Remedy Counseling, LLC
819 Ritchie Highway #1020
Severna Park, Maryland 21146
Phone: 410-431-5111 Fax: 410-431-5112
Website: Remedy-Counseling.com

REGISTRATION FORM

*** Our clinicians block out time for you to be seen and insurances cannot be charged if services are not rendered. Please be aware that if you do not cancel your evaluation 24 hours ahead of time you will not be able to re-schedule services at Remedy Counseling, LLC, unless you chose to pay a $99.75 fee which will be collected before you are re-scheduled. ALL documents are required so please sign them or arrive early so we can answer any questions you may have about the intake packet.**

Client's Name:_____ **Date of Birth:**_____ **SS#:**_____

Client's Age:_____ **Client's Sex:**_____ **Client's Ethnicity:**_____

Address:_____
Phone:_____ **E-Mail:**_____

Insurance Name:_____ **Member ID#:**_____

Insurance Authorization Obtained:_____ **Deductible:**_____ **Co-pay:**_____

***Bring your insurance card and driver's license. We will need the insurance holder's information if you are not the primary policy holder for billing purposes if you have private insurance.**

Insured Name:_____ **DOB:**_____

Employer/Address & phone#:_____

Emergency Contact Name #1:_____ **Relationship:**_____ **Phone:**_____

Emergency Contact Name #2:_____ **Relationship:**_____ **Phone:**_____

Please include medication & dosages and for what condition the medication is for, if applicable:

***Please e-mail (rcfrontoffice@gmail.com) or bring a copy of any court orders to your first appointment.**

INFORMED CONSENT FOR TREATMENT

I hereby give my permission and consent to the Remedy Counseling, LLC for treatment. I understand that this encompasses the intake and diagnostic evaluation process, as well as any therapies and/or referrals, which may be recommended.

I acknowledge that the "Client's Rights" and "Grievance Procedure" statements have been provided to me. I have had an opportunity to review it and to ask any question which I may have about my rights as a client of Remedy Counseling, LLC. "Client's Rights" and "Grievance Procedure" are posted on our website at Remedy-Counseling.com and in our lobby and can be accessed or printed at any time.

I understand that all my treatment at Remedy Counseling is voluntary, and that I may cease treatment at any time. Remedy Counseling, LLC has explained the procedures and reasons for discharge. Client understands that ending treatment can have an adverse effect on their mental wellbeing to include an increase in symptoms that can affect all areas of your life in a negative way without therapy as a support.

I understand that my clinical records and any verbal or written communications between myself, my parent (if applicable), or any authorized representative are strictly confidential. Further, no material or information concerning my family or me will be disclosed to another party without my expressed written consent and/or that of a legally authorized representative. This excludes circumstances when there is a clear and imminent danger to myself or to others or when disclosure is state-mandated (Reported sexual abuse, physical abuse or neglect as a child or if you are suicidal or homicidal with a plan and the means to act on these thoughts). Please be aware that by engaging in treatment can re-visit past trauma(s) that can have an emotional impact on you and your mental wellbeing. Therapy also offers relief from current symptoms and better overall functioning, and it is the client's obligation to follow therapeutic recommendations and attend therapy appointments to get the most out of the therapeutic process.

I understand and give my informed consent to include Remedy Counseling, LLC staff and or clinicians to contact police, emergency contacts and or emergency services if there is a medical emergency. I hereby request Remedy Counseling, LLC, and its qualified members to call for other related support services as deemed necessary and appropriate for my emotional and physical safety.

Remedy Counseling, LLC and all clinicians working under Remedy Counseling, LLC to including the owner of the practice, **DOES NOT** engage in research with clients under any circumstances, per the policy of Remedy Counseling, LLC. If this policy were to change at any time, a specific consent form will be developed to address with the client and signed after outlining their rights not to participate and details around participation in a research study. This will include whether treatment is given as part of a research study, the right of the participant to decline treatment; in the absence of penalties if the participant refuses/declines to participate in the research program.

This informed Consent has been explained to me, and I have been offered a copy for my records.

X _____
Printed Name of Client

X _____
Client Signature Date

_____
Witness signature Date

03/10 Revised 10/13, 12/14, 12/17 & 7/21

HIPPA

I have read and/or had the HIPPA policy explained to me and have received a copy of HIPPA. Our HIPPA policy is posted in our lobby and is also available on our website at Remedy-Counseling.com which can be reviewed or printed at any time.

X _____

Printed Name of Client

X _____

Client Signature Date

_____

Witness signature Date

03/10 Revised 10/13, 12/14 & 12/17

Discharge Policy

You will be discharged from Remedy Counseling, LLC for any of the following reasons:

1. If Remedy Counseling, LLC has successfully completed all interventions that are clinically indicated for your condition, and you have recovered sufficiently that you no longer meet justified medical necessity criteria to be covered by your insurance company for us to bill and be reimbursed for your services.
2. If your services are no longer authorized by the Department of Health and Mental Hygiene, Administrative Service Organization, Public Mental Health System, Private Insurance Policy, or lack of Payment for Services (including self-pay amounts, deductible amounts, co-pays, No Show Fee or Cancellation Fee (not giving 24 hours' notice). A No Show Fee or Cancellation Fee is $99.75 (Exception is Medical Assistance Clients) for clients with private insurance or self-pay for services at Remedy Counseling, LLC.
3. If you indicate in writing that our services are no longer appropriate to your condition(s), or you successfully terminate from treatment with your clinician due to stability of symptoms which indicate therapy is no longer indicated.
4. If you fail to avail yourself for services for more than 30 days (face to face).
5. If you cancel or miss appointments chronically or do not attend therapy as recommended by your clinician at Remedy Counseling, LLC.
6. If you terminate services without completing your therapy against Remedy Counseling, LLC's advice and understand that ending treatment can have an adverse effect on your mental wellbeing to include an increase in symptoms that can affect all areas of your life in a negative way without therapy as a support.
7. If you are referred to a higher level of care (Evaluation at the ER, securing a psychiatrist if indicated, day treatment recommendations, substance abuse treatment, etc.) and fail to follow clinical recommendations or when you step down from a higher level of care you do not follow the discharge recommendations which could include other interventions as well as outpatient therapy services.
8. If you engage in any unsafe behavior or conduct that creates an unsafe environment for you to continue to participate in Remedy Counseling LLC or endanger the safety of other clients/staff at Remedy Counseling, LLC. This includes disruptive children in the lobby who disrupt other clients in the lobby, the front office manager's and are loud enough to interfere with therapy sessions that are occurring. We understand that children can be challenging so you are always welcome to remove them to the outer lobby of the building outside of our office. After 1 warning if the issue is not resolved you will be discharged from treatment and you will be provided with 3 referrals for other therapists or a higher level of care if indicated. Disrespecting the front office managers is unacceptable and could lead to termination of services.
9. Failure to comply with clinical treatment recommendations.

X _____

Printed Name of Client

X _____

Client Signature Date

_____

Witness signature Date

03/10 Revised 10/13, 12/14, 12/17 & 7/21

Cancellation/Missed Appointment Policy

Keeping your scheduled appointments is an investment into you or your children and family's personal treatment and recovery. When you make an appointment at Remedy Counseling, LLC, you are asking a professional to hold a specific block of time for you. In order to efficiently serve the community, Remedy Counseling, LLC has instituted a 24-hour notification for canceling an appointment. Emergency cancellations are assessed by the clinician and the owner to waive fees when appropriate. If you must cancel a scheduled appointment, please do so at least 24- hours in advance (This can be done on the days the office is closed for Monday appointments). Failure to give the proper **24-hour notice** will result in a billing you directly for the missed appointment, your insurance cannot be billed for services that are not rendered. **You will be billed $99.75 for the missed appointment with the credit card on file after 24-hours of your missed, late cancellation or no show for your scheduled appointment (Exception is Medical Assistance Clients).** To cancel any appointment, please call (410) 431-5111 or email rcfrontoffice@gmail.com. **You will be taken off your assigned clinicians schedule and will not be permitted to schedule another appointment unless your fee is paid.** Failure to pay for your missed appointments/cancellations within **30 days** can result in your invoice being turned over to a collection agency and you will be responsible for any fees that our collection agency charge in addition to your original fee.

I agree to the terms of Remedy Counseling's Cancellation / Missed Appointment Policy:

X _____

Printed Name of Client

X _____

Client Signature Date

_____

Witness signature Date

03/10 Revised 10/13, 12/14, 12/17 & 7/21

Service Policies and Procedures Acceptance/Payment Authorization Form

I hereby affirm that I have read and understand the policies and procedures of services and operations of Remedy Counseling, LLC including granting us the right to share information and coordinate services with your primary care physician, psychiatrist, therapist and any agency involved with your treatment for instance Maryland Public Mental Health System (PMHS), Department of Health and Mental Hygiene (DHMH), Baltimore Mental Health System (BMHS), Anne Arundel Mental Health Agency, State Administrative Service Organizations, Private Insurance Agencies/Carriers, payers or for the purpose of collecting payment for services rendered, defending the agency, staff, representative or agent, in a legal litigation, arbitration or dispute of any kind, etc. and authorize payment of fees by your Medical Insurance Provider and/or payer to Remedy Counseling, LLC for services rendered. This includes the completion of all paper (1500 Insurance Claim Form) and Electronic Claims submitted by Remedy Counseling, LLC through a HIPPA approved billing company to bill and collect from your insurance company for payment of your services.

You are responsible for providing all insurance information and establishing the proper sequencing of primary and secondary coverage (coordination of benefits) at the time of registration. You are responsible to verify that your insurance company pays in a timely manner. Fulfilling this responsibility may require you to contact your insurance company. Your coverage is between you and your insurance company. We will help you present your claim, but you must take ultimate responsibility for your account. It is recommended you contact your insurance plan or provider directly if you have any questions or concerns about precertification or preauthorization. Please contact your carrier to verify your coverage and/or benefits. Based on your insurance plan, you may be responsible for deductibles, co-pays and co-insurance for fees not covered by your insurance company. If your insurance requires a printed 1500 medical claim form that needs to be mailed directly from the office, you will be charged $2 per visit for billing (Exception Medical Assistance Clients). Secondary billing at times requires paper billing for which there is a $2 charge per visit (Exception Medical Assistance Clients), or you may bill your secondary insurance yourself at no charge and you will be provided an invoice for you to submit to a secondary insurance. You are required to pay the co-pay for secondary insurances at the time of service. If you change insurances you must notify us immediately, if claims must be re-billed under new insurance and we were not notified then you will be responsible for a $2 charge for each visit that needs to be re-billed, payable immediately. If you inform us of an insurance change, we will put your billing on "hold" until you get your insurance information, and no charges will be incurred if services were not billed through your previous insurance.

X

_____

Printed Name of Client

X_____

Client Signature Date

_____

Witness signature Date

03/10 Revised 10/13, 12/14,12/17 & 7/18

SERVICE CONTRACT/FEE AGREEMENT

In order for our fees to remain as low as possible, we require payment at the time of each visit. It will not be possible to be seen without payment. Carrying a balance on your account is non-negotiable.

Payment is to be made at the Reception Desk before each session or through having a credit card on file in our secure Advanced MD Program to run copays, deductibles, or self-pay for therapy sessions. Cash, checks, money orders and major credit cards are accepted. (A receipt will be provided to you for reimbursement through your insurance company for out of network benefits, if applicable).

If your session is not paid for, as outlined above, counseling will be interrupted until payment is brought up to date. Sessions are scheduled and begin either on the hour, half-hour, quarter after or quarter of depending on your clinician. Please be punctual so that all your time is utilized. **If any checks are returned you will be a charged a $25.00 fee for each returned check and you will need to pay by credit card or cash for the remainder of the time you are with Remedy Counseling, LLC.**

All persons entering Remedy Counseling, LLC's offices are expected to observe our No Smoking/Drug Free policy. Any person(s) under the influence of drugs or alcohol will not be served. If such a situation arises, the person will be expected to leave the premises immediately and may result in the termination of services and a recommendation to a higher level of care.

Additional Service Charges for self-pay, loss of insurance coverage and not paying your insurance premium causing a lapse in coverage include:

$150 **Advanced Brainspotting (Some of the more complex Brainspotting interventions are not yet covered by your insurance company). Performed ONLY by: Brandy Kolenbrander, LCSW-C**

$175 Intake/Evaluation

$250 Bariatric Assessment- **Performed ONLY by: Brandy Kolenbrander, LCSW-C**

$140 Individual, Family & Couples Therapy

$60 Documentation fee: 30 minutes (clinical summaries, coordination of care with outside agencies, school forms, ST & LT Disability, FMLA, work letters/school letters, etc.). We must have 72 hours' notice to complete forms, have a release of information signed and submitted and the fee paid before, and documentation/phone consultations take place.

X _____

Printed Name of Client (Minor)

X _____

Client Signature Date

_____

Witness signature Date

03/10 Revised 10/13, 12/14, 12/17, 7/19, 8/20, 7/21 & 4/22

COMMUNICATION/DOCUMENTATION FEE SCHEDULE

Remedy Counseling, LLC provides communications in the form of paperwork or consultation for the following: paperwork (disability/forms/referral paperwork/letters/ etc.), coordination of care with outside agencies, therapists, or psychiatrists, etc.. **These fees are NOT covered by your insurance company and must be paid out of pocket before services or documentation is provided (Exception Medical Assistance Clients).** All fees for these services are subject to change and you must give 72 hours' notice in writing when requesting documentation, copies of your records, court documentation, clinical summaries, completing forms, consulting with other medical providers, school personnel, etc. We charge the allowable fees to photocopy your chart for your own records and we must have the request in writing 72 hours ahead of time and you will be notified when you can pick them up since we do not like to send confidential information by mail. Cash, checks, money orders and major credit cards are accepted. For check payments, services will not be rendered until checks are cleared through the bank.

Remedy Counseling, LLC's and all therapists affiliated under/with Remedy Counseling, LLC do not engage in court testimony under any circumstances, do not provide reunification therapy/family therapy related to a court case, custody issues, contempt of court, court ordered anger management, or any other court ordered services requiring court testimony, coordination with probation officers, coordination with lawyers, GAL's, coordination with court appointed evaluators, court letters, clinical summaries or any type of documentation related to you treatment, etc. Furthermore, if your situation changes during treatment that require any court related documentation, communication, or court appearances we will immediately give you 3 referrals to seek counseling services elsewhere and we will discharge you from treatment. Referrals are no guarantee that the 3 therapists are willing to engage in legal issues related to treatment. You can always access member services on the back of your insurance card for further referrals. In the event that you are being transferred to another therapist, with a signed release of information, we are happy to provide records to your new therapist which can include clinical notes if deemed appropriate, evaluation, treatment plan if applicable and a discharge summary outlining your treatment. This is applicable to having services under ALL Private Insurances, ALL Medicaid/HMOs, and ALL Private Pay clients.

Some forms, documents, e-mails, and short phone calls can be part of your session because it is therapeutic in nature, but you must give your clinician as much notice as possible, sign any necessary release(s) of information forms (Provided at the front desk on the counter or available on the website: remedy-Counseling.com) beforehand and have all necessary information (phone numbers, names, fax numbers, addresses and e-mails) with you when you meet with your clinician.

$60.00 30-minute Documentation fee (30 minutes-**minimum charge)** for clinical letters, clinical recommendation summaries, communication with school counselor's, doctors, pediatricians, psychiatrists, FMLA paperwork, and disability paperwork, etc.

X _____

Printed Name of Client

X_____

Client Signature Date

_____

Witness signature Date

03/10 Revised 10/13, 12/14, 12/17, 7/18, 7/19 & 7/21

SERVICE CONTRACT/FEE AGREEMENT

This will confirm our agreement during your first visit today regarding payment and guidelines of treatment through your insurance. You are responsible to contact your insurance to determine if you have an out of pocket deductible, co-pay or require authorization for your outpatient mental health services. Should your benefits run out or you do not renew your insurance when necessary, you will be held responsible for fees incurred during the lapse in coverage and will be charged to your credit card on file. If you have Medical Assistance and you have a lapse in coverage you are responsible for the amounts rejected by your insurance company. We follow the protocol to turn your account over to collections and you will be responsible for your fees and any fees they charge Remedy Counseling, LLC to collect unpaid fees. If you obtain new insurance and do not immediately inform the front desk and provide a copy of the insurance card to re-route the billing for services, you will be held responsible for all fees incurred during the lapse. In the event you change insurances be aware that we are in network with **most** major insurances but there may be an insurance we are not in network with, so it is your responsibility to check with your new insurance to ensure we are in network, determine if you have an out of pocket deductible, co-pay or require authorization for your outpatient mental health services. We do provide a sliding scale for those who qualify to continue services without insurance coverage, and this is only approved by the owner of Remedy Counseling, LLC. We provide a monthly super bill for you to submit to your insurance for out of network coverage.

If you must cancel a session, please contact this Remedy Counseling, LLC by email at rcfrontoffice@gmail.com, providing at least 24 hours' notice prior to the scheduled appointment time (Monday cancellations must be e-mailed 24 hours in advance on Sunday or earlier). Sessions are scheduled for forty-five (45) minutes and begin depending on how your clinician schedules clients which vary by clinician.

Please be punctual so that all your time is utilized, if you are more than 10 minutes late insurance cannot be billed and you will need to pay the required $99.75 fee (Exception is Medical Assistance Clients).

Due to limited seating in the waiting area, please do not bring additional children or relatives with you to the office unless they are being treated at the same time by another therapist or are involved in session for the identified client. Children in the waiting room must always be supervised and be re-directed if they become loud or disruptive to other clients in the waiting area, the receptionist or interfere with therapy sessions in progress. Remedy Counseling, LLC does not provide childcare services so you will need to make arrangement for childcare before you make appointments with your clinician. Children may not be left unattended in our Waiting Room under any circumstances due to liability issues. Due to confidentiality issues please do not bring family members, children, friends, or any other persons who are not currently receiving treatment at Remedy Counseling, LLC unless you are a parent/guardian/sibling/authorized family member transporting or engaging in part of a family session for a child or adolescent receiving treatment at Remedy Counseling, LLC.

X _____

Printed Name of Client

X _____

Client Signature Date

_____

Witness signature Date

03/10 Revised 10/13, 12/14 & 12/17

INFORMED CONSENT AGREEMENT FOR "BRAINSPOTTING"

ONLY: Brandy T. Kolenbrander, LCSW-C performs this therapy technique:

"Brainspotting" Therapy involves both benefits and risks. Risks include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness, and helplessness. Therapy often requires recalling difficult/traumatic experiences, some of which may be unpleasant. Therapy may involve making changes that can feel uncomfortable to you and those close to you. You could experience "unwanted events". These are events which occur parallel to or in the context of treatment and which are burdensome to the client and/or their environment, independent of whether they are unavoidable or even necessary to reach a treatment goal. Emergence of new symptoms to include: Deterioration of existing symptoms, lack of improvement or deterioration of illness, prolongation of treatment and distress following "Brainspotting." Emergency appointments are available by contacting the Office Manager at Remedy Counseling, LLC. "Brainspotting" Therapy also offers relief from current symptoms and better overall functioning, and it is the client's obligation to follow therapeutic recommendations and attend therapy appointments to get the most out of the therapeutic process.

THERAPEUTIC TOUCH:

On occasion, and only with your permission, we will use therapeutic touch during trauma therapy sessions. The touch may involve you remaining sitting on your chair or couch and receiving a supportive hand to hold, or the grounding touch of a hand on your shoulder, neck, or back. It is understood that therapeutic touch and the client-therapist relationship is always non-sexual and only happens if you as the client want or need it.

INSURANCE:

Brandy Kolenbrander, LCSW-C is the only therapist in the practice that has been trained in "Brainspotting". Conventional outpatient therapy methods are covered by your insurance in between "Brainspotting" sessions if you chose this modality as long as it is recommended by your therapist. You may be responsible for a copay or deductible amount for conventional outpatient mental health services that are covered by your insurance company.

Utilization of "Brainspotting" and advanced interventions are **NOT** covered by your insurance companies. I am considered to be an "Out of Network Provider". I will not bill your insurance company and payment is due at each session ($230 per session for fifty minutes). However, we will provide a "Super-bill" if you are eligible for reimbursement from your insurance company for "Brainspotting".

X _____
Printed Name of Client/Minor

X _____
Client/Parent/Guardian Signature Date

_____
Witness signature

CREDIT CARD AUTHORIZATION FORM

I hereby authorize the following charge(s) to be applied to my credit card which will be kept on file until treatment has been completed and my account balance is zero. A copy of the credit card is required for all self-pay clients and clients with private insurance. Your information will remain in a secured locked filing cabinet in a locked room to maintain the security of your information or it will be stored in our HIPPA compliant secured, password protected state of the art medical management system (ADP). We do not require your security code because we use a secured credit card/chip machine issued to Remedy Counseling, LLC through PNC Bank. (Exception is Medical Assistance Clients)
All insurance charges will be documented through your insurance's EOB's (eligibility of benefits) that are sent directly to you AND our office. No charges for insurance related issues will be charged to your credit card until we have received a denial of charges and have contacted you through e-mail to discuss the issue or resolve it if it is an insurance error. **If you do not respond within 24 hours to our e-mail for any billing issues your card will be charged for amounts due: deductibles, co-pays, returned checks, denial by the insurance, deductible amounts, missed appointments, forgetting your appointment, cancelling appointments without 24-hour notice, etc.. It is your responsibility to provide your e-mail and update us of any changes to your e-mail so that communication can take place. We use e-mail so that communications can be documented appropriately in your chart. We do not give reminder calls for appointments; however, we do give appointment cards after sessions are conducted, it is your responsibility to attend all scheduled appointments made through your clinician or by phone with the front office managers.**

1. Missed Appointment for non-emergent situations ($99.75).
2. Not showing up for scheduled appointments ($99.75).
3. Cancelling appointments without giving appropriate 24 hours' notice ($99.75).
4. Co-pays that are due at the time of service for family members, minors, spouses etc. if the co-pay is not remitted at the time of service (Amount is determined by your insurance company) then you may not be seen.
5. Deductible amounts that you are responsible for through your insurance (Amount is determined by your insurance company at a contracted rate and vary depending on the services you receive).
6. Any service amounts that are rejected by your insurance for lapse in coverage, not obtaining an appropriate referral, not providing the appropriate summary of your benefits which is required at admission or not securing your authorization for treatment through your insurance before admission (Amount is determined by your insurance company).

Credit Card: ❑ Visa ❑ MasterCard ❑ Discover ❑ Other: _____

Credit Card Number: Expiration Date:

I hereby authorize any of the above stated amounts be applied to my credit card:

Signature of Card Holder: _____ DATE: _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the amount indicated above or by your insurance company. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

03/10 Revised 10/13, 12/14 & 12/17

Telehealth Consent Form 1 of 2

1. I understand that my provider wishes me to engage in a telehealth evaluation (initial session) and ongoing therapy services.
2. My provider has explained to me how the video conferencing technology will be used to deliver therapy services and will not be the same as a direct patient/provider visit due to the fact that I will not be in the same room as my provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my provider or I can discontinue telehealth at any time if it is felt that the videoconferencing connections are not adequate for the situation. Under such circumstances my provider may switch to applications that allow for video face to face chat or through a phone call which are not HIPPA compliant or encrypted. My provider has explained to me that video chat or phone calls can be breached and confidentiality during the therapy sessions are not guaranteed to be secure.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
5. I have had the alternatives to a telehealth explained to me, and in choosing to participate in a telehealth therapy for my initial evaluation and ongoing therapy services (Individual, family, couples, etc.)
6. I understand that billing will occur from my provider's office which is Remedy Counseling, LLC.
7. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to telehealth. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
8. It has been explained to me that the platform for telehealth therapy services will be delivered to me by the "Doxy.me" platform. Doxy.me is the only platform which guarantees that all therapy sessions are HIPPA compliant and is an encrypted website platform that has been authorized by insurance companies to conduct telehealth therapy sessions. Telehealth sessions will be conducted by my therapist is a secure location in their homes. Your provider will only deliver therapy sessions in a secure location to protect your confidentiality and your therapy sessions are guaranteed to be completely private and you and your provider cannot be overheard by anyone in the household.
9. During times of emergency, insurances, licensing Boards and State laws can be adjusted to allow for other types of telehealth therapy services such as telephone and other NON-HIPPA compliant platforms. The COVID 19 pandemic is in effect from 3/20 until the state of emergency is deemed over and services can be resumed in person at your providers secured office space to protect the confidentiality of your ongoing therapy services.

Telehealth Consent Form 2 of 2

10. Telehealth therapy services will remain in effect until it is deemed "safe" to resume providing in person therapy services. Depending on your insurance company we may be able to continue to deliver telehealth therapy sessions when the state of emergency has been lifted. Some insurances will pay for ongoing Telehealth therapy sessions, and some will not. Please be aware that your therapist may chose not to provide in person therapy sessions after the state of emergency has ended and is up to each provider's personal discretion to only continue delivering Telehealth therapy services. This could potentially disrupt how your therapy services are delivered to you. This can include:
    - Continue with Telehealth therapy services if your insurance company provides coverage for Telehealth therapy services. You can continue with the convenience of receiving Telehealth therapy services if you do not wish to receive in-person therapy services with your provider.
    - Switch to in-person therapy services at Remedy Counseling, LLC office location as long as your provider is comfortable delivering in-person therapy sessions.
    - Transfer to another therapist within the practice who is comfortable delivering in-person therapy services, so your therapy services are covered by your insurance company. We will make every effort to make your transfer as smooth as possible and our therapists will collaborate with each other with your permission.
    - Provide 3 referrals to other mental health providers outside the practice who are willing to provide in-person therapy sessions if your insurance company requires in-person therapy services in order to provide coverage.
    - We are willing to offer a self-pay option that would include offering a "sliding scale fee" (We will only charge you for what your insurance company would reimburse Remedy Counseling, LLC instead of the $140 self-pay fee).

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of therapy sessions.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

X _____

Printed Name of Client

X_____

Client Signature Date

_____

Witness signature Date

3/20, 8/20, 7/21 & 4/22

Remedy Counseling, LLC
819 Ritchie Highway #1020
Severna Park, Maryland 21146
Phone: 410-431-5111 Fax: 410-431-5112
Website: Remedy-Counseling.com

RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

I, _____/ _____and/or _____
Name of Client Date of Birth Name of Parent or Guardian if applicable

I authorize Remedy Counseling, LLC clinicians/staff members to obtain from and/or disclose to:

Name of Provider/Organization: **Dr.**_____
Relationship to Client: **Primary Care Physician/Pediatrician** ***Insurance requires this release to be on file**

Address:_____

Phone Number: _____ Fax Number: _____

Specific medical and mental health information to be released: Please INITIAL "yes" or "no" for the following clinical areas:

Intake/Assessment	Initial-	Yes: _____	OR	No: _____
Psychosocial and Family History	Initial-	Yes: _____	OR	No: _____
Treatment Plan	Initial-	Yes: _____	OR	No: _____
Progress Notes	Initial-	Yes: _____	OR	No: _____
Discharge Summary	Initial-	Yes: _____	OR	No: _____
Progress in Treatment	Initial-	Yes: _____	OR	No: _____
Other: Medications if indicated	Initial-	Yes: _____	OR	No: _____

The purpose of this release of information is: Coordination of Care to Stabilize Mental Health Symptoms

This consent expires one year from the day, month and year that it was originally signed by the client, parent or guardian.

I understand that if the person or agency that receives this information is not a health care provider or health plan covered by the HIPPA privacy regulations, the information described above my be re-disclosed and is no longer protected by these regulations. I understand Remedy Counseling, LLC may not condition treatment on my decision to sign this authorization. I understand that these records are protected under Federal and State confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for in the law and regulations. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. I understand written notification is necessary to cancel this authorization and must be addressed to the "Brandy" Nina Routhier, LCSW-C at Remedy Counseling, LLC. I understand that ***this consent automatically expires 90 days after the end of the continuum of treatment at Remedy Counseling, LLC*** *unless otherwise noted. I further acknowledge that the information to be released was fully explained and that this consent was given of my own free will. This consent includes information placed in my records after the date of signature below.*

X _____
Printed Name of Client

X _____
Client Signature Date

_____
Witness Signature Date

Note, where information accompanies this disclosure form: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
03/10 Revised 10/13, 12/14, 12/17 & 7/19

Please Print any information you would like to provide to your therapist at the assessment.