

Client Name: _____ Client DOB: _____

CONNECT AND RESTORE, LLC
CONSUMER ORIENTATION

Welcome to Connect and Restore, LLC. This document contains important information about our professional services and business policies. Please read it carefully. If you have any questions, we can discuss them when we meet.

Your initials at each heading signify that you have read, understand, and agree to the information included.

INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES

Before beginning psychotherapy, it is important that you understand the process, benefits, risks, and confidentiality.

The type and extent of services you receive will be determined after an initial assessment and thorough discussion between you and your therapist. The goal of the assessment process is to determine the best course of treatment for you. There are many different methods your clinician may use to address the problems that you hope to address. Therapy requires the active effort of each participant. Typically, treatment is provided once a week over the course of several weeks.

Our first few sessions will involve an evaluation of your needs and by the end of evaluation, your clinician will offer insights regarding the best way to pursue your goals for treatment. The treatment planning process will be collaborative between you, your family, if you elect for their involvement, and your clinician.

Therapy modalities you may encounter at Connect and Restore include those with focuses on attachment and trauma resolution and have firm basis in neuroscience and neuropsychology. It is important to us that you are comfortable with the type of therapy you agree to participate in and your clinician will explain the model and answer any questions as they arise.

All information shared with the therapists at Connect and Restore is confidential and such information cannot be released without your authorization. Before any confidential information can be released, you must sign a written authorization that states what information will be released and to whom. However, there are some exceptions to confidentiality.

- ***Imminent Self-Harm:*** If you tell your therapist that you plan to cause serious harm or death to yourself and your therapist believes you have the intent and ability to carry out this threat in the very near future, the therapist must take steps to protect you from harming yourself.
- ***Imminent Harm to Others:*** If you tell your therapist that you plan to cause serious harm or death to someone else and your therapists believes that you have the intent and ability to carry out this threat in the very near future, the therapist must inform the police, and when possible, the person you intend to harm.
- ***Abuse of a Child or Elder:*** If you tell your therapist or any Connect and Restore employee about the physical, sexual, or emotional abuse of a child or the physical abuse, sexual abuse, or exploitation of an elder, we are required by law to report such abuse to the Oklahoma Department of Human Services or to the appropriate law enforcement authorities.

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- **Court Order:** If you are involved in a court case and the court requires that your therapist release information about your therapy, your therapist must do so. Your therapist will do all he/she can within the law to protect your confidentiality and if your therapist is required to disclose information to the court, he/she will inform you that this is happening.

In the case of a minor client, it is important to ensure that the legal guardians clearly understand confidentiality. **Although the legal guardian has the right to review the therapy records, by signing this consent, the guardian waives any and all access to progress notes.** Access will be limited to intake information, treatment plan, treatment plan updates and discharge information.

TERMINATING TREATMENT

You normally will be the one who decides when therapy will end, with some exceptions.

- If, in your therapist's judgement, the treatment you require falls outside their scope of expertise. If this occurs, your therapist will discuss this with you and refer you to another therapist who may meet your needs
- If you are unable to adhere to our cancellation policy listed in this document
- Consistent lack of participation in therapy services
- If you do violence to, threaten (verbally or physically), harass any Connect and Restore, LLC personnel or their families, or damage or destroy the property of any of the above-mentioned persons, Connect and Restore may terminate you unilaterally and immediately from treatment.
- Failure to make payments in a timely manner

If you are terminated from treatment, your clinician will provide you with a referral to another provider.

DRUG USE

Any individual engaging in psychotherapy services, whether the identified client or family member of the identified client is expected to present to treatment sober and of sound mind. If an identified client is using drugs, the therapist and client will engage in further discussion to determine if a referral to a Licensed Alcohol and Drug Counselor is more appropriate for your treatment.

CONSULTATION OUTSIDE OF OFFICE VISITS

Connect and Restore therapists charge a fee of \$50 per every 30 minutes of phone consultation provided to individuals involved in client care for whom appropriate releases are on file. Additionally, phone consultations with clients or client's parents/guardians will be charged the same rate and should be limited to urgent, non-emergency situations that cannot wait until the next scheduled appointment. Should an emergency occur, please follow the emergency procedures outlined below. Additionally, a fee of \$100 per hour will be charged for school consultations, including but not limited to classroom visitation and observation and IEP attendance. Please make sure to discuss appropriate reasons for a phone or school consultation with your individual therapist in order to ensure that your needs can be met appropriately.

EMERGENCY PROCEDURES

While having open communication with clients is a goal for every Connect and Restore employee, oftentimes we are not immediately available by telephone. Generally speaking, office staff is available

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Monday through Friday from 8 a.m. to 5 p.m. If you are experiencing an emergency, please inform the staff and if possible, a clinician will take your phone call.

If staff is not immediately available by phone, you may leave a message on the secure voicemail. Office staff will make every effort to return your call within 24 hours, with the exception of weekends and holidays.

If you are experiencing a crisis outside of regular office hours, please utilize the following free resource:

Community Outreach Psychiatric Emergency Services – Tulsa (COPES) at (918) 744-4800

In the event of a life-threatening emergency, please do not call the office. Rather, go to the nearest emergency room or dial 911.

CANCELLATION POLICY

Connect and Restore, LLC works diligently to provide the best quality therapy services to as many families as possible. One way we are able to ensure we are effectively treating families and individuals is our cancellation policy. Therapy is most effective when it is consistently attended. We reserve the right to terminate services with any individual who has missed 3 or more sessions without calling to cancel or cancelling via the patient portal at least 24 hours in advance. Please note that a cancellation is not considered official via the portal until you receive a return email to confirm. Frequent cancellations of sessions may also result in termination of services. We appreciate your adherence to this policy. All cancellations (other than for reasons of illness, death in the family, or inclement weather) not received 24 hours in advance will result in a \$100 charge. Please see Connect and Restore’s financial agreement for more information.

It is important for your therapeutic success that you are able to take advantage of your entire therapy session. If you are more than 15 minutes late to any session, your therapist has the right to cancel the session for that day. This cancelled session would be considered a “no-show,” and charged accordingly. If you believe you are going to be more than a few minutes late, please call the office and leave a message for your therapist or the office manager.

INTERN AGREEMENT INITIALS

Connect and Restore, LLC is a learning facility for mental health professionals obtaining a degree in a related field or obtaining hours for professional endorsements or licensures. You are able to consent to allow an intern to observe or participate in your therapy session to aid in their learning process. You may also decline this opportunity with no implications to your treatment at Connect and Restore. You also have the right to withdraw permission for an intern’s participation with verbal or written request.

CHILDREN’S THERAPY SCHEDULING

For children that receive therapeutic services at Connect and Restore, please note that after school and evening appointments are limited. In general, preference for after school and evening appointment times is given to high school and middle school students who lose course credit when missing class or students who attend more than one therapy session per week; however, all after school appointments are scheduled at the discretion and availability of the therapist. For students who miss school to attend therapy, we will provide, upon request, a note that states the student was seen for an appointment in our office.

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GRIEVANCE PROCEDURE

Connect and Restore, LLC strives to ensure you have only the very best therapeutic experience. Any problem or complaint that you may have concerning your care at Connect and Restore is important to us. Connect and Restore seeks to provide clients a fair, simple, effective, and timely system of problem resolution. Clients filing a grievance are free from restraint, coercion, reprisal, or discrimination. If you have a problem or concern, including a complaint of unfair treatment, you are encouraged to informally resolve a problem or concern before it becomes a grievance by sharing your concern with the offending person. If, after attempting to resolve the problem informally, you feel a resolution was not reached, you may file a formal written grievance using the Connect and Restore grievance form within 21 days of the incident. Upon receiving a formal, written grievance Kristen Hale, Connect and Restore, LLC's owner and clinical director will work to promptly resolve grievance within 14 days.

NOTICE OF PRIVACY PRACTICES

I have been provided a written notice of privacy practices within my consumer orientation packet. I have read this notice and have had the opportunity to ask questions. I understand I can download an additional copy of these practices at www.connectandrestore.com at any time.

I give consent to Connect and Restore, LLC for mental health treatment. This consent is given voluntarily. Treatment will end with verbal or written termination or if there has been no contact in over one month.

Consumer Signature _____ Date: _____

Parent/Guardian Signature (minors only): _____ Date: _____

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CONNECT AND RESTORE, LLC
CONSUMER FINANCIAL POLICY

Although we are contracted with several insurance companies, **it is your responsibility to make sure that our therapist(s) participates in your specific plan.** If our therapist(s) is not a participating provider for your plan, you may still select our office for your care; “out of network” benefits will apply.

It is also your responsibility to know your insurance benefits. Our office will verify your insurance benefits, however, this typically is just a **general quote** of benefits, as each insurance company/plan have different policies and exclusions. We advise you to contact your insurance company at the phone number printed on your insurance card to verify your benefits and obtain any authorization information. If you are selecting to have us file “out of network”, you will be required to pay \$150 per visit at the time of your appointment until claims are processed.

If you provide the correct insurance information to our office in a timely manner, we will file a claim on your behalf. We will refund to you any portion that is determined to not be your responsibility. **You are responsible for paying all co-pays at the time of service. Co-pays, co-insurance, deductibles and non-covered services cannot be waived by our office, as it is a requirement placed on you by your insurance carrier.** Failure to pay your portion of services rendered will be reported to your insurance company and could result in termination of your insurance plan.

You may choose to NOT file with your insurance and select our same day self-pay rate for all services. However, please note that in doing so, we cannot go back & refile these claims with your insurance for you at a later date. Likewise, if you have selected insurance filing, we are unable to void these claims to accept the self-pay rate. We will gladly stop filing with your insurance at such a time as you select this option.

If you must reschedule or cancel, please call at least 24 hours in advance of the appointment. If therapy is cancelled within 24 hours of therapy or is a no-show (for reasons other than illness, death in the family, or inclement weather), this will result in an automatic \$100 No Show/No Notice fee. If you would like to appeal the charge due to an extenuating circumstance, you may file a form with our administrative committee and they will evaluate your request. We value our clients and respect your time, so if a therapist needs to cancel therapy due to a training or meeting, if the schedule allows, every attempt will be made to reschedule therapy.

Returned Check Fee - a \$35 fee will be added to your account for all returned checks in addition to the amount of the check returned.

Credit Card on File Late Fee - if you select the Credit Card on File billing option and your credit card is denied for any reason, a \$35 fee will be added to your account for all balances that have not been paid within 30 days. Connect and Restore will make 3 attempts to contact you in regards to a denied/expired credit card, after that a \$35 fee will be added to the balance.

Our same day self-pay rate for individual and family therapy is \$100 / hour for fully licensed therapists and \$65 per hour for Licensure Candidates

Client/Parent/Guardian Name(signed): _____

Client/Parent/Guardian Name(printed): _____

Date: _____

Client Name: _____ Client DOB: _____

INSURANCE SELECTION

_____ I AM OPTING TO HAVE CONNECT AND RESTORE FILE WITH MY INSURANCE FOR ALL SERVICES.

By completing the information below and signing, I understand that I am asking Connect and Restore to file with my insurance on my behalf. I understand that this is a courtesy to me and the balance on the claims is ultimately my responsibility even if my insurance does not approve the claims for payment. I recognize anything left unpaid by my insurance will need to be paid within a timely manner (30 days) or could result in late fees. *I also understand that unless I have provided my insurance information, Connect and Restore will collect \$150/ hour at the time of service until benefits can be verified.* Likewise, when deductibles and/or coinsurance are due, Connect and Restore requires me to pay \$150/hour or the coinsurance percentage of this rate, until insurance has processed my claims and notified Connect and Restore of my exact allowable and responsibility. At that time, Connect and Restore will notify me of any credit or balance due. If there is a credit, Connect and Restore will issue any remaining credit back to my account to apply to future services.

Insurance: _____ ID #: _____
Group #: _____ Policy Holder: _____
Policy Holder DOB: _____ Expected copay: _____ Ded/coins: _____

Secondary Insurance: _____ ID #: _____
Group #: _____ Policy Holder: _____
Policy Holder DOB: _____ Expected copay: _____ Ded/coins: _____

SELF-PAY SELECTION

_____ I AM OPTING TO NOT FILE WITH MY CURRENT INSURANCE AND ELECTING TO PAY THE \$100 (Licensed Therapists) or \$65 (Licensure Candidates) PER HOUR SELF-PAY RATE.

You may choose to NOT file with your insurance and select our same day self-pay rate for all services. However, please note that in doing so, we cannot go back and refile these claims with your insurance for you at a later date. Likewise, if you have previously selected insurance filing, we are unable to void these claims to accept the self-pay rate. We will gladly stop filing with your insurance at such a time as you select this option.

PLEASE SEE THE SECTION BELOW FOR SELECTING SELF-PAY: (Please initial)

_____ By signing below, I acknowledge that I am choosing to not have claims filed with my current insurance plan from this point forward.

_____ I am electing to be a same day self-pay client and will pay out of pocket for these services at the time service is rendered.

Client/Parent/Guardian Name(signed): _____

Client/Parent/Guardian Name(printed): _____

Date: _____

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OFFICE POLICY REGARDING CO-PAYS AND SERVICE PAYMENTS:

It is our policy that our clients leave a credit card on file with our office to cover all fees associated with services including co-pays or weekly appointment cash payments. This allows for our therapist(s) to focus solely on the client(s) and their care. If you would rather not leave a credit card on file, you are welcome to bring a check or cash in order to make these payments on the day services are rendered. Credit Cards are typically run within one week of services rendered.

I choose to leave a credit card on file and have attached the appropriate form

I choose to use a check or cash to pay the day of service while in the office.

Client/Parent/Guardian Name(signed): _____

Client/Parent/Guardian Name(printed): _____

Date: _____