My Life Counseling

520 Washington Road Suite 203 Pittsburgh, PA 15228

Practice Policies

Payment:

- Payment is expected at the time of appointment by cash, check, or card on file.
- A separate and detailed fee schedule will be provided.
- Please note that practitioner will not see clients for appointments if there is any outstanding balance.

No-Show/Discharge Policies:

- If the client does not show or call to cancel their scheduled appointment, a $100 fee will be assessed. If a client cancels in 24 hours or less of a scheduled appointment, a $75 fee will be assessed. If a client cancels with 48 hours, a $50 fee will be assessed.
- After three no show appointments or three less than 24 hour cancellations, the patient will be discharged from service.
- The practitioner reserves the right to discharge clients from the practice at her discretion (for example, because the client needs support that is outside the scope of the practice, or because there have been multiple cancellations) and would then facilitate transition to new care.
- If you have not attended a session or have been discharged for longer than 12 weeks and would like to pursue continued therapeutic treatment, we will do our best to accommodate scheduling requests, but cannot guarantee a time slot with your preferred therapist will be available. If a time is not available, we will provide three referrals to alternative therapists that can meet your desired treatment plan.

Policies on Divorce and/or Custody Cases:

- We are not custody evaluators and cannot make any recommendations on custody. We can refer you to a licensed professional who does provide custody evaluation, if needed.
- Due to the sensitive nature of divorce and all potential issues that may arise in such cases, we have very specific policies to which you must agree before we enter a counseling relationship:
    - We require a copy of any most current standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session.
    - In most cases, we need to have contact and written/signed consent with/from both legal guardians before we see the patient for counseling. In the case there is a final decision maker on health related issues who would like the patient to be seen for counseling, even in the case the

other parent does not agree, it is to the discretion of your therapist as to whether the patient will be seen.

- o We will provide an interview with any court-ordered Guardian ad Litem (GAL) and/or custody evaluator (CE) whom the court has ordered. Any time spent speaking with the GAL or CE will be billed as a non-insured, out-of-pocket expense at our court-related-fee hourly rate.
- o We will be in equal contact with both parents who share in the legal custody of the patient being seen for counseling and will offer and encourage opportunities for both parents to participate in parent consultations.
- o We require all clients waive the right to subpoena any of our therapists to court. By signing this agreement, you are acknowledging and agreeing not to have us subpoenaed to court. This policy is set in order to preserve the integrity of the therapeutic process and relationship with you and/or your child(ren). There are exceptions to this and we can discuss this further should the issue arise and the policy needs to be waived.
- o In the case the above policy regarding subpoenas and court is waived (or disregarded) and we are subpoenaed to appear in court – even with a waiver of this policy – you will be billed for the full standard fee for court-related-work of $200/hour for all professional time. Any time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the Guardian ad Litem, time at the court hours, on the stand, and any travel time will be billed at $200/hour.

Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Confidentiality is maintained with the following exceptions:

- Communication with other health care providers (if the client agrees).
- Interaction with family members (if the client agrees).
- If the client is an immediate and significant danger to herself/himself or to others.
- If the practitioner learns of behaviors that may constitute legal child abuse or neglect.
- If the client's ability to drive becomes an obvious and serious concern, the state requires that this be reported.
- If the practitioner is court-ordered by a judge to provide information about the treatment (every attempt would be made to preserve confidentiality).
- If a law enforcement official requires information to identify or locate a suspect, fugitive, material witness, or missing person.
- The practitioner will occasionally discuss details of the client's case with a consulting therapy supervisor. This is for the purpose of ongoing education and no identifying information will be shared.

Telehealth and Your Confidentiality:

- Email Policy: Email cannot be a guaranteed as a secure means of transmitting/receiving your private health information. Whenever possible, use of email should be for scheduling and payment issues only. Please understand that, by utilizing email for anything outside of scheduling and payment, you are accepting the risk and limit of your confidentiality. There is a charge for time spent reading emails that go beyond brief exchanges (3 sentences) about scheduling and payment issues. Please see fee outlines.

- Texting Policy: Texting should be used for brief notification regarding scheduling or notification of running late for appointment. If you choose to use texting to communicate sensitive information, you do so with full knowledge and full acceptance that this is a risk and limit of your confidentiality. We do not participate in discussions with clients via text messaging for your privacy.

- Phone Policy: Cell phone communications cannot be guaranteed as a confidential form of communication. The only method HIPAA acknowledges as a secure way to have a phone conversation is when both parties are talking on a landline phone that is hard wired from hand set to wall. In this day and age, we would all have difficulty finding a way to have that kind of phone conversation. We do utilize cell phone technology as most of our clients do, as well. We make every effort to ensure our phone conversations are held confidential within our ability to do so. When we have a conversation via cell phone, you are acknowledging and accepting the risk and limits of your confidentiality. If you don't wish to take this risk, we advise you only use phone communication to schedule an in person appointment.

- Voicemail Policy: Per the above policy with regard to cell phone use, please be informed that our voicemail systems are housed on cellular and internet bases and cannot be guaranteed confidential, although we take every measure to protect your confidentiality. It is advised that you do not leave sensitive information on voicemail, rather utilize voicemail to request a return call and/or to schedule an in-person appointment.

- Social Media Policy: In order to protect your confidentiality and in line with our professional ethics, we cannot accept friend or connection requests from patients on any social media platform.

- Public/Social Interaction Policy: In the case we cross paths in a public setting, it is our policy not to approach or initiate contact with you in order to protect the confidentiality of our therapeutic relationship.

Practice Duties:

- Practice is required by law to maintain the privacy of client's health information, to abide by the terms of this Notice, and to provide a copy of this Notice.
- Practice reserves the right to amend this Notice in the future and to make the new Notice provisions applicable to client's health information.

Records Custodian Policy:

- In the case of unforeseen emergency, discontinued practice, or untimely death, patients will be dispersed and/or referred out of the practice based on experience and caseload amongst the following practitioners:
- Alyssa Pirain, MA, LPC, NCC
- Ashley McCombs, MA, LPC, NCC
- Ann-Michele Corbi Potvin, MA, LPC, BC-DMT
- Kristina Smail, M.S. Ed, LPC, NCC
- Holly Jasin, MA, LPC, NCC
- Michele Garon, MS, LPC
- Kimberlee Love, LCSW, CCTP-II
- Lauren Filip, MS, LPC, NCC, CAADC
- Justin Fichter, LMSW

Client Rights:

- Client has the right to request restrictions on the uses and disclosures of health information. Practice is not, however, required to comply with the request.
- Client has the right to inspect and copy his/her health information.
- Client has the right to request that the practice correct or amend his/her health information that is incorrect or incomplete. Practice is not, however, required to comply with the request.
- Client has the right to make complaints to the Secretary of the Department of Health and Human Services (DHHS) if s/he feels his/her privacy rights have been violated. The DHHS address is 200 Independence Avenue, SW, Washington, DC 20201 and the phone number is 202-619-0257.

Client Responsibilities:

- Client has the responsibility to give the practitioner all information needed for her to provide the client with appropriate care.
- Client has the responsibility to follow the practitioner's recommended plans and instructions for care and to participate in the treatment process through development of a mutually agreed upon treatment plan.
- Client has the responsibility to inform the practitioner of any changes in his/her health insurance coverage, home address or telephone number.

I have received the above notice, was given the opportunity to ask questions about My Life Counseling's practice policies, and my questions were answered.

Client _____________________ Date ____________

Financial Policy

All co-payments are due at the time of service. Please note that we are not considered in network providers for the following insurance products: UPMC For You, UPMC For Life, Gateway, Value Options, and/or any Medicare/Medicaid plan. Services will be rendered to patients covered under these, or any other out of network insurance plans, at an out of pocket expense.

Clinical Services to Be Billed to Insurance

New Patient Evaluation	$175.00
50 minute Psychotherapy	$150.00
No-Show fee	$100.00
24 hour or less cancellation	$75.00
48 hour cancellation	$50.00

Administrative Services

Returned Checks	$35.00
Telephone Consultation*	$20/15 minutes
Email Consultation* (Requires writing/reading more than 3-4 sentences)	$35/exchange $80/4 exchanges on one string of emails within 48 hours
Copying Medical Records*	$50.00
Letter in Response for Records*	$50.00
Letter to the Court (1 page)*	$75.00
Letter to the Court (1+ pages) *	$250.00
Expert witness testimony, portal to portal*	$200.00/hour
Retainer fee due 3 days prior to testifying*	$500.00

**Insurance will NOT pay for these services. Full payment (in the form of cash, money order, cashiers check, or debit/credit card) is due 72 hours PRIOR to needing these services. Services requiring travel beyond an hour radius will necessitate travel reimbursement including, but not limited to, wage reimbursement at $200/hr, hotel fees, as well as per diem meal and mileage reimbursement at current destination rate. Unfortunately, we cannot accept personal checks for Administrative Services. The above prices are an estimate and we cannot guarantee this is the final amount due—as needs will vary case-by case. We do not provide letters or recommendation of disability.*

Patient's signature: ______________________________ *Date:* ____________

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Credit Card Authorization Form

Beginning January 1st 2017, it is mandatory office policy for all patients to have a **current and active** credit card on file. The information you provide will be kept in a secure location and will be used only for purposes of processing co-pays, balances, and no-show/late cancellation fees. Your signature on this form authorizes the employees/therapists of My Life Counseling to charge your card for the services listed above.

Cardholder Name: ____

Card #: ____

Expiration Date: ____________ CVV Code (3 digits on back): ____________

Billing Zip Code: ___________

E-mail Address: ____

I, _________________________________, authorize My Life Counseling to charge the above credit card account for payments owed to my account for services (including no-show and late cancellation fees) rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature: ____

Date: ________________

New Patient Intake—Demographic Information

Name ____ Date____________________

Preferred name: ________________________

Address : (street)_____________________________ (city, state)_________________________

(Zip code) ___________ Phone: (home) _______________ (work) ______________________

(cell) ______________________ Email: ____

Social Security #: ___________________________Date of birth: _________________________

Gender: ________________________

Marital Status: _____ Single _____ Married _____Divorced _____Widowed

Physical contact preference: (hug) ________ (hand shake) ________ (neither) ________

Family Doctor: ____________________ Have a mental health provider before? ___________

How did you hear about My Life Counseling? ____________________

What is the main reason for this appointment?

____

____

Emergency Contact: Name: ________________________Relation: _____________________

Phone: ______________________

What type of insurance do you have? ____

ID Number: __________________________ Group Number: __________________________

Policyholder name and DOB if other than yourself: _________________________________

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Name___________________________________ DOB ___________ Age ______ Date ___________

Address____ City _______________ State _________ Zip

Phone # ____________________ Cell#__________________ Work# _____________________

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

APPROXIMATE DATE OF ONSET:

PSYCHOSOCIAL STRESSOR(S): (Describe i.e.: work, family, financial, etc.)

SELF DESTRUCTIVE BEHAVIORS(i.e.:Chemical/alcohol abuse, cutting, etc.)

Chemical Use: Yes No
Alcohol or Drugs: __________________
How long? ___________________________

CURRENT LEVEL OF FUNCTIONING: (Brief description of Limitations)

DATING/MARITAL HISTORY WITH FAMILY COMPOSITION/LIVING ARRANGEMENTS:

1.

2.

3.

4.

PAST PSYCHIATRIC HISTORY:

FAMILY HISTORY OF MENTAL HEALTH DIAGNOSIS
(please list relation and diagnosis)

1.
2.
3.
4.

PREVIOUS TREAMENT:

CURRENT MEDICATIONS: ___________________________
____

MEDICAL HEALTH PROBLEMS: (PAST/PRESENT)

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520 Washington Road Suite 203 Pittsburgh, Pa. 15228

Phone: 412-668-2038

Name___________________________________ Date______________

PLEASE COMPLETE THIS CHECKLIST:

Have you in the past, especially within the last two (2) months or so, experienced any of the following?

1. Distinct period of unpleasant mood or continuous loss of interest or pleasure that is a major part of your problem and relatively persistent? ( )yes ( )no
2. Felt sad, blue, down in the dumps? ( )yes ( )no
3. Feelings of worthlessness? ( )yes ( )no
4. Feelings of hopelessness? ( )yes ( )no
5. Loss of interest in usual activities? ( )yes ( )no
6. Loss of interest in sex? ( )yes ( )no
7. Excessive feelings of self-reproach or guilt? ( )yes ( )no
8. Loss of ability to enjoy usual activities? ( )yes ( )no
9. Troubled by diminished concentration? ( )yes ( )no
10. Preoccupied by thoughts of death or dying? ( )yes ( )no
11. Preoccupied by suicidal thoughts or ideas? ( )yes ( )no
12. Crying spells or feeling on the verge of tears? ( )yes ( )no
13. Poor appetite or weight loss? ( )yes ( )no
14. Increased appetite or weight gain? ( )yes ( )no
15. Felt restless, fidgety or unable to sit still? ( )yes ( )no
16. Feeling better in the evening? ( )yes ( )no
17. Sleep difficulty:
    a) trouble falling asleep? ( )yes ( )no
    b) trouble staying asleep (sleep broken up)? ( )yes ( )no
    c) unable to go back to sleep after awakening too early? ( )yes ( )no
18. Sleeping more than usual? ( )yes ( )no
19. Loss of energy, fatigue, tiredness? ( )yes ( )no
20. Felt slowed down, sluggish, lying around a lot? ( )yes ( )no

NAME________________________________DATE___________________________AGE_______

Patient-Rated Anxiety Scale*

Part 1: Endogenous Factor

Instructions: Below is a list of problems and complaints that people have. Check (√) one of the spaces to the right that best describes how such that problem bothered you during the past three months. Mark only one space for each problem and do not skip any lines.

How much were you bothered by:	0 Not At All	1 A Little Bit	2 Moderately	3 Quite A Bit	4 Extremely
1. Light-headedness, faintness, or dizzy spells.					
2. Sensation of rubbery or “jelly” legs.					
3. Feeling off balance or un-steady like you might fall					
4. Difficulty getting your breath or over-breathing					
5. Skipping or racing of your heart.					
6. Chest pain or pressure.					
7. Smothering or choking sensation or lump in throat.					
8. Tingling or numbness in parts or your body.					
9. Hot flashes or cold chills.					
10. Nausea or stomach problems.					
11. Episodes of diarrhea.					
12. Headaches or pains in neck or back.					
13. Feeling tired, weak, and exhausted easily.					
14. Spells of increased sensitivity to sound, lights or touch.					

How much were you bothered by:	0 Not At All	1 A Little Bit	2 Moderately	3 Quite A Bit	4 Extremely
15. Bouts of excessive sweating					
16. Feeling that things around you are strange, unreal, foggy, or detached from you.					
17. Feeling outside or detached from part or all of your body or a floating feeling.					
18. Worrying about your health too much.					
19. Feeling you are losing control or going insane.					
20. Having a fear that you are dying or that something terrible is about to happen.					
21. Shaking or trembling.					
22. Unexpected waves of depression occurring with little or no provocation.					
23. Emotions and moods going up and down a lot in response to change around you.					
24. Being dependent on others.					
25. Having to repeat the same action in a ritual, eg, checking, washing, counting.					

How much were you bothered by:	0 Not At All	1 A Little Bit	2 Moderately	3 Quite A Bit	4 Extremely
26. Recurrent words or thoughts that persistently intrude on your mind and are hard to get rid of, eg, recurrent, un-wanted aggressive or sexual thoughts or poor impulse control.					
27. Difficulty falling asleep.					
28. Waking up in the middle of the night or restless sleep.					
29. Avoiding situations because they frighten you.					
30. Tension and inability to relax.					
31. Anxiety, nervousness, restlessness					
32. Sudden unexpected panic spells that occur with little or no provocation (that is, major anxiety attacks with 3 or more of the symptoms listed above.)					
33. Sudden unexpected spells of symptoms (eg, those listed above) without full panic that occur with little or no provocation (that is, minor attacks associated with 1 or 2 of the symptoms listed above.)					
34. Anxiety episodes that build up as you anticipate (before) doing something and that are more intense than most people experience in such situations.					