Integrative Counseling, LLC
REGISTRATION FORM

Client Name (First, MI, Last): _____ **Gender**: □ **M** □ **F** □ _____

Address: _____ **City**: _____ **ST**: _____ **Zip**: _____

Date of Birth: _____ **SSN**: _____ **Email**:*** _____

****Your monthly bills will be sent to this email***

Phones:* Mobile: (_____) _____ Mobile Carrier: _____

Your appointment reminder may be sent by text (if you provide your carrier) or email. Also, please circle preferred number for calls.

Home: (_____) _____ Other: (_____) _____

Race: __ White __ Black __ Asian/Pacific Island __ American Indian __ Other: _____

Parent/Guardian Name: _____ □ M □ F □ _____

Relationship to client: _____ *(Please provide proof of guardianship)*

Social Security Number: _____ Email:*** _____

Address: _____ Date of Birth: _____

_____ Phones: (H) _____ (M) _____

Emergency Contact: _____ Relationship to client: _____

Address: _____ Home Phone: _____

_____ Mobile Phone: _____

Referral Source: _____ Phone Number: _____

Agency: _____ Fax Number: _____

May we contact your Referral Source? ( ) yes ( ) no If yes, please be sure to complete a ***Release of Information***

Probation Officer/Monitor: _____ Phone Number: _____

Agency: _____ Fax Number: _____

May we contact your P.O./Monitor? ( ) yes ( ) no If yes, please be sure to complete a ***Release of Information***

Lawyer: _____ Phone Number: _____

Agency: _____ Fax Number: _____

May we contact your Lawyer? ( ) yes ( ) no If yes, please be sure to complete a ***Release of Information***

Financial Policy and Authorizing Consent:

Payment is due at the time service is provided. All charges you incur are ultimately your responsibility. Upon request, we will provide a statement you may use for third party reimbursement; ***Integrative Counseling does not participate with any insurance and does not submit claims to third party payers***. *The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. Telephone, Internet, and Email communications carry an inherent risk to privacy. By signing below, I indicate acceptance of these conditions.* ***I give permission to receive communication – such as reminders and account statements – through email.***

_____ _____ _____

CLIENT/GUARDIAN SIGNATURE **PRINTED NAME** **DATE**

_____ _____ _____

CLIENT/GUARDIAN SIGNATURE **PRINTED NAME** **DATE**

Administrative use only **Treatment Recommendations**

( ) Group Counseling ( ) Individual Counseling ( ) Family Counseling ( ) _____

( ) Referred to: _____

Counselor: _____

Group Days: M T W Th F Sa Su Time: _____

Brief Addiction Monitor (BAM)

Participant Name: _____ **Date:** _____

Instructions: This is a standard set of questions about several areas of your life such as your health, alcohol and drug use, etc. The questions generally ask about the past 30 days. Please consider each question and circle the choice that best describes your answer.

1. In the past 30 days, how would you say your physical health has been?
   Excellent (0) **Very Good** (1) **Good** (2) **Fair** (3) **Poor** (4)

2. In the past 30 days how many nights did you have trouble falling asleep or staying asleep?
   0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

3. In the past 30 days, how many days have you felt depressed, anxious, angry or very upset throughout most of the day?
   0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

4. In the past 30 days, how many days did you drink any alcohol?
   0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

5. In the past 30 days, how many days did you have at least 5 drinks (if you are a man) or at least 4 drinks (if you are a woman)? [One drink is considered one shot of liquor, one can/bottle of beer or one glass of wine]
   0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

6. In the past 30 days, how many days did you use any illegal or street drugs or abuse any prescription medication?
   0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

7. In the past 30 days, how many days did you use any of the following drugs?

   7.a Marijuana (cannabis, pot, weed)?
   0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

   7.b Sedatives and or Tranquilizers (benzos, Valium, Xanax, Ativan, Ambien, barbs, Phenobarbital, downers, etc.)?
   0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

   7.c Cocaine and/or Crack?
   0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

   7.d Other Stimulants (amphetamines, methamphetamine, Dexedrine, Ritalin, Adderall, speed, crystal meth, ice, etc.)?
   0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

   7.e Opiates (Heroin, Morphine, Dilaudid, Demerol, Oxycontin, oxy, codeine (Tylenol 2,3,4), Percocet, Vicodin, Fentanyl, etc.)?
   0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

   7.f Inhalants (glues, adhesive, nail polish remover, paint thinner, etc.)?
   0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

Brief Addiction Monitor (BAM) p.2

Participant Name: _____ **Date:** _____

7.g Other Drugs (steroids, non-prescription sleep and diet pills, Benadryl, Ephedra, other over-the-counter or unknown medications)?
0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

8. In the past 30 days, how much were you bothered by cravings or urges to drink alcohol or use drugs?
Not At All (0) **Slightly** (1) **Moderately** (2) **Considerably** (3) **Extremely** (4)

9. How confident are you that you will NOT use alcohol and drugs in the next 30 days?
Not At All (0) **Slightly** (1) **Moderately** (2) **Considerably** (3) **Extremely** (4)

10. In the past 30 days, how many days did you attend self-help meetings like AA or NA to support your recovery?
0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

11. In the past 30 days, how many days were you in any situations or with any people that might put you at an increased risk for using alcohol or drugs (i.e., around risky "people, places and things")?
0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

12. Does your religion or spirituality help support your recovery?
Not At All (0) **Slightly** (1) **Moderately** (2) **Considerably** (3) **Extremely** (4)

13. In the past 30 days, how many days did you spend much of the time at work, school, or doing volunteer work?
0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

14. Do you have enough income (from legal sources) to pay for necessities such as houses, transportation, food and clothing for yourself and your dependents?
No (0) **Yes** (4)

15. In the past 30 days, how much have you been bothered by arguments or problems getting along with any family members or friends?
0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

16. In the past 30 days, how many days did you contact or spend time with any family members or friends who are supportive of your recovery?
0 (0) **1-3** (1) **4-8** (2) **9-15** (3) **16-30** (4)

17. How satisfied are you with your progress toward achieving your recovery goals?
Not At All (0) **Slightly** (1) **Moderately** (2) **Considerably** (3) **Extremely** (4)

IC Fee Schedule, Policies, Information (1 of 2)

Intake and Assessment	$195	Medication Authorization	$25	No Show Fee – Group/Indiv	$50/$75
Group Counseling/Education	$50	Written Report (*per half hour*)	$50	No Show Fee - Prescriber	$100
DUI/DWI 2 hr Education	$80	Psychiatrist/MD/NP Evaluation	$300	Disability/Workers Comp Report	$300
2hr Adolescent Education	$100	Medication Management	$150	Psychiatric Report (*per half hour*)	$100
Family Group/Parent Education	$50	Individual/Family	$175	Letters/Forms	$35
DUI/DWI Ed – Weekend/Telehealth	$500	Consultation Only	$195	Crisis Session/Call (*per 5 min)*	$45
Relationship Counseling	$175	Consultation w/Mark Donovan	$300	Urine Screen *(see Lab Svcs below)*	$40

This is not a comprehensive list of all possible charges.

Cancellation and No Show Policy

It is office policy to charge for missed appointments not canceled at least 24 hours prior to the scheduled appointment. This includes groups: unless prior arrangements are made, you will be expected at the next scheduled meeting. In the event a courtesy reminder is not made, it *does not excuse* a missed appointment. Cancellation, Fees and Payments policies have been provided on the client copy of the Fee Schedule and Policies.

Fees and Payment

Fees will be collected at the time service is rendered. Payment may be made by cash, check, or credit card. Checks returned for non-payment will result in a $25 bounced check charge, and may result in checks no longer being accepted from the client. Integrative Counseling does not accept insurance payments. ***Statements are regularly e-mailed and can be mailed upon request***.

Failure to Pay

The client agrees that failure to pay the expected service fee within ten business days of the service date may, at the option of Integrative Counseling, be construed as a discharge of services by the client. ***Client accounts sent to collections for non-payment will be charged the amount owed plus any and all associated collection fees***. The client agrees that information pertinent to the collection of any amount due be released to a third-party collection agency or attorney. The client further agrees that if legal action is taken to collect any money under this agreement, the client shall pay the amount due as attorney collection fee as well as any cost of any legal action; and consents to legal action being held in Howard County, Maryland, and waives any right to claim improper jurisdiction and/or venue.

Court Appearances, Legal Requests and Associated Costs

Integrative Counseling charges $400 per hour with a minimum of $3,200 for any court appearance or legal request (such as administrative hearing, subpoena) whether requested or summonsed, regardless of requesting party. Clients will also be charged per hour for any travel time, consultation time, preparation time, and any time spent waiting. Costs incurred by the company for associated legal fees will be passed on to the client. In the case of minors, the signing parent is responsible for this fee unless otherwise pre-arranged with the non-signing parent. A deposit of $3,200 is due 10 days prior to any court appearance or legal request. If a court appearance or legal request is canceled or rescheduled, staff must be given ten business days' notice; without this notice, IC may still charge up to $3,200 for each day if unable to reschedule appointments and for any preparation time, administration time, and reports completed.

Understanding of Separate Practices

The client recognizes and understands that although they share space, Congruent Counseling Services, LLC (CCS) and Integrative Counseling, LLC (IC) are separate practices, and as such require the opening of a separate client chart. The client understands that any insurance benefits utilized with CCS cannot be utilized with IC. IC has no insurance contracts. Clients may continue to receive services from either or both programs. Additionally, the client understands that each program may exchange information with the other and the client signature below serves as a release for the programs to exchange such information as needed to ensure appropriate treatment.

Medication Changes or Refills between Appointments

We understand you may sometimes need a brief refill to get you through to your next appointment. Refills between appointments will be billed at $35. These refills will be for no longer than two weeks or until you are able to see your psychiatrist in person. You may choose to schedule a Telepsychiatry appointment if the next appointment is too far away.

Laboratory Services

IC works with a private laboratory, Dominion Diagnostics, to perform urine drug screening. Dominion submits to insurance directly and provides test results to IC. ***Please contact Dominion directly at 410.387.3890 for billing questions***. If the client prefers not to use insurance or doesn't have insurance, please let the counselor know and IC will use Friends Lab and charge the fee as noted above.

IC Fee Schedule, Policies, Information (2 of 2)

Client Portal

We offer you the option to access a portal to your account through which you can communicate with your provider, pay your bill, and verify your schedule. Please ask the front office for a login if you were not provided with one. If at any time you want to opt out of the portal, please let us know.

Communication, Reminders, Statements

We wish to communicate with you in the most efficient way possible. That may be by phone, email, or text message. Telephone, email, and text messaging communications carry an inherent risk to privacy. Please do not use email for an emergency or rapid response request, or for sensitive information. We may use your email, mobile phone text messaging, or home phone for appointment reminders, statement delivery, or general information. By signing below, you acknowledge recognition and acceptance of risk to privacy in the use of email and text message.

Telephone and Internet Session – Teletherapy or Telepsychiatry (Telehealth)

Clients regularly seen in the office may schedule teletherapy/telepsychiatry appointments. Credit cards must be kept on file with Integrative Counseling for telehealth sessions. Initial sessions must be face-to-face and in person. In the case of a missed appointment, therapists may opt to conduct a 15-30 minute phone session during your already scheduled individual, family, or couples appointment time. This session will be charged at a rate of $50, which is less than the full missed appointment charge. The missed appointment phone option may only be used once in a 30-day period.

Provider Contact Outside of Sessions

It is our goal to provide you with the best treatment we can provide. If there is an emergency, please call emergency services or 911, or Grassroots at 410-531-6677. If you are calling to make or change your appointment or to address billing issues, please call the office. Your provider has given you personal contact information to help address your needs. If you would like to talk with your provider, and cannot wait until the next appointment, please be respectful of their time. Calls, texts, or emails taking over five minutes will be charged as a crisis session at a rate of $45 per 5 minute increment. Contacts about medication clarification more than a week after your appointment will be charged as a Crisis Session. Crisis Sessions are not billable to insurance and are the responsibility of the client or responsible party.

Client Responsibilities, Rules, Emergency Contact Information, Family Involvement

As part of this Client Orientation Packet, you will receive a copy of the Client Responsibilities and Rules and contact information for your assigned counselor, contacts for Emergency Services, and our grievance policy. You are encouraged to include your family in therapy and you are given the times for family group sessions.

Advance Directive

If you have an Advance Directive, please provide a copy of the document if you wish to have it on record. If you do not have an advance directive and would like to make one, please notify the front desk staff; they will provide you with the "Maryland Advance Directive for Mental Health Treatment" from the State of Maryland DHMH.

Scope of Practice – Description of Services

The complete description of program services is available on the website: http://www.integrative-counseling.com.

Statement about Clinical Supervision

As part of this Client Orientation Packet, you receive a copy of information regarding Clinical Supervision of Services, and have the opportunity to discuss it with your counselor.

Infectious Disease Education/Risk Reduction

As part of this Client Orientation Packet, you receive a copy of risk reduction education about TB, STDs, HIV/AIDs and Hepatitis.

Your signature indicates understanding and acceptance of the fees and policies as delineated above.

I have reviewed and understand these options and I have received a copy of these policies.

Client Signature	Date		
Parent/Guardian Signature	Date	Witness Signature	Date

Integrative Counseling, LLC

Notice of Privacy Practices (HIPAA), Client Bill of Rights and Confidentiality of Client Records

Client Bill of Rights

Each Client has the right to:

1. Have self and property be treated with consideration, respect, and full recognition of the client's human dignity and individuality;
2. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;
3. Not be physically or mentally abused by the program staff;
4. Be free from discrimination;
5. Be free from restraints;
6. Privacy and confidentiality; and
7. Refuse participation in any experimental research unless the research complies with 45 CFR Part 46. 45 CFR Part 46 is the Code of Federal Regulations Protection of Human Subjects.
8. Refuse treatment at any time, and request a referral for outside services.

Confidentiality of Client Records and Records Request

The Federal Law and Regulations protect the confidentiality of patient records maintained by this program. Generally, the program may not disclose to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug user unless:

1. Clients aged 14 and older receiving substance use services and all other clients aged 16 and older provides consent in writing;
2. The disclosure is allowed by court order;
3. The disclosure is made to medical personnel in an emergency or to qualified personnel for research, audit, or program evaluation.

Violation of Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state and local authorities.

All records requests must be made in writing to the Columbia office; a response will be made within 21 working days. Records copies are charged $30 to the client prior to preparation.

Acknowledgment and Consent Regarding Notice of Privacy Practices *(available upon request)*

The Notice of Privacy Practices (NPP) of Integrative Counseling (IC) provides information about how IC may use and disclose your protected health information (PHI). The NPP states that IC reserves the right to change its terms. Should this happen, understand that IC will make the changed notice available in its office. You have the right to revoke this consent, in writing, except where IC has already made disclosures in reliance on your prior consent. Understand that you have the right to request restrictions on how your PHI may be used or disclosed for treatment, payment and health care operations. IC is not required to agree to your restrictions, but if it does, it is bound by its agreement with you. By signing below, you consent to the use and disclosure of your PHI for treatment, payment and health care operations as described in the NPP. You specifically consent to IC communicating with you using the contact information you provide, as further described in the NPP.

Discharge

Clients who choose to terminate services will be discharged immediately. Clients who have not attended sessions for 30 days or more and who do not have an appointment scheduled will be discharged at the discretion of the provider with no prior notice. Discharged clients are no longer under the care of the provider or program. Discharged clients may be re-admitted at the discretion of the practice upon request.

I have reviewed and understand these rights and I have received a copy of this Notice.

Client Signature	Date		
Parent/Guardian Signature	Date	Witness Signature	Date

As of 2019-0618

Credit Card Recurring Payment Authorization Form

As a courtesy to you, we can schedule your payments to be automatically charged to your credit card. Please complete and sign this form to get started. Once a month, with this authorization, we will charge the balance due on your account to the credit card you list on file.

You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged once each billing period for the total amount due for that period. The charge will appear on your credit card statement.

If the credit card fails to authorize, or there is any other difficulty using this information to process the payment, the authorization will be removed from our records and information will be sent to the client requesting an alternative method of payment.

Please complete the information below:

I, _____, authorize Congruent Counseling Services, LLC and/or Integrative Counseling, LLC to charge the credit card indicated below once between the 15th and 20th of each month for payment of any balance due for _____.
(name of client or clients)

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email: _____

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Is this for a(n): ☐ HSA ☐ FSA ☐ Other Consumer Spending Account?

***For all consumer spending accounts, be advised that if the card cannot be processed, you will be billed and should seek reimbursement from them directly.**

Cardholder Name _____

Account Number _____

Expiration Date _____ CVV _____ (3 digits on back of Visa/MC, 4 digits on front of AMEX)

If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

I authorize the business to charge the credit card indicated in this authorization form according to the terms outlined above.

_____ _____

CARDHOLDER SIGNATURE DATE

Integrative Counseling, LLC
Release of Information

I, _____ hereby authorize Integrative Counseling, LLC

to exchange information with: _____.
Name of Program, Agency, or Individual

_____ _____
Phone Fax

The following information may be exchanged:

_____ Full client record
_____ Progress and attendance reports
_____ Admission and discharge diagnosis and recommendations
_____ Reason for termination of treatment and discharge summary
_____ Urinalysis/Breathalyzer results
_____ Immunization and physical records
_____ Other _____

The above information will be exchanged for the following reason(s):

_____ To coordinate treatment
_____ As a condition of probation, parole, or adjudication
_____ As required by my employer or EAP
_____ To assist my attorney
_____ Other _____

This consent will expire one year from the date of signature unless otherwise noted:

_____.

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that the information has already been disclosed in reliance with this consent.

Prohibition of Re-disclosure: This information has been disclosed to you from records protected under Federal Law. Federal Regulations (42CFR Part II) prohibit you from making further disclosures of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ _____
Client Signature Date

_____ _____ _____ _____
Parent/Guardian Signature Date Witness Signature Date

IC Consent for Treatment (1 of 2) _____

Counseling

Services are provided in an individualized person-centered manner primarily through individual and group counseling sessions to include personal growth and awareness. The counseling process is a partnership between you and the counselor to work on areas of concern or dissatisfaction in your life, develop growth and insight, and help you achieve your desired goals and improve your overall well-being. It is expected that you take an active role in this process to ensure the best outcome.

You will be given a clear description from your counselor regarding the problems, diagnosis, personal strengths/limitations and treatment interventions proposed. You will be given a clear recommendation for the types of treatment recommended, such as individual counseling, group counseling, and family counseling. You and your counselor will discuss and agree on dates, times, and session length.

Your counselor cannot guarantee results from services; however, there will be clearly stated reasons, goals, and objectives for services developed with your input.

Barriers and Risks

While counseling is often beneficial for many people there may be some risks. These may include, but are not limited to, addressing painful emotional experiences and/or feelings or being challenged or confronted on a particular issue. The counseling process can also evoke strong feelings and sometimes produce unanticipated changes in one's behaviors, thoughts, and feelings. To maximize your experience, it is helpful to discuss with your counselor any questions or discomfort you may experience during the therapeutic process. Your counselor will work to help you to understand the experience and/or use different methods or techniques and/or provide referrals that may be lead you towards the growth you desire.

Grievances

Grievance information has been provided on the client copy of the Telephone, Email and Grievance Policies.

Confidentiality

Any of the team working with you or supervising staff on your team may have access to your record to provide you with the best services and meet all State and Federal regulations. All staff recognizes that confidentiality is essential to effective counseling. In order for counseling to be most effective, you must feel safe about sharing your personal information with your counselor. Your counselor and treatment team will maintain your confidential information. In most cases, information shall not be released to another party without your written consent. However, in certain circumstances, information can be shared legally without your permission. These circumstances include, but are not limited to:

- If you are determined to be in imminent danger of harming yourself or someone else.
- If you disclose abuse or neglect of children, the elderly, or a disabled person(s).
- Disclosure is allowed by a court order.
- Disclosure is made to medical personnel in a medical emergency.
- Disclosure is made to qualified personnel for research, audit or program evaluation.
- Where otherwise legally required.

The above list is considered a summary. If you have questions about specific situations or any aspects of confidentiality, please feel free to discuss your concerns with your counselor. See additional information on the Notice to Privacy Practices.

Appointments and Emergencies

Emergency information has been provided on the client copy of the Client Responsibilities and Rules.

Cancellation, Fees and Payments

Cancellation, Fees and Payments policies have been provided on the client copy of the Fee Schedule and Policies.

IC Consent for Treatment (2 of 2)

Termination

You may terminate the therapeutic relationship at any time. Your counselor may want to discuss this with you, but you reserve the right to stop treatment. You will be given a list of referrals for counselors in the community and be referred back to your referral source as appropriate. You will be responsible for any outstanding fees for services received.

Email

Use of Email information has been provided on the client copy of the Fee Schedule, Policies, Information.

Legal Information

Please note your counselor is not able to provide legal advice. If you have legal questions and are requesting legal advice, it is recommended you speak with an attorney to act in your best interests.

Concurrent Services

Your counselor may coordinate with concurrent services within our program and/or the community as needed, such as care coordination, crisis intervention, veteran services, vocational services, medical services, etc.

Consent for Counseling

The above information is not intended to be "all inclusive" of aspects of your services. It is only intended to provide some useful information before deciding to engage in treatment.

I have read the information contained on this form. I voluntarily agree and give my consent to participate in counseling. I have had the opportunity to ask questions about these details.

Client signature	Printed Name	Date
Responsible Party signature (if appropriate)	Printed Name, Relationship	Date
Counselor signature	Printed Name	Date

Integrative Counseling, LLC
Notice of Privacy Practices (HIPAA), Client Bill of Rights and Confidentiality of Client Records

Client Copy

Client Bill of Rights

Each Client has the right to:

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2. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;
3. Not be physically or mentally abused by the program staff;
4. Be free from discrimination;
5. Be free from restraints;
6. Privacy and confidentiality; and
7. Refuse participation in any experimental research unless the research complies with 45 CFR Part 46. 45 CFR Part 46 is the Code of Federal Regulations Protection of Human Subjects.
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Integrative Counseling, LLC
Client Responsibilities and Rules

Client Copy

Counselor: _____

Refer to business card provided for counselor and program contact information.

Group Days: M T W Th F **Group Time: _____**

( ) Adolescent IOP Family Group: Friday 5:00pm
( ) Adult IOP Family Group: Thursday 5:30pm
( ) Clients in outpatient or other treatment programs may request family sessions with an individual therapist. All clients are encouraged to participate in family sessions with their families.

Client Expectations and Rules

1. A client who makes a threat or becomes violent will be discharged.
2. A client who brings a weapon will be discharged.
3. A client who becomes verbally abusive will be discharged.
4. All state, county and federal laws will be observed. Violators will be turned in to the appropriate authorities. (Confidentiality – 42 CFR, part II will be observed.)
5. If a client misses three appointments, the client will be discharged.
6. If a client chooses to not actively participate in treatment, he/she may be discharged.
7. A client's refusal to pay for a service is grounds for discharge.
8. Each session will begin and end on time. If a client is more than 10 minutes late, he/she will be considered as a no-show.
9. Clients may be asked to give random urine drug screens or alcohol breathalyzer screens on a weekly basis. If the client refuses, he/she may be discharged at the discretion of the program directors. Clients receiving two positive urine or breathalyzer screens may be discharged from the program at the discretion of the program directors. Clients will be monitored while giving urine.
10. If a client appears to have used illicit drugs or alcohol, staff will ask to speak with the client in private, a urine screen may be required and the client may be asked to leave treatment for the day. Clients will not be treated when under the influence of any illicit drug or alcohol.
11. It is unlawful to manufacture, distribute, dispense, possess, use, or be under the influence of a controlled substances (without a prescription) in the program. Clients caught doing so may be discharged from the program immediately and referred for other services.
12. All clients are expected to maintain the confidentiality of other clients.

Emergency Contact Information

Emergency Services	911
Grassroots Crisis Intervention	410-531-6677

Advance Directive

If you have an Advance Directive, please provide a copy of the document if you wish to have it on record. If you do not have an advance directive and would like to make one, please notify the front desk staff; they will provide you with the "Maryland Advance Directive for Mental Health Treatment" from the State of Maryland DHMH.

Scope of Practice – Description of Services

The complete description of program services is available on the website: http://www.integrative-counseling.com.

Clinical Supervision Provisions

Services may be provided by an LG, a State of Maryland Certified Counselor, or ADT under the supervision of the Clinical Director Mark D. Donovan, LCPC, LCADC who can be reached at 10630 Little Patuxent Pkwy, Ste 209, Columbia, MD 21044, 410-740-8066. Counselor names and certification details can be viewed at www.integrative-counseling.com, or by request from your counselor. Certification can be verified at https://mdbnc.dhmh.md.gov/pctVerification/default.aspx. The client agrees to release such information as is required for supervision to the Clinical Supervisor for a period of one year.

Integrative Counseling, LLC
Fee Schedule, Policies, Information (1 of 2)
Client Copy

Intake and Assessment	$195	Medication Authorization	$25	No Show Fee – Group/Indiv	$50/$75
Group Counseling/Education	$50	Written Report (*per half hour*)	$50	No Show Fee - Prescriber	$100
DUI/DWI 2 hr Education	$80	Psychiatrist/MD/NP Evaluation	$300	Disability/Workers Comp Report	$300
2hr Adolescent Education	$100	Medication Management	$150	Psychiatric Report (*per half hour*)	$100
Family Group/Parent Education	$50	Individual/Family	$175	Letters/Forms	$35
DUI/DWI Ed – Weekend/Telehealth	$500	Consultation Only	$195	Crisis Session/Call (*per 5 min)*	$45
Relationship Counseling	$175	Consultation w/Mark Donovan	$300	Urine Screen *(see Lab Svcs below)*	$40

****This is not a comprehensive list of all possible charges.***

Cancellation and No Show Policy

It is office policy to charge for missed appointments not canceled at least 24 hours prior to the scheduled appointment. This includes groups: unless prior arrangements are made, you will be expected at the next scheduled meeting. In the event a courtesy reminder is not made, it *does not excuse* a missed appointment.

Fees and Payment

Fees will be collected at the time service is rendered. Payment may be made by cash, check, or credit card. Checks returned for non-payment will result in a $25 bounced check charge and may result in checks no longer being accepted from the client. Integrative Counseling does not accept insurance payments. ***Statements are regularly e-mailed and can be mailed upon request.***

Failure to Pay

The client agrees that failure to pay the expected service fee within ten business days of the service date may, at the option of Integrative Counseling, be construed as a discharge of services by the client. ***Client accounts sent to collections for non-payment will be charged the amount owed plus any and all associated collection fees***. The client agrees that information pertinent to the collection of any amount due be released to a third-party collection agency or attorney. The client further agrees that if legal action is taken to collect any money under this agreement, the client shall pay the amount due as attorney collection fee as well as any cost of any legal action; and consents to legal action being held in Howard County, Maryland, and waives any right to claim improper jurisdiction and/or venue.

Court Appearances, Legal Requests and Associated Costs

Integrative Counseling charges $400 per hour with a minimum of $3,200 for any court appearance or legal request (such as administrative hearing, subpoena) whether requested or summonsed, regardless of requesting party. Clients will also be charged per hour for any travel time, consultation time, preparation time, and any time spent waiting. Costs incurred by the company for associated legal fees will be passed on to the client. In the case of minors, the signing parent is responsible for this fee unless otherwise pre-arranged with the non-signing parent. A deposit of $3,200 is due 10 days prior to any court appearance or legal request. If a court appearance or legal request is canceled or rescheduled, staff must be given ten business days' notice; without this notice, IC may still charge up to $3,200 for each day if unable to reschedule appointments and for any preparation time, administration time, and reports completed.

Understanding of Separate Practices

The client recognizes and understands that although they share space, Congruent Counseling Services, LLC (CCS) and Integrative Counseling, LLC (IC) are separate practices, and as such require the opening of a separate client chart. The client understands that any insurance benefits utilized with CCS cannot be utilized with IC. IC has no insurance contracts. Clients may continue to receive services from either or both programs. Additionally, the client understands that each program may exchange information with the other and the client signature below serves as a release for the programs to exchange such information as needed to ensure appropriate treatment.

Medication Changes or Refills between Appointments

We understand you may sometimes need a brief refill to get you through to your next appointment. Refills between appointments will be billed at $35. These refills will be for no longer than two weeks or until you are able to see your psychiatrist in person. You may choose to schedule a Telepsychiatry appointment if the next appointment is too far away.

Laboratory Services

IC works with a private laboratory, Dominion Diagnostics, to perform urine drug screening. Dominion submits to insurance directly and provides test results to IC. ***Please contact Dominion directly at 410.387.3890 for billing questions***. If the client prefers not to use insurance or doesn't have insurance, please let the counselor know and IC will use Friends Lab and charge the fee as noted above.

Integrative Counseling, LLC
Fee Schedule, Policies, Information (2 of 2)
Client Copy

Client Portal

We offer you the option to access a portal to your account through which you can communicate with your provider, pay your bill, and verify your schedule. Please ask the front office for a login if you were not provided with one. If at any time you want to opt out of the portal, please let us know.

Communication, Reminders, Statements

We wish to communicate with you in the most efficient way possible. That may be by phone, email, or text message. Telephone, email, and text messaging communications carry an inherent risk to privacy. Please do not use email for an emergency or rapid response request, or for sensitive information. We may use your email, mobile phone text messaging, or home phone for appointment reminders, statement delivery, or general information. By signing below, you acknowledge recognition and acceptance of risk to privacy in the use of email and text message.

Telephone and Internet Session – Teletherapy or Telepsychiatry

Clients regularly seen in the office for sessions under insurance may schedule teletherapy/telepsychiatry appointments; some insurances pay for telehealth sessions. Credit cards must be kept on file with Congruent Counseling Services. Initial sessions must be face-to-face in person. In the case of a missed appointment, therapists may opt to conduct a 15-30 minute phone session during your already scheduled individual, family, or couples appointment time. This session will be charged at a rate of $50, which is less than the full missed appointment charge. The missed appointment phone option may only be used once in a 30-day period.

Provider Contact Outside of Sessions

It is our goal to provide you with the best treatment we can provide. If there is an emergency, please call emergency services or 911, or Grassroots at 410-531-6677. If you are calling to make or change your appointment or to address billing issues, please call the office. Your provider has given you personal contact information to help address your needs. If you would like to talk with your provider, and cannot wait until the next appointment, please be respectful of their time. Calls, texts, or emails taking over five minutes will be charged as a crisis session at a rate of $45 per 5-minute increment. Contacts about medication clarification more than a week after your appointment will be charged as a Crisis Session. Crisis Sessions are not billable to insurance and are the responsibility of the client or responsible party.

Client Grievance Procedures

Clients have the right to discuss treatment issues, and if necessary to review with the Program Director, disagreements about treatment, discharge, or change in status. No retaliation will be taken against clients who present a grievance. Clients will first be asked to discuss concerns with their counselor. The counselor will attempt to resolve the client's concerns. If the client is unsatisfied, they can write their complaint to the Program Director using the contact information below. The Program Director will communicate with all parties involved to gain a full picture of what occurred. Based on this information, the Program Director will create a resolution which best meets the needs of all involved. The Program Director will then write a response to the client within ten business days.

Adult Program Director:	**Adolescent Program Director:**
Katie Downes	Meghan Hesterberg
katie.downes@ccs-ic.com	meghan.hesterberg@ccs-ic.com
443-917-2583	443-917-2590
11:00am – 6:00pm	11:00am – 6:00pm

If the client is dissatisfied with the response from the Program Director, they can contact the following agencies:

DHMH/OHCQ:	**ACHC *(Accreditation Body)*:**
Behavioral Health	919-785-1214
410-402-8198	8:00am – 5:00pm EST
8:00am – 5:00pm	

Local Addictions Authorities:

Roe Rodgers-Bonaccorsy	Sue Doyle	Sandra O'Neill	Mary Viggiani
LAA, Howard County	LAA, Carroll County	LAA, Anne Arundel Cty	LAA, Baltimore County
410-313-7316	410-876-4800	410-222-7164	410-887-3828
9:00am – 3:30pm	9:00am – 3:30pm	9:00am – 3:30pm	9:00am – 3:30pm

Integrative Counseling, LLC
Infectious Disease Education

Client Copy

Tuberculosis

Tuberculosis (TB) is an infectious disease that usually infects the lungs, but can attack almost any part of the body. Tuberculosis is spread from person to person through the air. When a person with TB in their lungs or throat coughs, laughs, sneezes, sings, or even talks, the germs that cause TB may spread through the air. If another person breathes in these germs, there is a chance that they will become infected with tuberculosis.

It is not easy to become infected with tuberculosis. Usually a person has to be close to someone with TB disease for a long period of time. TB is usually spread between family members, close friends, and people who work or live together. TB is spread most easily in closed spaces over a long period of time.

If it is not treated, TB can be fatal. But TB can almost always be treated and cured if you take medicine as directed by your healthcare provider. Once you begin treatment, within weeks you will no longer be contagious. That means you can't spread the disease to others. If you take your medicine just as your healthcare provider tells you, all the TB germs should be killed.

Risk Reduction: Travelers should avoid close contact or prolonged time with known TB patients in crowded, enclosed environments (for example, clinics, hospitals, prisons, or homeless shelters). If you think you have been exposed to someone with TB disease, contact your healthcare provider or local health department to see if you should be tested for TB. Be sure to tell the doctor or nurse when you spent time with someone who has TB disease.

American Lung Association, http://www.lung.org/lung-disease/tuberculosis/

CDC: http://www.cdc.gov/tb/topic/infectioncontrol/

Tobacco Smoking

Cigarette smoking has been identified as the most important source of preventable morbidity (disease and illness) and premature mortality (death) worldwide. Smoking-related diseases claim an estimated 443,000 American lives each year, including those affected indirectly, such as babies born prematurely due to prenatal maternal smoking and victims of "secondhand" exposure to tobacco's carcinogens. Smoking cost the United States over $193 billion in 2004, including $97 billion in lost productivity and $96 billion in direct health care expenditures, or an average of $4,260 per adult smoker.

Risk Reduction: Quitting smoking is the single most important step a smoker can take to improve the length and quality of his or her life. Stopping smoking can be tough but smokers don't have to quit alone. The American Lung Association has lots of options to help adult and teen smokers quit smoking for good.

American Lung Assocation, <http://www.lung.org/stop-smoking/how-to-quit/>

HIV/AIDS

HIV is the human immunodeficiency virus. It is the virus that can lead to acquired immune deficiency syndrome, or AIDS. HIV damages a person's body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases. Within a few weeks of being infected with HIV, some people develop flu-like symptoms that last for a week or two, but others have no symptoms at all. People living with HIV may appear and feel healthy for several years and can still spread the virus. HIV is spread primarily by not using a condom when having sex with a person who has HIV, sharing needles, and being born to an infected mother. If you believe you may have been exposed you need to see a doctor and get tested. Early treatment can reduce the spread of HIV and allow you to start treatment early to reduce the impact of the disease on your body.

Risk Reduction: Use condoms consistently and correctly. Reduce the number of people you have sex with. Talk to your doctor about pre-exposure prophylaxis (PrEP). PrEP should be considered if you are HIV-negative and in an ongoing sexual relationship with an HIV-positive partner. Talk to your doctor right away (within 3 days) about post-exposure prophylaxis (PEP) if you have a possible exposure to HIV. Get tested and treated for other sexually transmitted diseases (STDs) and encourage your partners to do the same. If your partner is HIV-positive, encourage your partner to get and stay on treatment.

CDC: http://www.cdc.gov/hiv/topics/basic/index.htm

AIDS.Gov: www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/sexual-risk-factors/

Congruent Counseling Services, LLC
Infectious Disease Education

Client Copy

STDs

Sexually transmitted diseases, or STDs, can be painful and embarrassing. Unfortunately, they are especially common when safe-sex precautions are not taken. Luckily, most STDs are easily treatable by your doctor. If you're afraid you might have an STD, consider these seven warning signs: painful urination; painful intercourse; open sores or bumps near the mouth or genitals; unusual discharge from the genitals/unusual odor; itching or swelling in the genital area; changes in menstruation; high fever, fatigue, or nausea. These can all be symptoms of an STD. If you feel as if you might be coming down with something shortly after having unprotected sex, don't assume that it's just a common cold. If you believe you might have an STD, you should make an appointment with your doctor as soon as possible.

Risk Reduction: There are several ways to avoid or reduce your risk of sexually transmitted infections: Abstain from sex; Stay with 1 uninfected partner; Avoid vaginal and anal intercourse with new partners until you have both been tested for STDs; Get vaccinated. Vaccines are available to prevent human papillomavirus (HPV), hepatitis A and hepatitis B. Also, Use condoms and dental dams consistently and correctly; Don't drink alcohol excessively or use drugs. Communication: Teach your child that becoming sexually active at a young age tends to increase a person's number of overall partners and, as a result, his or her risk of STDs. Consider male circumcision.

Reference: http://www.cdc.gov/STD/

Mayo Clinic: www.mayoclinic.org/diseases-conditions/sexually-transmitted-diseases-stds/basics/prevention/con-20034128

Hepatitis

Hepatitis is an inflammation of the liver. The condition can be self-limiting or can progress to fibrosis (scarring), cirrhosis or liver cancer. Hepatitis viruses are the most common cause of hepatitis in the world but other infections, toxic substances (e.g., alcohol, certain drugs), and autoimmune diseases can also cause hepatitis. There are 5 main hepatitis viruses, referred to as types A, B, C, D and E. These 5 types are of greatest concern because of the burden of illness and death they cause and the potential for outbreaks and epidemic spread. In particular, types B and C lead to chronic disease in hundreds of millions of people and, together, are the most common cause of liver cirrhosis and cancer.

Risk Reduction: Good personal habits will help reduce the spread of hepatitis A and hepatitis E. If you're in a place where you're not sure things are clean, boil water. Cook all food well and peel all fruit. If you're a healthcare worker or caregiver for someone who has a contagious form of hepatitis, take extra steps to stay clean. Wash your hands, utensils, bedding, and clothes with soap and hot water. To prevent the spread of hepatitis B, stay away from the blood or body of someone who has it. That means no kissing or sex. Don't share razors, scissors, nail files, toothbrushes, or needles. If you plan to travel to countries where hepatitis is widespread, get protected. You can get vaccinations for hepatitis A and B. In the U.S., all children are advised to receive a series of hepatitis B vaccine before they start school. Kids who live in places with a lot of hepatitis A should get that vaccine. There isn't a vaccine for hepatitis C.

WHO: www.who.int/features/qa/76/en/

Web MD: www.webmd.com/hepatitis/understanding-hepatitis-prevention

For Treatment or Testing

See your doctor, or we recommend Dr. Patel, Family Health Center, 10632 Little Patuxent Pkwy, Suite 111, Columbia, MD 21044. Phone: 410.997.9751.