INFORMED CONSENT

Informed Consent for Counseling and Psychotherapy Mental Health Service
Rachel LaVergne LCMHC recognizes that it may not be easy to seek help from a mental health professional; we hope that with our help you will be better able to understand your situation and feelings and will be able to move toward resolving your difficulties. The therapist will strive to help you grow toward greater health and wholeness by providing counseling services within a biopsychosocial, cognitive-behavioral perspective. Our therapists work within the context of each individual's beliefs, and no attempt is made to impose a personal theology.

THE THERAPY PROCESS

Therapy is a collaborative process where you and your Provider will work together on equal footing to achieve goals that you define. This means that you will follow a defined process supported by scientific evidence, where you and your Provider have specific rights and responsibilities. Therapy generally shows positive outcomes for individuals who follow the process. Better outcomes are often associated with a good relationship between a client and their Provider. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit.

Therapy begins with the intake process. First, you will review your Provider's policies and procedures, talk about fees, identify emergency contacts, and decide if you want health insurance to pay your fees depending on your plan's benefits (see "INSURANCE AND PAYMENT POLICIES") Second, you will discuss what to expect during therapy, including the type of therapy, the length of treatment, and the risks and benefits. Third, you will form a treatment plan, including the type of therapy, how often you will attend therapy, your short- and long-term goals, and the steps you will take to achieve them. Over time, you and your Provider may edit your treatment plan to be sure it describes your goals and steps you need to take. After intake, you will attend regular therapy sessions via telehealth (see "TELEHEALTH SERVICES" below). Participation in therapy is voluntary - you can stop at any time. At some point, you will achieve your goals. At this time, you will review your progress, identify supports that will help you maintain your progress, and discuss how to return to therapy if you need it in the future.

THERAPIST

The therapist is a licensed professional engaged in providing mental health care services to clients directly as an employee. The therapist has discussed with me the various aspects of psychotherapy. This includes a discussion of the evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. You may withdraw from treatment at any time, but please discuss this with your therapist.

TELEHEALTH SERVICES

To use telehealth, you need an internet connection and a device with a camera for video. Your Provider can explain how to log in and use any features on the telehealth platform. If telehealth is not a good fit for you, your Provider will recommend a different option. There are some risks and benefits to using telehealth:

Risks

• Privacy and Confidentiality. You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your Provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards.

• Technology. At times, you could have problems with your internet, video, or sound. If you have issues during a session, your Provider will follow the backup plan that you agree to prior to sessions.

• Crisis Management. It may be difficult for your Provider to provide immediate support during an emergency or crisis. You and your Provider will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services.

Benefits

• Flexibility. You can attend therapy wherever is convenient for you.

• Ease of Access. You can attend telehealth sessions without worrying about traveling, meaning you can schedule less time per session and can attend therapy during inclement weather or illness.

• Recommendations

• Make sure that other people cannot hear your conversation or see your screen during sessions.

• Do not use video or audio to record your session unless you ask your Provider for their permission in advance.

• Make sure to let your Provider know if you are not in your usual location before starting any telehealth session.

APPOINTMENTS AND CANCELLATIONS

Appointments are made by calling 603-858-9281, Monday through Friday between the hours of 8:00 am and 5:00 pm or directly on the TherapyNotes portal. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. Clients who repeatedly miss appointments may be discharged from services. (see “NO SHOW & CANCELLATION POLICY” below). Your therapist reserves the right to cancel your appointment if you show up sick or with minor children that might interfere with the counseling session.

NO SHOW & CANCELLATION POLICY

When you schedule an appointment with Rachel LaVergne LCMHC, reserves that time just for you. That is why we require 24-hour advance notification of cancellation. Leaving a message on our voicemail is fine, even on weekends. The time you called will be posted with the message. Should you fail to show for your scheduled appointment or cancel less than the required 24 hours in advance, you will be charged the fee of $100 for missed sessions. We appreciate the courtesy you extend to us by honoring this agreement. Please note that we cannot bill your

insurance company for missed sessions or for late cancellations. You will not be seen again by your therapist until the fee is paid. You may be placed on a call- back list to be seen the same day. If you have three no shows or late cancellations within a calendar year, you may be discharged from services. By signing this agreement, I acknowledge my understanding of all the policies listed above. I, the undersigned, accept and agree to all of the above terms during the course of my treatment at Rachel LaVergne LCMHC, LLC

NUMBER AND LENGTH OF SESSIONS

The number of sessions needed depends on many factors and will be discussed by the therapist. The length of therapy sessions range depending on several factors, and the therapist will discuss this with you.

RELATIONSHIP

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social and personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

GOALS, PURPOSES, AND TECHNIQUES OF THERAPY

There may be multiple interventions to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting goals of your therapy. As therapy progresses, these may change.

RECORD KEEPING

Your Provider is required to keep records about your treatment. These records help ensure the quality and continuity of your care, as well as provide evidence that the services you receive meet the appropriate standards of care. Your records are maintained in an electronic health record provided by TherapyNotes. TherapyNotes has several safety features to protect your personal information, including advanced encryption techniques to make your personal information difficult to decode, firewalls to prevent unauthorized access, and a team of professionals monitoring the system for suspicious activity. TherapyNotes keeps records of all log-ins and actions within the system.

CONFIDENTIALITY

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases, suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose; fee disputes between therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority. If you have any questions regarding confidentiality, you should bring them to the attention of the

therapist when you and the therapist discuss this matter further. By signing the Receipt form for the Informed Consent and Privacy Practices, you are giving your consent to the therapist to share confidential information with all persons mandated by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN

In the event that the therapist reasonably believes that the client is a danger, physically or emotionally, to themselves or another person, consent is given for the therapist to warn the person in danger and to contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. This authorization shall expire upon the termination of therapy. By signing Informed Consent and Privacy Practices form, you acknowledge that you have the right to revoke this authorization in writing at any time to the extent the therapist has not acted in reliance on this observation. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the Notice of Privacy Practices section of this form. You acknowledge that you have been advised by the therapist of the potential of the re-disclosure of your protected health information by the authorized recipients, and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the therapist was conditioned on you providing this authorization.

RISKS OF THERAPY

Therapy is the Greek word for change. Clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. The success of therapy depends upon the quality of the efforts of both the therapist and client, along with the reality that clients are responsible for the lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

PAYMENT OF SERVICES

The charge for your initial one-hour session (53 minutes with therapist) is $195.00 and the charge for any subsequent session is $150.00. Shorter sessions will be a percentage of the full fee. We will look to you for full payment of your account, and you will be responsible for payment of all charges. If you have insurance, different copayments are required by various group coverage plans. Your copayment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the copayment may be different for the first visit than for subsequent visits. You are responsible for and shall pay your copay portion of the therapist's charges for the services at the time services are provided. You are responsible for notifying the practice immediately of any changes to your insurance. If you fail to notify the practice of any changes to insurance, you may be billed for services that are not covered.

INSURANCE AND PAYMENT POLICIES

If you choose to utilize your health insurance and we are in-network, our billing specialist will collect your insurance information to reach out to your insurance provider in order determine what your out of pocket costs may be. We will make every effort to collect the cost of services from your insurance company. This office will only submit to one insurance company, the primary, and does not submit to secondary insurances. Any cost leftover from the primary insurance company will be the patient's responsibility. Payment: You are required to submit a valid credit/debit card or HSA card (health savings) to be kept on file so that any patient responsibility cost that is not paid at the time of service can be collected. This can include but is not limited to: copayments, deductibles, co-insurances, missed appointment fees, denied claims, and self-pay fees. Your information will be kept confidential and you will be notified via email prior to any charges being submitted.

Copayments, deductibles, and co-insurances are due at the time of service. Any outstanding balance must be paid before future sessions will be rendered. Any balance that is outstanding for more than 60 days may result in discontinuation of treatment. If you have difficulty paying your patient responsibility, please request a payment plan.

COURT

Although it is the goal of the therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. In the event disclosure of your records or the therapist's testimony are requested by you or required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's normal hourly rate of $350.00 for giving that testimony. Such payments are to be made at the time prior to the time the services are rendered by the therapist. The therapist may require a deposit for anticipated court appearances and preparation.

AFTER-HOUR EMERGENCIES

A mental health professional is on call when the office is closed and can be reached for emergencies on a 24-hour, seven-days-per-week basis, by calling 603-858-9281. Emergencies are urgent issues requiring immediate action. Therapist's Incapacity or Death In the event the therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of client records. In the event of a therapist being unable to take calls during after hours a plan will be outlined to work with your local emergency services.

CONSENT OF TREATMENT

By signing the Informed Consent and Privacy Practices Receipt, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment, or services at any time. By signing the Informed Consent and Privacy Practices Receipt, you acknowledge that you have both read and understood all the terms and information contained herein. Ample opportunity has been offered for you to ask questions and seek clarification of anything that remains unclear.

CONTACT INFORMATION

By signing the Informed Consent and Privacy Practices Receipt, you are consenting to communicate with you by mail, email, and phone at the address and phone numbers provided at the initial appointment, and you will immediately advise in the event of any change. You agree to notify the Center if you need to opt out of any form of communication.

SOCIAL MEDIA POLICY

The American Counseling Association has specific guidelines in the ethical codes that I follow, regarding social media and clients; adding clients as friends or contacts on these sites. As it can compromise your confidentiality and our respective privacy. Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Tik Tok, etc). I will not respond and am not liable for any interactions on those types of platforms. It may also blur the boundaries of our therapeutic relationship. In that respect, I request that clients do not communicate with me via any interactive or social networking websites. If you have questions about this, please bring them up when we meet and we can talk more about it.

NOTICE OF PRIVACY PRACTICES

This notice tells you how we make use of your health information at our Center, how we might disclose your health information to others, and how you can get access to the same information. Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy. We have a legal responsibility under the laws of the United States and the state of New Hampshire to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice. This notice took effect on April 14, 2016 and will be in effect until we replace it. We have the right to change any of these privacy practices as long as those changes are permitted or required by law. Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at Rachel LaVergne LCMHC LLC. These changes could also affect how we protect the privacy of any of your health information we had before the changes. When we make any of these changes, we will also change this notice and give you a copy of the new notice. When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you. If you have any questions or concerns about the material in this document, please ask us for assistance, which we will provide at no charge to you. Here are some examples of how we use and disclose information about your health information. We may use or disclose your health information... 1. To your physician or other healthcare provider who is also treating you. 2. To anyone on our staff involved in your treatment program. 3. To any person required by federal, state, or local laws to have lawful access to your treatment program. 4. To receive payment from a third-party payer for services we provide for you. 5. To our own staff in connection with our Center’s operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities. 6. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization, it will only affect your health information from that point on. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you

object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects of your health information that is necessary to respond to the emergency. 8. To the appropriate State agency if, we suspect the neglect or abuse of a minor or adult. If, in our professional judgment, we believe that a patient is threatening serious harm to another, we are required to take protective action, which may include notifying the police, or seeking the client's hospitalization. If a client threatens to harm him or herself, we may be required to seek hospitalization. We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission. As a client of Rachel LaVergne LCMHC, you have these important rights: A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use. B. You can ask us for photocopies of the information in part "A" above. There will be a $5.00 charge for copies made here at the Center. If you need copies of your health information due to a Third-party request, we will charge a fee of $25.00 for the first 10 pages, then $1.00 for each additional page. D. You have a right to a copy of this notice at no charge. E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if you request that we contact you on an alternative phone number other than your residence, or if your primary language is not spoken at this Center) Your written request must specify the alternative means and location. F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency. G. You can make a written request that we amend the information in part "A" above. H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing. I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request. J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center's operations. This can go back as far as six years, but not before April 14, 2016. K. If you request the accounting in "J" above more than once in a 12-month period we may charge you a fee based on our actual costs of tabulating these disclosures. L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person: Board of Mental Health Concord, NH. M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request. July 2018

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Rachel LaVergne LCMHC providing health care services to me via telemedicine. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Rachel LaVergne LCMHC. As long as this consent is in force (has not been revoked) Rachel LaVergne LCMHC may provide health care services to me via telemedicine without the need for me to sign another informed consent.