected Healthcare Information (PHI) for the purpose of treatment, payment, or healthcare operations. We may also access information about you when considering a request from you, or when exercising our rights under the law or through any agreement with you. We safeguard all information according to established security standards and procedures.

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate, or not current, please inform us. We will take appropriate steps to correct any erroneous information as quickly as possible.

We limit who receives information and what type of information is shared. To help us offer you services we may share information with you insurance companies or managed care organizations for the purpose of claims processing and authorization. These companies act on your behalf and are obligated contractually to keep the information we provide to them confidential. Any other patient-specific data is released only when required to provide a service for you and must include a separate signed consent by you. Data is then released with the condition that the person receiving the information will not release it further, unless you give permission. Please be advised that once the PHI leaves the clinic according to the terms of the authorization, the clinic and its personnel have no control over how it will be used by the recipient.

The only exceptions to the requirement to obtain consent prior to releasing information are: emergency medical situations when we must notify first responders for life-saving measures, when the information is required by court order, or when we have information that a client is an imminent danger to themselves or others. We are also mandated reporters for suspected or known abuse toward a minor child or elderly vulnerable adult.

We do not share customer information with government agencies or third party marketers who offer products to our clients.

Client/Guardian Signature_____ Date: _____

Patient Rights and HIPPA Authorization

The following specifies your rights about authorizations to release Protected Healthcare Information or PHI under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPPA").

• Tell your mental health professional if you don't understand the authorizations, and they will explain it to you.

• You have the right to revoke or cancel an authorization at any time, except (a) to the extent information has already been shared based on the authorization; or (b) the authorization was obtained as a condition of obtaining insurance coverage for treatment. To revoke or cancel an authorization, you must submit a request in writing to your mental health professional and your insurance company, if applicable.

• You may refuse to sign an authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment or affect your eligibility for benefits. If you refuse to sign an authorization, and you are in a research –related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

• Once the protected health information leaves this office according to terms of the authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPPA.

• If this office initiated the authorization, you must receive a copy of the signed authorization.

• Special Instructions for completing authorizations for the use and disclosure of Psychotherapy Notes: HIPPA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy notes recorded on any medium (i.e., paper, electronic by a mental health professional must be kept by the author and filed separate from the rest of the individual's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPPA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and prognosis to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign the authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

Client/Guardian Signature_____ Date: _____

Acme Counseling and Consulting Services * Valerie Peckham, LCP

BILLING AUTHORIZATION FORM

I authorize Valerie Peckham DBA Acme Counseling and Consulting Services to charge my balance/bill directly to the credit/debit card(s) listed below:

Primary Card Account:

_____
Name on credit card (exactly as printed)

_____
Billing Address for credit card (Street, Apt. #)

_____
City, State Zip

_____
Credit card number

_____
Expiration Date CVV

_____
Signature Today's Date

Secondary Card Account:

_____
Name on credit card (exactly as printed)

_____
Billing Address for credit card (Street, Apt. #)

_____
City, State Zip

_____
Credit card number

_____
Expiration Date CVV

_____
Signature Today's Date

Cancellation Policy Reminder

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for your missed appointment.

A $75 fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. Your credit/debit card will be charged directly if do not show up for or fail to cancel an appointment.

Client/Guardian Signature_____ Date: _____