Higher Ground Counseling, LLC
find perspective, find higher ground

Insurance and Billing Information

Client Name: ____

DOB: _______________ Social Security #:________________________________

Address: ____

Phone: ___________________ ____________________ ___________________
(home) (cell) (work)

OK to leave messages? ______ email: ___________________________________

Parent's name (if minor) ____

Insured's name: ____

Insured DOB: __________ Insured Social Security # _______________________

Address: ____________________________________ Phone: ________________

Insurance Company: ____

Insurance Address: ____

Insurance Phone: ____

Subscriber ID#:____

Group#: ________________________ Insured's Employer: ___________________

Secondary Insurance: ______________________ ID #: ______________________

Group#:_________________________________ Phone: ____________________

EAP: _____ Yes _____ No # Sessions Approved: __________________________

EAP Company Name: _______________________ Phone: __________________

EAP Authorization number: ____

Private Pay:_____ Yes ______ No Rate/ 50 Minute session ________________

Referring Physician: ____

Referral Source: ____

Billing Policies and Financial Agreement

Clinic rates are as follows:
Intake and Evaluation $200 per clinical hour for individual therapy
Ongoing sessions are $180 per clinical hour for individual therapy

Insurance does not cover:
Couples sessions $180 per clinical hour
Assessments: SDI, MAWASI, PTSI-R, IPAST $250
Late cancel (less than 48 hours)/no show $165
Consultation or records preparation $180/hour

Rates subject to change with 30 day notice.

Self-Pay Clients: You may have a credit card agreement on file to pay the balance in full every session. You may also pay in session using cash, check, or credit. Any client who has a 3rd party payor paying their fees will be **required** to have a credit card on file (ie parent paying minor or adult child's fees).

Late Fees/ Collection: Any balance left unpaid beyond 30 days of statement mailing is subject to a 1% per month late payment charge. After 90 days, a notice will be sent to inform you your count will be sent to collections. In the event that collection efforts become necessary to collect on my account, I agree to pay all costs including collection fees and attorney's fees. Returned checks for insufficient funds will incur a fee of $50.

Initial Late Fees/ Collection Policy: ______

Insurance Clients: Higher Ground Counseling, LLC is an in-network provider for some insurance panels. It is the client's responsibility to verify provider is in their plan/ network and all the associated fees/ deductibles for individual plan. All co-pay and deductible amounts are due on the day services are rendered. Coinsurance amounts will become your responsibility after our office receives an explanation of payment from the insurance company. Insurance reimbursement takes 3-4 weeks after we submit the claim. In signing this document, you attest to the fact that you are fully aware of your insurance plan, co-payments, deductibles, coverage etc. and acknowledge that **Financial responsibility is ultimately yours in the case of a lapse in coverage, not meeting deductible, or any insurance denial reason, due to this financial agreement between you the client and Higher Ground Counseling, LLC.**

Cancellation Policy

If you need to cancel or reschedule an appointment call your primary counselor at: 608-205-5212, at least 48 hours prior to the appointment. If you do not provide a 48 hour notice or no-show for an appointment, you will be charged for your full session fee. No Show/Late Cancel fees are the client or responsible parties' responsibility and must be paid within 30 days. **Insurance and EAP's do not cover no-show fees.**

I have read and understand the above billing policies and financial agreement:

Print Client Name: ____

Signature: ____ Date: ______________

3rd Party Payor Name: ____

3rd Party Payor Signature: _____________________________ Date: ______________

Therapist Signature: _________________________________ Date: _______________

Credit/Debit Card Authorization Agreement

Client Name / Address: ____________________________ DOB: _______________

____

____

Your signature authorizes Higher Ground Counseling, LLC to bill the credit card listed below. Three situations may apply to credit/debit card users. 1) Recommended for self-pay clients that prefer to pay the entire balance in full every session using their credit/debit card. 2) For insurance deductibles and copays, cards can be charged one time per month to pay full amount. 3) Clients may request a payment plan that will bill a flat amount every month until the bill is paid in full.

For changes to existing credit cards on file, please call billing at 608-697-8530. After services are discontinued and account balance(s) are paid in full, this agreement will become null and void.

Type of Credit Card: MasterCard/Visa/Discover

(Circle One)

Card #:________-________-________-________ Exp. Date:____-____

3-digit Security Code: ___________

Name and Address with zip code of Credit Card Holder:

____

____

____

Relationship to Client: self parent spouse other

Signature on File:________________________________Date:_________________

Please check one of the boxes below:

____For Self Pay clients: I am opting for payment to be made at the time of service. $______________

____For Insurance Deductibles and Copays: I am opting for payments in full every month.

Notice of Privacy Practices

I have received / declined (please circle one) a notice of the Privacy Practices for Higher Ground Counseling, LLC.

Print Client Name ____

Signature ______________________________Date _____________________

Print Guardian Name ____

Guardian Signature _______________________Date _____________________

Therapist Name: Loren Fisher, MSW, LCSW

____ _____________
Therapist Signature Date

Consent to Treatment

Higher Ground Counseling, LLC wants you to be aware of your rights and responsibilities as a patient/client of our clinic. We ask for your INFORMED CONSENT to receive treatment. A copy of the *Client Rights and Grievances* appears in our waiting room and you have been given a copy of the *Client Rights and Grievances* to take with you. Please read this. In addition, please read the following general information about the psychotherapy process.

CONSENT TO TREATMENT

1. The benefits to psychotherapy are to help alleviate the problems and symptoms that you present. As a client you will be involved in the formulation and evaluation of your treatment plan through the therapy process.
2. Psychotherapy is conducted in a professional and appropriate manner between psychotherapist and patient/client talking about the presenting problem.
3. If there is any expected side effects from psychotherapy (or medication when that is a consideration) they will be discussed with you.
4. The psychotherapist will suggest alternative treatment methods and will make referrals to other psychotherapists when appropriate or necessary.
5. The possible consequences of not receiving psychotherapy may be discussed.
6. What you say to your therapist, as well as any case notes or other records, are confidential and generally will not be shared with others unless you provide written consent. However, there are exceptions to this:
    1. Sound ethical treatment as well as state mental health policy requires periodic review of psychotherapy performed by your therapist. The review will be done by other licensed professional counselors in consultation with Higher Ground Counseling, LLC.
    2. If your therapist has reason to believe you or someone else may be in danger of physical harm, state law and professional ethics require your therapist to take steps to protect you and/or other persons involved. This may include notification of appropriate social service and legal agencies. Examples of such instances include:
        1. Danger of suicide or other self-injurious behavior
        2. Danger of causing physical harm to another
        3. Occurrence or suspicion of child abuse or neglect.

CLIENT RESPONSIBLITIES

1. The client will devote time and energy to therapy. The client will follow through with treatment recommendations. This commitment strengthens your chances of reaching the goals of treatment that you and your therapist develop.
2. Refrain from physical or other types of abusive behavior to yourself, to others or to any property.
3. Be honest regarding your thoughts and feelings about your treatment.
4. Keep appointments made. Cancellations with less than 24 hour notice will be charged to your account.
5. Stay current with your bill. Full payment is expected at time of service.

DISCHARGE POLICY:

Reason(s) for discharge: Client competed services; Client referred out for services; Client discontinued treatment.

Reason(s) for involuntary discharge: Three No-shows and/or late cancellations in a 6month period; Non-compliance with treatment recommendations; a threat to clinician's safety.

INFORMED CONSENT I have read the above statements regarding my rights and responsibilities, including the discharge policy. I herby give my consent to be assessed and treated by this clinic. I have discussed any concerns I might have about the above statements.

Client Signature: ____ Date:__________

Parent/ Guardian Signature: ___________________________________ Date:_________

Therapist Signature: ____ Date: _________

Authorization for Release of Information

______________________________ from Higher Ground Counseling, LLC has

permission to: ____ release to ____ obtain from ____ exchange with (check one):

Name of individual, agency, program: ___________________________________

Address: ___________________________________

Phone / Fax: ___________________________________

Information regarding:

___________________________ _______________ ____________________

Full Name of Client DOB SSN

I understand that the purpose or need for release of this information is to aid in providing and coordinating assessment, treatment, and after care services. I have checked specific information being requested:

____ Psychological evaluations ____ Psychiatric records ____ Personal History

____ Counseling records ____ Medical records ____ Other

I understand that my records are protected under Wisconsin State Statues governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in State Statues.

I understand that my consent may be revoked by me at any time, except to the extent that action has already been taken. This consent expires one year from this date unless expressly revoked earlier. I hereby release you and Higher Ground Counseling, LLC from all legal responsibility or liability that may arise from this act. I may cancel this authorization in writing in one of the following three ways:

1. Sign and date a revocation form. This form is available from your therapist.
2. Write, sign, and date a letter to your therapist to cancel the authorization.
3. Sign, date and write “CANCEL” on this original form.

Once your therapist gives out information, he or she has no control over it. The recipient might re-release it. Privacy laws may no longer protect your information.

____ _______________________

Client signature / Parent Signature Date

____ _______________________

Witness / Therapist Date

Social Media Policy

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

I keep a Facebook Page for my professional practice to allow people to share my posts and practice updates with other Facebook users. You are welcome to view my Facebook Page and read or share articles posted there, but I do not accept clients as Fans of this Page. I believe having clients as Facebook Fans creates a greater likelihood of compromised client confidentiality and I feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list.

Note that you should be able to subscribe to the page via RSS without becoming a Fan and without creating a visible, public link to my Page. You are more than welcome to do this.

My primary concern is your privacy.

My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Interacting

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an

already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

If you need to contact me between sessions, the best way to do so is by phone. Direct email at loren@highergroundwi.com is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

Use of Search Engines

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Business Review Sites

You may find my practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it.

If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing.

If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

Location-Based Services

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone.

Email

I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Conclusion

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

______________________________	______________
Client signature / Parent Signature	Date
______________________________	______________
Witness / Therapist	Date

TELEMENTAL HEALTH CONSENT

Telemental Health is the practice of mental health when patient care, treatment or services are provided through the use of medical/mental health information exchanged from one site to another via electronic communications.

Services delivered via telemental health rely on a number of electronic, often Internet-based, technology tools. These tools can include videoconferencing software, email, text messaging, virtual environments, specialized mobile health ("mHealth") apps, and others.

Higher Ground Counseling, LLC typically provides telemental health services using the following formats: **Zoom, Doxy, or Ring Central Phone App**

• You will need access to Internet service and technological tools needed to use the above-listed tools in order to engage in telemental health work with your provider.

• If you have any questions or concerns about the above tools, please address them directly to your provider so you can discuss their risks, benefits, and specific application to your treatment.

BENEFITS AND RISKS OF TELEMENTAL HEALTH

Receiving services via telemental health allows you to:

• Receive services at times or in places where the service may not otherwise be available.

• Receive services in a fashion that may be more convenient and less prone to delays than in-person meetings.

• Receive services when you are unable to travel to the service provider's office.

• The unique characteristics of telemental health media may also help some people make improved progress on health goals that may not have been otherwise achievable without telemental health.

Receiving services via telemental health has the following risks:

Telemental health services can be impacted by technical failures, may introduce risks to your privacy, and may reduce your service provider's ability to directly intervene in crises or emergencies. Here is a non-exhaustive list of examples:

• Internet connections and cloud services could cease working or become too unstable to use.

• Cloud-based service personnel, IT assistants, and malicious actors ("hackers") may have the ability to access your private information that is transmitted or stored in the process of telemental health-based service delivery.

• Computer or smartphone hardware can have sudden failures or run out of power, or local power services can go out.

Interruptions may disrupt services at important moments, and your provider may be unable to reach you quickly or using the most effective tools. Your provider may also be unable to help you in-person.

There may be additional benefits and risks to telemental health services that arise from the lack of in-person contact or presence, the distance between you and your provider at the time of service, and the technological tools used to deliver services. Your provider will assess these potential benefits and risks, sometimes in collaboration with you, as your relationship progresses.

ASSESSING TELEMENTAL HEALTH'S GOODNESS OF FIT

Although it is well validated by research, service delivery via telemental health is not a good fit for every person. Riverstone Counseling, LLC will continuously assess if working via telemental health is appropriate for your case. If it is not appropriate, Riverstone Counseling, LLC will help you find in-person providers with whom to continue services.

Please talk to your provider if you find the telemental health media so difficult to use that it distracts from the services being provided, if the medium causes trouble focusing on your services, or if there are any other reasons why the telemental health medium seems to be causing problems in receiving services.

Raising your questions or concerns will not, by itself, result in termination of services. Bringing your concerns to your provider is often a part of the process.

You also have a right to stop receiving services by telemental health at any time without prejudice. In-person and services are available and if you are reasonably able to access the in-person services, you will not be prevented from accessing those services if you choose to stop using telemental health.

YOUR TELEMENTAL HEALTH ENVIRONMENT

You will be responsible for creating a safe and confidential space during sessions. You should use a space that is free of other people. It should also be difficult or impossible for people outside the space to see or hear your interactions with your provider during the session. If you are unsure of how to do this, please ask your provider for assistance.

OUR COMMUNICATION PLAN

At our first session, we will develop a plan for backup communications in case of technology failures and a plan for responding to emergencies and mental health crises. In addition to those plans, your provider has the following policies regarding communications:

• The best way to contact your provider between sessions is:

Phone: (608)205-5212

EMail: loren@highergroundwi.com (email should NOT be used for emergencies)

• Your provider will work to respond to your messages within 48 hours or two working business days. Please note your provider's hours. Your provider may not respond at all on weekends or holidays. Your provider may also respond sooner than stated in this policy. That does not mean they will always respond that quickly.

Please note that all textual messages you exchange with your provider, e.g. emails and text messages, will become a part of your health record.

OUR SAFETY AND EMERGENCY PLAN

As a recipient of telemental health-based services, you will need to participate in ensuring your safety during mental health crises, medical emergencies, and sessions that you have with your provider.

Your provider will require you to designate an emergency contact. You will need to provide permission for your provider to communicate with this person about your care during emergencies.

Your provider will also develop with you a plan for what to do during mental health crises and emergencies, and a plan for how to keep your space safe during sessions. It is important that you engage with your provider in the creation of these plans and that you follow them when you need to.

YOUR SECURITY AND PRIVACY

Except where otherwise noted, your provider employs software and hardware tools that adhere to security best practices and applicable legal standards for the purpose of protecting your health care services are not lost or damaged.

As with all things in telemental health, however, you also have a role to play in maintaining your security.

Please use reasonable security protocols to protect the privacy of your own health care information. For example: when communicating with your provider, use devices and service accounts that are protected by unique passwords that only you know. Also, use the secure tools that your provider has supplied for communications.

RECORDINGS

Please do not record video or audio sessions without your provider's consent. Making recordings can quickly and easily compromise your privacy, and should be done so with great care. Your provider will not record video or audio sessions. If a situation occurs where your provider would record a session, your consent will be sought prior to any recording.

INFORMED CONSENT I have read the above statements regarding my rights and responsibilities. I herby give my consent to engage in telemental health services with Higher Ground Counseling, LLC. I have discussed any concerns I might have about the above statements.

Client Signature: ____ Date:__________

Parent/ Guardian Signature: _________________________________ Date:__________

Therapist Signature: _______________________________________ Date: __________

Permission to Treat

I hereby grant my permission to ________________________________

Name of Therapist

of Higher Ground Counseling, LLC to provide psychotherapeutic treatment to my child/protectee.

____ _____________

Name of Child Date

I have been informed of this client's rights and understand that as the guardian of the child/protectee, I have the right to be informed and involved in the development of the treatment plan recommended for this individual.

____

Print name Date

____

Signature of Parent or Guardian

____

Witness Date

Communication Policy re: Adult Children in Treatment

Thank you for helping your son or daughter in finding a safe place to process emotions and get support. I am grateful to have the honor of walking alongside him or her on the healing journey.

While I know that having an adult child in counseling can be difficult and anxiety provoking, it is important for them to have a confidential space and a place where they feel it is completely their own. He or she is my client, and they are an adult.

Sometimes parents will contact me to download information, or give me “head’s ups” about things. This usurps my therapeutic relationship with your adult child. While your heart is in a good place, it actually can hurt therapy, and we call it “therapy interfering behavior.” In order to create a safe place for an adult to differentiate and grow, treatment needs to be their responsibility as well as their privilege.

I tell my clients that they are in the driver’s seat of their therapy. They get to decide how fast or slow, and also what modalities of treatment we may try. I offer options, and they get to choose. I would appreciate your cooperation and encouragement in this area.

Lastly, while I know that you may be the one paying the bill, this does not give the right to have sessions “downloaded to you.” Meaning, please allow the client space and time to process what happens in therapy before asking any questions. He or she may be sharing things that are difficult even with a therapist present, so they may not feel an ability or readiness to share with loved ones. This may be something that can eventually be shared, but it doesn’t have to. Adults get to have their own thoughts and feelings without having to explain or justify, even to their parents.

Please know this policy is based on years of working with family systems, while understanding the real fears and anxieties that families face for their loved ones in treatment. Please also know that the greatest chance for your son or daughter heal is giving them space and time to do so.

____________________________ ______________

client date

____________________________ ______________

Parent date

Higher Ground Counseling, LLC 6000 Gisholt Drive #202 Monona, Wisconsin 53713

Phone: 608-205-5212 Fax: 608-807-4474

Insurance Opt-Out Agreement / Private Pay Agreement

I understand and agree that:

• I have voluntarily elected not to use my insurance for counseling sessions;

• My therapist did not encourage, initiate, coerce, persuade, imply, or otherwise cause me to opt out of my insurance, verbally or otherwise; this decision is my own for my own reasons;

• I am not opting out of using my insurance to gain a specific time slot or any auxiliary benefits provided by my therapist, implied or otherwise;

• My treatment was not threatened in any way by either signing (or not signing) this opt out form;

• Opting out of my insurance means that I must pay out-of-pocket for the counseling sessions;

• I have made my therapist aware that I am voluntarily decided to opt out of using my insurance for counseling sessions even if she is in-network or out-of-network;

• I will let my therapist know if anything changes, and I either obtain alternative insurance and/or decide that I would like my sessions billed to my insurance;

• If I opt of out using my insurance, I cannot use the payment of sessions towards my deductible and my therapist will not provide superbills for reimbursement purposes;

• I cannot opt out of services individually (i.e.., I want to opt out of insurance for video sessions but not for in-person sessions) and that by opting out, I am opting out of entirely using my insurance for all services;

• If I elect to voluntarily use my insurance in the future, my therapist reserves the right not to allow me to opt out of using my insurance again;

• If I choose later to use my insurance, my therapist is not liable and is not obligated to reimburse previous sessions where I have chosen to opt out of billing my insurance; and

• If I choose later to use my insurance, my opting back into using insurance will start from the day I notify my therapist of the change and cannot be backdated to previous sessions.

• This agreement is in effect from ___________ until I voluntarily elect to make changes and use my insurance; I acknowledge that I have been given the opportunity to ask questions, and that Loren Fisher, MSW, LCSW, CSAT has verbally explained the risks and benefits of signing the Insurance Opt Out Agreement.

I have read, understood, and agree to the terms contained in the Insurance Opt Out Agreement.

____ ______________

Client Signature (Client's Parent/Guardian if under 18) Date