**Affinity Mental Wellness** **Samantha Runnion, LSCSW, RPT-S**
**9235 W. Central Ave. Wichita, KS 67212-5178**
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## INFORMED CONSENT AND CONTRACT FOR THERAPY SERVICES

Welcome to my practice Affinity Mental Wellness. I am pleased to have the opportunity to serve you. This contract will identify my practice policies and expectations. Please read this thoroughly and fill out any pertaining information as needed. If you have any questions, please ask me.

I am a Licensed Clinical Social Worker through the State of Kansas and am practicing independently at Affinity Mental Wellness. My clinical work centers on helping individuals, couples and/or families strengthen their relationships and working through the issues that may keep them from full participation in meaningful relationships and life.

Name:_____Date: _____

Date of Birth:_____SSN#:_____Gender:_____

Address: _____
Street City State ZIP

Home Phone:_____ Work Phone: _____ Cell Phone: _____Okay to leave a message? Yes No

Email Address: _____

Religious Preference:_____Referral Source:_____

Person filling out the form if not client:_____Relationship: _____

Person responsible for payment:_____Relationship: _____

Address: _____
Street City State ZIP

Home Phone:_____ Work Phone: _____

**Are you or the client involved in any legal proceedings which may involve your therapist? (I.e. Worker's compensation claim, child custody, domestic, criminal history, etc.) Yes No**

**If yes, please describe**

_____

_____

_____

_____

**Emergency Contact:_____Phone:_____**

**Relationship: _____**

Revised 3/2019

***It is important that, as the client, you are fully informed about the therapy services you will be receiving. Your signature below indicates that you have received, read, and understand the practice policies at Affinity Mental Wellness in helping you make an informed decision about entering therapy.***

## Office & Services

- I understand that my therapist is associated Affinity Mental Wellness and is practicing independently. I understand that my therapist currently holds a current license by the State of Kansas Behavioral Sciences Regulatory Board, and is bound by the Code of Ethics for her profession. I can request a copy of those ethics at any time. I understand that my therapist is able to treat individuals, couples, families, and groups. My therapist is not able to prescribe medication.
- My office is located on the South side of Central just West of Tyler Rd. Upon your arrival to my office, please have a seat in the waiting area, and I will come to get you. In addition, please have your insurance card, so that I may photocopy it for your file.

## Client Rights

- I understand that the relationship with my therapist is an important relationship and that my therapist will assume that I want to reach my goals. If at any time I am unhappy with the service I am receiving, or feel as if I am not benefiting from therapy, or if I am uncertain about goals of treatment, I understand that I can express these concerns with my therapist.
- CLIENT'S RIGHTS: As a client, you have rights regarding your participation in therapy and these include:
    - The right to ask questions about your therapy.
    - The right to decide not to receive therapeutic help from me. I will be happy to provide you with the names of other qualified professionals upon your request.
    - The right to end therapy at any time without any moral, legal or financial obligations other than those already incurred.
    - The right to determine therapy goals and to redefine them when necessary.
    - The right to be fully informed of your rights to privacy of protected health information.
    - The right to be fully informed about the fees for therapy and method of payment.
    - The right to know about the Code of Ethics for my specific licensure that guides my work.

## Benefits & Risks

- Any time you seek therapy to work with the difficulties, there are benefits and risks involved in the changes that may occur. The benefits of therapy can include the ability to handle or cope with personal issues and interpersonal relationships in healthier, more positive ways. You may also gain a great understanding of personal and family goals and values. However, during this time, change can be uncomfortable and you might find that you or others are resistant to these changes and you may be tempted to end therapy prematurely. Although this new understanding may lead the way to greater maturity and happiness as an individual, as a couple, or as a family. In addition, there may be benefits that come as you work at specific concerns you have brought into therapy.
- I understand there can be risks and benefits associated with therapy and I have discussed those with my therapist.

## Confidentiality

- I understand that, except under specific circumstances mandated by law, communications with my therapist will remain confidential as will any records regarding the consulting process unless I sign a "Release of Information" form. The release of information will be in accordance with K.S.A. 65-6410. If more than one family member participates in a session, each family member must consent prior to the release of the file information. The client's family members are not entitled access to client information just because they are family.
- I understand my therapist, will not follow or accept friend requests on social media, nor will they address me in public, outside of the therapy office, in order to respect my confidentiality and privacy.
- A therapist interacting with a client on social media can compromise the client's confidentiality, can blur the boundaries of the therapeutic and professional relationship, and can impact the working relationship.
- The therapist will not accept friend requests from current or former clients on any social media sites (including, but not limited to: Facebook, Twitter, Snapchat, Instagram, Friendster, etc.).
- If you use an easily recognizable name on Twitter or blog commentaries, and you decide you want to follow the therapist's professional stream of tweets or blogs, the impact of this on the therapeutic relationship may be discussed. If you choose to follow this therapist, please note that the therapist will not follow you back due to privacy concerns and appropriate professional boundaries.

- It is not part of regular therapeutic practice to search for clients on the Internet using Google, Facebook, or other search engines. Extremely rare exceptions may be made during times of crisis (i.e.: if there is reason to believe that you are in danger and there is a concerning amount of lack of contact with the therapist).
- With the exception of information about your therapy that is used or disclosed for treatment, payment, or other healthcare operations, information may be released to other persons only with your permission and after you have signed an "Authorization to Release and Obtain Information" request.
- I understand that, under Kansas Law, specific circumstances require my therapist to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when: a) a therapist believes a client may be a danger to him or herself or to others; b) the therapist believes that a child, elderly, or disabled person may be subject to abuse or neglect; and, c) when a court order exists that information regarding the therapy process be provided. I understand that any such breaches of my right to confidentiality will be discussed with my therapist's post-graduate supervisor, if applicable.

## Consultation With a Physician

- I understand that under Kansas Law, my therapist is required to consult with my primary care physician, or other health care provider, to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, my therapist will request that I complete an "Authorization to Release and Obtain Information" form. I also understand that I may waive this consultation, in writing, and that my therapist will discuss this process with me at any time if I so request.

## Cancellation Policy & Rescheduling

- Please be aware that your therapist will hold a special appointment time for you. You will need to give a 24-hour notice to cancel or reschedule your appointment, unless there are circumstances that we would both define as an emergency. If you no show your therapist, or cancel your appointment with little or no notice, your therapist may choose to process with you your readiness for therapy. Due to availability, if you no show an appointment and you have future appointments scheduled, those future appointments <u>will not</u> be confirmed until you call and confirm them. After 2 no shows, or a pattern of cancellations, it will be discussed whether or not to continue services and your therapist has the right to close your file. You will be subject to pay a no show fee of <u>$65</u> before you return for your next appointment. This fee is to compensate the therapist for the billable time that could have been given to other clients.
- If you are using your medical insurance to be reimbursed for the sessions, your insurance company will not be billed for a missed appointment, but rather you will need to pay the fee for a missed appointment.
- If you do not schedule an appointment with your therapist after a missed appointment, after 2 weeks of no contact, your file will be considered to being closed. Should you wish to re-open your file, you will be subject to the same procedures as any client opening a new file, including changes in session rates, or lack of availability of your therapist to take new clients if the therapist's caseload is full.

## Health Insurance

- I understand that if I have health insurance, my therapist may or may not be able to take my insurance. In the event that my insurance is not accepted, I will pay in accordance with the applicable fees. If my therapist is able to take my insurance, I will be responsible for paying any expenses not covered unless otherwise stated by my therapist. It is also my responsibility to notify my therapist about any changes in health insurance coverage.
- However, if I'm considered an Out-of-Network Provider with your insurance, your insurance may reimburse you directly. In this case, you are responsible for all fees reimbursed, as well as your copay. Should you choose to use the Private Pay method and not use insurance, I will provide you with a receipt of payment for your records.

## Messages

- As we work together, you will notice that I do not accept phone calls when I am with my clients and I do not have a receptionist. Messages may be left for me on my confidential voicemail or email. Please use email or secure messaging system through therapyappointment.com to communicate with me.
- Please discuss the option of texting with me. Due to confidentiality, please limit texts regarding appointments or information regarding your therapy to a minimal.
- Automated text or email reminders of your appointments will be delivered within 24 hours of your appointments if you choose.
- Messages are returned within 24 hours or on the next business day.

## Fees

- I understand that my therapist's standard fee is $185 for intake, $175 per 53+ min. session, $135 per 45-min. clinical session, $145 per family session and if play therapy is used during a session there will be an additional $20 fee per session. If I am not able to pay this fee for service, my therapist can discuss fees based on a payment plan, and proof of my income may be required. I understand that I am expected to make payments including co-pays at each session I attend.
- I understand the cancellation policies and also understand that I am responsible for the fee of any missed sessions, if I do not cancel a session at least 24 hours in advance, unless I am unavoidably prevented from attending due to accident or illness.
- I understand the financial policies and that a finance charge of 1.5% each month (18% annually) will be charged to my account balance, if I carry a balance, unless other payment arrangements have been made with my therapist.
- I understand that if I choose to pay with my debit or credit card, the information is stored with a secured merchant account. I acknowledge and authorize that my card will be processed for any monies owed for therapy services, and only amounts which I am responsible. I understand that my therapist will discuss this process with me if I authorize said monies to be taken from my financial account routinely.
- I understand that if I am involved in any court matters regarding the assistance of an attorney, and require involvement from my therapist, that there will be additional costs incurred for any reports, appearances in court, etc. by my therapist, as outlined in my therapist's court and agency fee schedule. This will also apply if I'm involved with an agency that requires reports and updates, such any case management and probation officers.
- I understand that a third party billing or collection service, or receptionist/secretary may contact me on behalf of my therapist regarding any outstanding monies owed to my therapist, and I give my permission accordingly.
- You may pay with cash, check, debit card or any major credit cards. Should you choose to use your debit or credit card, I have a secure system which stores that information and your card will be charged accordingly, at the end of each session. Should you pay with a check and if for any reason a check is returned, payment for the returned check as well as a $30.00 fee will be required. If a check is returned, credit card payment must be made for all future sessions, unless other arrangements have been discussed with your therapist. Should your credit card be declined or rejected, you are responsible for the full amount, plus a $30 return fee or any other expenses incurred by your therapist from the bank or credit card company.
- If you borrow a book from your therapist, you may treat it as a library book. It is due to be returned after 2 weeks of the date you borrowed it. If it's not returned by the due date or is returned damaged, you will be charged a replacement fee of a minimum of $20, unless otherwise discussed and agreed upon with your therapist.

***My signature below indicates I give my full and informed consent to receive therapy services. (To be signed by all participating members over the age of 13 years.)***

_____ _____

Client's Signature Date Client's Signature Date

_____

Therapist's Signature Date

***This is a strictly confidential client mental health record, to be used only by the authorized recipient. Law expressly prohibits re-disclosure or transfer of the information to any other party.***

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## Authorization to Release and Obtain Information

Client Name: _____ DOB_____

Parent/Guardian of Minor Client:_____DOB_____

***PLEASE READ, INITIAL THE APPROPRIATE STATEMENT AND SIGN BELOW.***
***If giving permission, please fill in the physician's/professional's information below:***

**I understand that Samantha Runnion, LSCSW, RPT-S may find it necessary to refer to and consult with my physician(s) or other professionals and/or the physician(s) of minor children involved in the process of therapy. I also understand that Samantha Runnion, LSCSW, RPT-S is requesting specific permission to consult either by written and/or verbal communication with the professionals involved in my care, and it is my choice to agree or not to agree to give her such permission as follows:**

_____I ***give permission*** to Samantha Runnion, LSCSW, RPT-S to consult in written and/orverbal communication with my medical care provider and/or other professionals as listed in the Authorization & Request for Release of Confidential Information and Privileged Communication. My therapist has my permission to both give and receive information pertinent to my care and the care of any minor children listed on the signed minor consent form.

_____I ***do not*** give permission for Samantha Runnion, LSCSW, RPT-S to contact my medical care provider or other professionals for consultation either by written or verbal communication, and therefore, waive the right.

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**Agency/Person for Disclosure:**

Name:_____Address:_____

Phone:_____Fax:_____

**Information to be disclosed: Mark all that apply**

__Assessment/Intake Summary __Master Treatment/Safety Plan __Discharge/Transfer Summary
__Psychological/Psychiatric Eval __Treatment Update __Educational Information
__Presence/Participation in Session __Medication Management Info __Diagnosis
__Drug/Alcohol diagnosis/treatment __All Clinical Records
__Consultation and/or Verbal Communication Between the Above Named Parties
__Other _____

I understand that my records are protected and cannot be released without my written consent. This consent may be withdrawn in writing at any time except to the extent that the person or organization which is to make disclosure has already acted on it. Upon revocation of consent, further release of information is to cease immediately. If not previously revoked, this consent will terminate at discharge of the case.

I further acknowledge that the information to be released/obtained was fully explained to me and this consent is given of my own free will.

Client or Parent/Guardian of Dependent Signature_____Date_____

Witness/Therapist Signature_____Date_____

Revised 3/2019

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# NOTICE OF PRIVACY PRACTICES/HIPAA REGULATIONS

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

**I. OUR RESPONSIBILITIES:**
We reserve the right to change this Notice of Privacy Practices and to make any new Notice of Privacy Practices effective for all protected health information that we maintain. Any new Notice ofPrivacy Practices adopted will be posted at our website and can be made available at your next appointment.

**II. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)?**
Protected health information ("PHI") is demographic and individually identifiable health information that will or may identify the patient and relates to the patient's past, present or future physical or mental health or condition and related health care services.

**USES AND DISCLOSURES OF INFORMATION**
Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment and health care operations.

**III. WHAT DOES "HEALTH CARE OPERATIONS" INCLUDE?**
Health care operations include activities such as communications among health care providers, conducting quality assessment and improvement activities; evaluating the qualifications, competence, and performance of health care professionals; training future health care professionals; other related services that may be a benefit to you such as case management and care coordination; contracting with insurance companies: conducting medical review and auditing services; compiling and analyzing information in anticipation of or for use in legal proceedings; and general administrative and business functions.

**IV. HOW IS MEDICAL INFORMATION USED?**
We use medical records as a way of recording health information, planning care and treatment and as a tool for routine health care operations. Your insurance company may request information such as procedure and diagnosis information that we are required to submit in order to bill for treatment we provide to the patient. Other health care providers or health plans reviewing your records must follow the same confidentiality laws and rules required of us.
Patient records are also a valuable tool used by researchers in finding the best possible treatment for diseases and medical conditions. All researchers must follow the same rules and laws that other health care providers are required to follow to ensure the privacy of patient information. Information that may identify patients will not be released for research purposes to anyone without written authorization from the patient or the patient's parent or legal guardian.

**V.HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**
- Medical information may be used to justify needed patient care services, (i.e., lab tests, prescriptions, treatment protocols, research inclusion criteria).
- We will use medical information to establish a treatment plan.
- We may disclose protected health information to another provider for treatment (i.e. referring physicians, specialists and providers, therapists, etc.)
- We may submit claims to your insurance company containing medical information and we may contact their utilization review department to receive pre-certification (prior approval for treatment). We will submit only the minimum amount of information necessary for this purpose.
- We may use the emergency contact information you provided to contact you if the address of record is no longer accurate.
- We may contact you to remind you of your appointment.
- We may contact you to discuss treatment alternatives or other health related benefits that may be of interest.

**VI. WHY DO I HAVE TO SIGN A CONSENT FORM?**
When you, as the patient or guardian of a patient, sign a consent form, you are giving us permission to use and disclose protected health information for the purposes of treatment, payment and health careoperations. This permission does not include psychotherapy notes, psychosocial information, alcoholism and drug abuse treatment records and other privileged categories of information which require a separate authorization. You will need to sign a separate authorization to have protected health informationreleased for any reason other than treatment, payment or healthcareoperations.

**VII. WHAT IS PSYCHOSOCIAL INFORMATION?**
Psychosocial information is information provided regarding your social history and counseling or psychiatric services you received before

treatment with me.

**VIII. WHY DO I HAVE TO SIGN A SEPARATE AUTHORIZATION FORM?**
In order to release patient protected health information for any reason other than treatment, payment and health care operations, we must have an authorization signed by the patient or the parent or guardian of the patient that clearly explains how they wish the information to be used and disclosed.

**IX. CAN I CHANGE MY MIND AND REVOKE AN AUTHORIZATION?**
You may change your mind and revoke an authorization, except (1) to the extent that we have relied on the authorization up to that point, (2) the information is needed to maintain the integrity of the research study, or (3) if the authorization was obtained as a condition of obtaining insurance coverage. All requests to revoke an authorization should be in writing.

**X. SHARING INFORMATION WITH BUSINESS ASSOCIATES**
There are some services provided through contracts with business associates. Examples include billing services and transcript ion services. When these services are contracted, we may disclose your health information to the business associate so that they can perform the job we have contracted them to do.

**XI. WHEN IS MY AUTHORIZATION / CONSENT NOT REQUIRED?**
The law requires that some information may be disclosed without your authorization in the following circumstances:
- In case of an emergency
- When there are communication or language barriers
- When required by law
- When there are risks to public health
- To conduct health oversight activities
- To report suspected child abuse or neglect or abuse/neglect to other disabled persons
- To specified government regulatory agencies
- In connection with judicial or administrative proceedings
- For law enforcement purposes
- To coroners, funeral directors, and for organ donation
- In the event of a serious threat to health or safety

**XII. YOUR PRIVACY RIGHTS**
The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**1. You have the right to inspect and copy your health information.**
This means you may inspect and obtain a copy of your PHI that is contained in a "designated record set" for so long as we maintain the PHI. A designated record set contains medical and billing records and any other records that we use in making decisions about your healthcare. You may not however, inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and certain PHI that is subject to laws that prohibit access to that PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed.

**2. You have the right to request a restriction of your health information.**
This means you may ask us to restrict or limit the medical information we use or disclose for the purposes of treatment, payment or healthcare operations. We are not required to agree to a restriction that you may request. We will notify you if we deny your request. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

**3. You have the right to request to receive confidential communications by alternative means or at alternative locations.**
We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact. We will not request an explanation from you as the basis for the request.

**4. You have the right to request amendments to your health information.**
This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement.

**5. You have the right to receive an accounting of disclosures of your health information.**
You have the right to request an accounting of certain disclosures of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures
that you agreed to by signing an authorization form, to family or friends involved in your care, or certain other disclosures we are permitted to make without your authorization.

**6. You have the right to receive a paper copy of this Notice of Privacy Practices**

**Client Signature:** _____ **Date:** _____

**Parent Of Minor:** _____ **Date:** _____

**Therapist Signature:** _____ **Date:** _____

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## DEPENDENT CLIENTS

If you are the guardian or parent of a child, or the guardian of a dependent adult referred to as a "Dependent" here on, and are requesting my services for your dependent, the client rights outlined in the Informed Consent applies.

However, if I am seeing your dependent in individual sessions, it is important that they are able to completely trust me. In such situations, I keep confidential what your dependent says in the same way that I keep confidential what an adult says. If I feel the information shared is vital to the therapeutic goals for the family, I will encourage such information be shared with family members. In family therapy, these boundaries can become rather confused regarding confidentiality. As the parent or guardian, you have the right and responsibility to question and understand the nature of my activities and progress with your dependent, and I must use my clinical discretion as to what is an appropriate disclosure. In general, I will not release specific information that the dependent provides to me; however, I feel it appropriate to discuss your dependent's progress and your participation in therapy.

This is to certify that I, _____, the legal custodial parent or guardian of _____, a dependent child or adult, give consent for him/her to receive individual and/or family therapy from Samantha Runnion, LSCSW, RPT-S. I have read the policy for therapy with a dependent child or adult and understand the limits for sharing confidential information.

_____

Client/Minor Signature Date

_____

Parent/Guardian Signature Date

_____

Samantha Runnion, LSCSW, RPT-S