IN-HOME COUNSELING SERVICES
COUNSELING IN THE COMFORT OF YOUR HOME

800 Main Street Suite 210 Antioch, IL 60002
www.inhomecounselingservices.com
Phone: (888) 903-5604 - Fax: (224) 788-5112

Dear Client,

Welcome to In-Home Counseling Services and thank you for choosing to work with our exceptional team.

Please review the following information which includes the company policies, client packet and consents required for services. All applicable forms must be filled out and returned to In-Home Counseling Services. You can return the completed and signed forms in the self-addressed stamped envelope or give them directly to your assigned clinician.

The required forms that are to be completed and returned are:

- Acknowledgement of Receipt of Notice
- Informed Consent for Psychotherapy Services
- Informed Consent for In-Person Services During Covid-19 Public Health Emergency
- Telehealth Informed Consent
- Notice of Privacy Practices
- Notification to Primary Care Physician (Required for IL)
- Authorization for Release of Health Care Information
- Client Financial Agreement and Acknowledgement of Company Policies
- Consent to be Contacted for Post-Visit Satisfaction Survey

If you have any questions, feel free to ask your clinician or contact our office at (888) 903-5604 option 2.

Respectfully,

Erin Krupinski-Christor
Executive Director
In-Home Counseling Services
(888) 903-5604 Ext. 1003
Erin@inhomecounselingservices.com

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

In-Home Counseling Services' Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a client's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- IHCS protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- IHCS reserves the right to change the privacy policy as allowed by law.
- IHCS has the right to restrict the use of the information, but IHCS does not have to agree to those restrictions.
- The client has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- IHCS may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES____ NO____

May we leave a message on your answering machine at home or on your cell phone? YES____ NO____

May we discuss your medical condition with any member of your family? YES____ NO____

If YES, please name the members allowed:

_____

_____

_____

_____
Signature of Client or Personal Representative & Authority

_____
Printed Name of Client or Personal Representative & Authority

_____
Date

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INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES

PSYCHOLOGICAL SERVICES

As a client in psychotherapy with In-Home Counseling Services, you have certain rights and responsibilities that are important for you to understand. There are legal limitations to those rights that you should be informed of and your clinician with In-Home Counseling Services has equivalent responsibilities to you as their client. These rights and responsibilities are as follows:

Psychotherapy carries both benefits and risks. Benefits from psychotherapy can be increased satisfaction in interpersonal relationships, reduction in feelings of distress, strengthened skills for managing stress and problem-solving, substantial increase of personal awareness and insight, however, there is no guarantee that this will happen. Risks with psychotherapy can include uncomfortable feelings, such as anger, anxiety, frustration, guilt, helplessness, loneliness, and sadness. This is because the process of psychotherapy often involves discussing unpleasant aspects of your life. Success in psychotherapy requires diligent effort on your part and is most effective if you work on things discussed outside of sessions.

The first 2-4 sessions will involve a comprehensive assessment at which time the clinician will evaluate your needs. During this time, you and the clinician will discuss your treatment goals and create an initial treatment plan. You should also evaluate the information and make your own judgement about whether you feel comfortable working with your clinician. If you have questions about services or your plan of treatment, you should discuss them with your clinician. If doubt persists, you should discuss with your clinician or In-Home Counseling Services staff about meeting with a different clinician. Receiving services from In-Home Counseling Services is at-will and you can terminate services at any time.

THERAPY SESSION

Sessions with your clinician will usually run around 60-minutes, once a week on a day and time dually agreed upon. These sessions may be more or less frequent depending on your need. The time and day scheduled for your sessions are assigned to you specifically. In the event you need to cancel or reschedule an appointment, it is requested that you provide your clinician with a 24-hour notice. Your clinician will try to find time to reschedule your session, however, rescheduled sessions are not guaranteed.

INSURANCE AND PAYMENT

In order to set realistic treatment goals, it is important to consider cost and your resources to cover services. Health insurance usually covers a portion of mental health treatment. With your permission, In-Home Counseling Services will assist in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and updating your clinician and/or In-Home Counseling Services if/when your coverage changes.

You should also be aware that some insurance companies require advance authorizations in order to cover services. Some insurance companies limit psychotherapy coverage to short-term treatment approaches and approval may be necessary for additional coverage of services. Most insurance companies require that you authorize our clinicians to provide them with a clinical diagnosis for

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treatment. At times, insurance companies will require additional clinical information such as treatment plans or summaries as well as copies of your entire record (very rare). This information will become a part of the insurance company's files and In-Home Counseling Services has no control over your files once in the possession of your insurance company.

With most insurances, there is an out-of-pocket expense that is your responsibility. In-Home Counseling Services will verify your insurance coverage prior to services and notify you of any anticipated out-of-pocket expense. Payment is due at the time of service. You can provide payment by cash or credit in-person to your clinician or by calling our office. It is easiest to have a credit card on profile to bill per session.

CONFIDENTIALITY

Confidentiality and information about your privacy rights are fully described in a separate document, entitled Notice of Privacy Practices. You have been provided with a copy of that document. If you have any questions or concerns regarding your privacy, please discuss with your clinician.

PROFESSIONAL RECORDS

In-Home Counseling Services is required to keep appropriate records of the psychological services that you receive. Your records are maintained in a secure location. In compliance with state laws, you have the right to a copy of your records. Because these are professional records they may not be correctly interpreted by an untrained reader. It is recommended if you would like a copy of your records, that you review them with your clinician in order to understand the contents within. You also have the right to request that a copy of your records be made available to other health care providers with a written consent form. You have been provided with a copy of that document and another copy can be provided at your request.

PARENTS AND MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. In-Home Counseling Services provides services to children ages 11-17 and consent from the client is required in order to be shared with the parent unless the clinician feels there is a safety concern (see also above section on Confidentiality for exceptions), in which case the clinician will make every effort to notify the client of their intention to disclose information.

CONTACTING YOUR CLINICIAN

Your clinician is often not immediately available by phone. You may leave a message on their confidential voicemail and your call will be returned as soon as possible. Non-emergent messages will be returned within the next few business days. You may also contact In-Home Counseling Services at (888)903-5604 and speak to a staff member. In case of a medical or mental health emergency, call 911 or go to your nearest emergency room.

OTHER RIGHTS

If you are unhappy with your current services, you can speak to your clinician so that your concerns can be addressed. Any discussion of discontent will be taken seriously and handled with care and respect. You may also call In-Home Counseling Services at (888) 903-5604 and speak to a staff member.

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Services with In-Home Counseling Services are at-will, and you are free to end the services at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of your services and about your clinicians specific training and experience.

CONSENT FOR PSYCHOTHERAPY

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

Signature of Client or Personal Representative & Authority

Printed Name of Client or Personal Representative & Authority

Date

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH EMERGENCY

This document contains important information about the decision to resume/continue in-person services during the COVID-19 public health emergency (PHE). Please review the following information and complete appropriate sections to confirm you agree to in-person services.

I, _____, would like to resume/continue in-person sessions with my In-Home Counseling Services clinician for psychotherapy services. I am aware that COVID-19 is a contagious respiratory virus and exposure to people increases my chances of contracting or spreading the virus. I understand if there is a resurgence of COVID-19, services may have to transition to telehealth in order to protect my clinician and myself. I understand that my clinician may chose to return to telehealth services to protect his/her safety.

I understand that telehealth coverage is determined by the insurance company and is subject to their discretion. I understand that In-Home Counseling Services will update both the clinician and client with information regarding PHE coverage changes when the information is available to them.

CLIENT RESPONSIBILITY TO MINIMIZE EXPOSURE

While participating in in-person sessions with In-Home Counseling Services, I agree to take reasonable precautions to limit my exposure to and reduce my risk of contracting and spreading COVID-19. Please initial after each statement to indicate that you understand and agree to the contents therein.

- I agree to only keep my in-person visit if I am symptom free of COVID-19 or any other communicable illness. ___
- I agree to notify my clinician if I have been exposed to anyone who has tested positive for COVID-19 or any other communicable illness within the week prior to my scheduled session. My clinician and I will decide whether to cancel the session or proceed with telehealth. ___
- I agree to adhere to safe distancing precautions during my session. ___
- I agree to no physical contact (i.e. shaking hands) during my session. ___
- I agree to follow safety precautions (i.e. handwashing, sanitize hands) during my session if warranted. ___

IN-HOME COUNSELING SERVICES RESPONSIBILITY TO MINIMIZE EXPOSURE

In-Home Counseling Services and their clinicians have taken steps to reduce the risk of spreading COVID-19. Your clinician agrees to the same responsibilities as you to reduce the risk of contracting and spreading COVID-19. If your clinician is exposed to COVID-19, has a fever, symptoms of COVID-19 or other communicable illness, they will notify you to decide whether to cancel the session or proceed with telehealth.

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INFORMED CONSENT

This form is a supplement informed consent, regarding COVID-19.

Your signature below indicates that you have read this Agreement and agree to their terms.

Signature of Client or Personal Representative & Authority

Printed Name of Client or Personal Representative & Authority

Date

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TELEHEALTH INFORMED CONSENT

I, _____, hereby consent to participate in telehealth services, with In-Home Counseling Services (IHCS) as part of my psychotherapy. I understand that telehealth is the practice of delivering clinical mental health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to telehealth services:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telehealth services, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth services unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate, and a higher level of care is required.

6) I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call your clinician at _____ to discuss since we may have to re-schedule.

7) I understand that my clinician may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

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Emergency Protocols

Your IHCS clinician needs to know your location in case of an emergency. You agree to inform your clinician of the address where you are at the beginning of each session. We also need a contact person who we may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is:

_____

My emergency contact person is:

Name: _____

Address:_____

Phone:_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____

Signature of Client or Personal Representative & Authority

_____

Printed Name of Client or Personal Representative & Authority

_____

Date

_____

Signature of Clinician

_____

Date

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NOTICE OF PRIVACY PRACTICES

EFFECTIVE 01/01/2023

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. OUR PLEDGE REGARDING HEALTH INFORMATION:

In-Home Counseling Services (IHCS) understands that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from IHCS. These records are needed to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. Also described are your rights to the health information we keep about you, and certain obligations we have regarding the use and disclosure of your health information. In-Home Counseling Services is required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information.
- Follow the terms of the Notice that is currently in effect.
- Changes to the terms of this Notice are allowed, and such changes will apply to all information we have about you. The new Notice will be available upon request and on our website.

II. HOW IHCS MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that IHCS can use and disclose health information. Below, each category of uses or disclosures will be explained. Not every use or disclosure in a category will be listed. However, all the ways IHCS is permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers (who have a direct treatment relationship with the client) to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. IHCS may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

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Lawsuits and Disputes: If you are involved in a lawsuit, IHCS may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. Any use or disclosure of such notes requires your authorization unless the use or disclosure is:
    - For use in treating you.
    - For use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
    - For use in defending in legal proceedings instituted by you.
    - For use by the Secretary of Health and Human Services to investigate HIPAA
    - compliance.
    - Required by law and the use or disclosure is limited to the requirements of such law.
    - Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
    - Required by a coroner who is performing duties authorized by law.
    - Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. IHCS will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. IHCS will not sell your PHI in the regular course of business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION:

Subject to certain limitations by law, IHCS can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although our preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring during a session.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or helping to ensure the safety of those working within or housed in correctional institutions.

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9. For workers' compensation purposes. Although our preference is to obtain an Authorization from you, IHCS may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. IHCS may use and disclose your PHI to contact you to remind you that you have an appointment with us. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that are offered.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:

1. Disclosures to family, friends, or others. IHCS may provide your PHI to a family member, friend, or other person that you indicate participates in your care or the payment for your health care, unless you object in whole or in part.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on uses and disclosures of your PHI. You have the right to ask IHCS not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request and may say "no" if it is believed to affect your health care.
2. The Right to Request restrictions for out-of-pocket expenses paid for in full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose how IHCS sends PHI to you. You have the right to ask IHCS to contact you in a specific way (for example, home or office phone), or to send mail to a different address, and we will agree to all reasonable requests.
4. The Right to see and get copies of your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that IHCS has about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request. IHCS may charge a reasonable, cost-based fee for doing so.
5. The Right to Get a list of the disclosures made for you. You have the right to request a list of instances in which IHCS has disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided authorization for. IHCS will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we provide you will include disclosures made in the last one year unless you request a longer period of time. IHCS will provide the list to you at no charge, but if you make more than one request in the same year, we may charge you a reasonable cost-based fee for each additional request.
6. The Right to Correct or Update your PHI. If you believe that there is a mistake in your PHI, or that essential information is missing from your PHI, you have the right to request that IHCS corrects the existing information or add the missing information.
7. The Right to Get a paper or electronic copy of this notice. You have the right to get a paper copy of this notice, and you have the right to get a copy of this notice via e-mail.

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Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

By signing below, I am agreeing that I have read, understood, and agree to the terms contained within this document.

Signature of Client or Personal Representative & Authority

Printed Name of Client or Personal Representative & Authority

Date

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NOTIFICATION TO PRIMARY CARE PHYSICIAN

Client Name: _____ DOB:_____

I, _____, understand that the state of Illinois requires my Primary Care Physician (PCP) to be notified that I am receiving mental health services from In-Home Counseling Services. I further understand that I can elect to refuse to have my PCP notified of my participation with In-Home Counseling Services.

☐ I choose to have In-Home Counseling Services notify my Primary Care Physician of my participation with In-Home Counseling Services.

☐ I choose not to have In-Home Counseling Services notify my Primary Care Physician of my participation with In-Home Counseling Services.

My Primary Care Physician is:

Name:_____

Address:_____

Phone:_____

My In-Home Counseling Clinician is:

Name:_____

_____
Signature of Client or Personal Representative & Authority

_____
Printed Name of Client or Personal Representative & Authority

_____
Date

NOTIFICATION TO PRIMARY CARE PHYSICIAN OF CLIENT RECEIVING MENTAL HEALTH SERVICES

Pursuant to Illinois law requiring that Licensed Clinical Social Workers inform their client's PCP that they are receiving mental health services, you are hereby notified that our mutual client, _____ is receiving such services. Our client has agreed to have In-Home Counseling Services notify you of their participation in our services. Please maintain a copy of this agreement for your records. In-Home Counseling Services looks forward to working alongside you in the care of the above-mentioned client.

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AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Client Information

Name:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____

Clinician:_____

I,_____, receive mental health services from In-Home Counseling Services. I authorize In-Home Counseling Services to release information regarding my treatment to:

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____ Fax Number:_____

The information that I authorize to release to the above mentioned is:

- ☐ All information (no limitations)
- ☐ Attendance and participation in mental health treatment
- ☐ Behavioral and Psychological reports
- ☐ Clinical notes
- ☐ Coordination of care
- ☐ Discharge planning
- ☐ Intake and history
- ☐ Screening Information
- ☐ Substance abuse treatment records
- ☐ Treatment plan
- ☐ Other:_____

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This release will be valid until the termination of treatment, authorization from the client to revoke or otherwise stated.

Expiration Date:_____

This authorization for release of information can be revoked at any time by the client listed above.

_____

Signature of Client or Personal Representative & Authority

_____

Printed Name of Client or Personal Representative & Authority

_____

Date

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CLIENT FINANCIAL AGREEMENT AND ACKNOWLEDGEMENT OF COMPANY POLICIES

Thank you for choosing In-Home Counseling Services (IHCS) as your mental health provider. We are committed to providing quality mental health services to all of those in need. IHCS believes that part of good health care practices is to establish and communicate a company and financial policy to our clients proactively and effectively. We are dedicated to providing the best possible care for you, and we want you to have a full understanding of our policies.

Information: Client or guardian is responsible for notifying their clinician or our office of any changes to demographics or insurance and billing information.

Payment: Payment of your bill is a part of your treatment. Fees are payable at the time of service. IHCS accepts cash and credit at the time of service paid to your clinician, or you can call in your credit card payment to our office staff. Payment includes any unmet deductible, co-insurance, co-payment amount and/or charges not covered by your insurance company. If you do not carry insurance, payment in full is expected at the time of service.

Insurance: IHCS clinicians are participating with most insurance plans. As a courtesy, we will verify your insurance coverage and inform you of any anticipated out-of-pocket expense prior to services based on the information provided by you. However, our verification is not a guarantee of benefits payable by your insurance company. We will file all claims for these plans. Please remember that insurance is a contract between the client and the insurance company and ultimately the client is responsible for payment in full. It is your responsibility to provide the most recent and up to date insurance information to IHCS and to know your own covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. In order to bill your insurance and to meet filing guidelines, IHCS will require a copy of your insurance card(s) and a photo ID.

If our providers are not listed in-network with your plan, you may be responsible for partial or full payment.

Network Status: If IHCS has a contract with your insurance company we will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-90 days from the time the claim is received by the insurance company. Your claim may be processed Out-of-Network if we are not contracted with your insurer. Some Out-of-Network benefits have co-insurance charges, higher co-payments and limited annual benefits. If your received services are part of an Out-of-Network benefits, your portion of financial responsibility may be higher than the In-Network rate. If IHCS is not contracted with your insurance company, you will be expected to pay for services at the time they are rendered. If needed, we will provide you with a statement that you can submit to your insurance company for reimbursement.

Policy of Non-Covered Services: IHCS offers services that may not be covered by some insurances. In some cases, you will be able to complete an Advanced Beneficiary Notice (ABN) for these services prior to receiving them. You will be responsible for the payment in full at the time of services.

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Referrals: If your insurance company requires a referral for services, it is the client's responsibility to obtain the referral prior to your session. If IHCS discovers a referral is required for services upon insurance verification, we will notify the client and/or physician to request a referral.

Responsibility for Payment: I understand that I, personally, am financially responsible to IHCS for charges not covered by the assignment of insurance benefits and non-covered charges.

Authorization and Assignment of Insurance Benefits: I hereby authorize IHCS to furnish information to insurance carriers concerning my diagnosis and treatments and I hereby assign to IHCS all payments otherwise payable to me for IHCS services.

Consent and Disclosures: I voluntarily consent to mental health treatment for myself and/or dependents.

Release of Information: I hereby authorize and direct IHCS to release (verbally and in writing) confidential medical information to any person, entity, government agencies, insurance companies, or others who are financially responsible to IHCS for charges of my treatment for claims processing, quality management, utilization review, transfer of medical care, and follow-up purposes. I understand that a copy of this document may be used with the same effectiveness as an original.

Self-Pay Clients who are Insured: Self-pay clients will be identified when they make initial contact with the office and will be defined as a client who:

- Has no health insurance coverage of any kinds, including federal and state health care programs such as Medicare, Medicaid, or other insurance coverage such as insurance provided by school or AFLAC.
- Does not claim third party liability for the client's health care treatment.
- Is not eligible for workers' compensation coverage; and
- Has no other responsible party covering expenses associated with the care received from IHCS.

Self-pay clients will be required to pay in full for services at the time of service.

Billing and Collection Fees: IHCS will submit claims for payment to your insurance company. In the event your insurance company denies the services provided, you will be responsible for payment in full. We appreciate prompt payment for any outstanding balance. If you are unable to submit payment in full, please contact our office to set up a payment plan.

Medicare Beneficiaries: I request that payment of authorized Medicare Beneficiaries be made to IHCS. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

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I certify that I have read and agree to the In-Home Counseling Services (IHCS) Financial and Billing policy. I also understand and agree that such terms may be amended by the practice at any time.

Signature of Client or Personal Representative & Authority

Printed Name of Client or Personal Representative & Authority

Date

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CONSENT TO BE CONTACTED FOR POST-VISIT SATISFACTION SURVEY FORM

Client First Name:_____ **Client Last Name:** _____

Client Date of Birth: _____

In-Home Counseling Services ("Center") is committed to ensuring clients' satisfaction of services received. The Center has contracted with a third party – Burke, Inc. – to conduct satisfaction surveys on our behalf. The survey will be provided online and will take no more than 10 minutes to complete. If you agree to be contacted to participate in a survey about our services, please indicate your consent by checking one of the boxes below:

☐ I agree to be contacted by Burke, Inc. via email (at the email listed below) for purpose of the survey and understand that the invitation will mention Center. I acknowledge and agree that these messages, which may contain Protected Health Information, will be sent via unencrypted means and there is some risk of disclosure or interception of the messages.

Email Address: _____

I understand that this consent may be withdrawn by me at any time via the email I receive from Burke, Inc., via telephone by calling **(888) 903-5604** or via email message at **info@inhomecounselingservices.com.** I understand that my withdrawal of consent to be contacted for a post-visit satisfaction survey shall not withdraw my consent to otherwise by contacted by the Center.

☐ I do not wish to be contacted for purposes of this survey.

Signature

I confirm that I have read and fully understand the above information prior to my signing and all of my questions regarding this form have been answered to my satisfaction. I agree that I am signing this Consent to be Contacted for Post-Visit Satisfaction Survey Form freely and voluntarily. I understand that my consent given with my signature below will remain in effect unless and until I cancel such consent in writing pursuant to the terms set forth above.

_____

Signature of Client or Personal Representative & Authority

_____

Printed Name of Client or Personal Representative & Authority

_____

Date