NEW DIRECTIONS
COUNSELING SERVICES, LLC
WEXFORD • ROBINSON

Receipt of NPP Acknowledgement and Consent to Treatment and Fee Agreement

Adult – Group Therapy

I, the undersigned, acknowledge that I have read or heard the **Notice of Privacy Practices** (NPP). This notice reminds you that during evaluation and treatment at New Directions Counseling Services, LLC, we will be collecting "protected health information" (PHI) about you. We may use or disclose your PHI for treatment, payment, and health care operations purposes with your consent. With your signature below, you are consenting to the use of your PHI for these purposes. If we make changes to our NPP, it will be updated in our waiting room and on our website, or you can get a copy from any staff member. You may revoke this authorization to use or disclose your PHI at any time, but you must do so in writing. If we have already relied on this authorization, we cannot change that, and third party insurers have a right to contest this claim.

I, the undersigned, further acknowledge that I have read or heard the **Treatment and Fee Agreement – Group Therapy** (Agreement), I fully understand the Agreement, and I intend to abide by the Agreement. If I pay for services with third party benefits, I authorize New Directions Counseling Services, LLC to release any and all information necessary to obtain authorization and/or payment for services. I understand that if I am responsible for any part of the payment for services, it is due on the date of service. I acknowledge that I have been given the opportunity to ask questions about the Agreement with a representative of New Directions Counseling Services, LLC. I acknowledge that New Directions Counseling Services, LLC reserves the right to make changes to this Agreement with 30 days' notice.

I seek and consent to actively participate in group treatment at New Directions Counseling Services, LLC:

_____	_____	_____
Printed Name of Client	**Signature of Client (or legal representative)**	**Date of Receipt**
_____	_____	_____
Printed Name of Additional Client (required for couples or family therapy)	**Signature of Client (or legal representative)**	**Date of Receipt**

Email Consent:

I consent to receive correspondence from New Directions Counseling Services, LLC by email:

- ❑ NO
- ❑ YES Email Address: _____
  Client name associated with email: _____

Text Consent:

I consent to receive correspondence from New Directions Counseling Services, LLC by text:

- ❑ NO
- ❑ YES Mobile Phone Number: _____
  Mobile Phone Service Provider (e.g., Verizon): _____
  (Text reminders are not available for Cricket or Mobile PCS Phones)

Consent to Communication with Primary Care Provider

Most health insurance companies and managed care organizations request that our office have communication with your Primary Care Physician's (PCP) office for the purposes of coordination of care and of meeting quality assurance standards. This communication typically includes date of first contact, diagnostic information, medications, and treatment recommendations. You have the option of declining to provide your consent for communication between our office and your PCP's office.

If you would like to ***grant consent*** for our office to release information to your PCP's office, please print your name, sign and date below, and please provide your PCP's name and address where indicated:

Consent granted for:

_____	_____	_____
Printed Name of Client	**Signature of Client/Legal Guardian**	**Date**

Name and address of PCP:

_____

_____

_____

_____

Phone and Fax of PCP: _____

If you prefer to ***deny consent*** for our office to release information to your PCP's office, please print your name, sign and date below:

Consent denied for:

_____	_____	_____
Printed Name of Client	**Signature of Client/Legal Guardian**	**Date**

Credit Card Authorization

PLEASE PRINT INFORMATION CLEARLY:

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: **Month** ___ ___ **Year** ___ ___ ___ ___

CVV Code (back of card): ___ ___ ___

Type of Card: ❑ **Credit** ❑ **Debit** ❑ **Health Savings/Flexible Spending Account**

Name and Address associated with Card:

_____

_____

_____

_____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY:

I authorize New Directions Counseling Services, LLC to apply charges to the card listed above under any of the following circumstances:

- At the time of participation in services for the expected amount of an appointment fee to be applied to a health insurance deductible.
- At the time of participation in services for the portion of each appointment fee for which I am responsible including self-pay fees, health insurance copayment amounts and health insurance coinsurance amounts.
- After violation of the practice's cancellation policy requiring payment of a fee for a ***late cancelation or missed appointment*** per the practice's Consent to Treatment and Fee Agreement.

I am aware that New Directions Counseling Services, LLC will be unable to notify me before processing this card on file and that my card may be charged at any time at the discretion of New Directions Counseling Services, LLC for the reasons listed above.

_____	_____	_____
Printed Name of Client	**Signature of Client/Legal Guardian**	**Date**

Treatment and Fee Agreement - Group Therapy

PLEASE REVIEW THIS INFORMATION CAREFULLY AND TAKE IT WITH YOU FOR FUTURE REFERENCE.

At New Directions Counseling Services, LLC (NDCS) our aim is to nurture transformation and foster sustainable well-being for individuals and families. We are a heart-centered practice dedicated to helping our clients create positive, life-altering changes through traditional and alternative health care solutions. Our team is focused on building connections and providing personalized care for each client.

General Information about Group Therapy:

The group therapist will perform an initial evaluation with you to determine if the group that you are interested in would be an appropriate fit for you. There will be a charge for this initial evaluation, and it typically lasts about 30 minutes. If it is determined that the group would be appropriate for you, and you determine that you would like to join the group, please plan to commit to attending every group session. Group sessions are typically 60-90 minutes in length. Please make every effort to arrive on time for each group session as it can be disruptive to the group environment to have clients arriving at different times. Please respect all group members including their ideas and experiences. Please also give a good faith effort to complete any recommended homework exercises.

If you are not able to attend a particular group session, you are required to provide the group therapist with 24 hours advance notice. ***You will be charged $60 for any group sessions that are canceled without such notice or completely missed without any notice.*** Such late cancellation or missed session fees cannot be reimbursed to any extent through third party benefits, and you will be responsible for this fee.

Financial Arrangements for Group Services:

Each group session fee is $60. If you have a health insurance policy or some other type of third-party benefits that you would like to utilize to pay for services, please notify us at your initial appointment. The office will submit claims directly to your benefits carrier. Clients assume ultimate responsibility for knowing the specific coverage provided by their benefits, including fees for services, coverage limitations, and service authorization requirements. Patients maintain financial responsibility for any claims denied by their third-party benefits carrier.

If you accumulate a balance of more than $100, you will be required to make payment to reduce your account balance before you can schedule additional appointments at our practice.

Any account with an outstanding balance more than 90 days past due, without a payment arrangement approved by our office, will be sent to a Collections Agency. In these situations, you (the client) agree to reimburse New Directions Counseling Services, LLC for the amount of the fees of any Collections Agency (initially 33% of the total debt and over time up to 50% of the debt), and all costs and expenses (including reasonable attorneys' fees) that New Directions Counseling Services, LLC incurs in such collection efforts.

Finally, there is a $25.00 charge for any checks returned to our office by a financial institution due to insufficient funds.

We require a valid credit card on file at all times when you are participating in Group Therapy. There is a Credit Card Authorization form included with this packet for you to complete. We will charge your credit card at the following times:

- When you are using third party benefits to pay for our services and you have a deductible, we will charge your credit card *after each visit at our practice* for your benefits carrier's contracted rate that we anticipate will be applied to your deductible.
    - Please note that we will issue you a refund once your deductible has been met if we have processed your credit card for payments that exceed the amount of your deductible.
- At each appointment if you are self-pay.
- At each appointment for any copayment or coinsurance payment amounts due.
- Any time you have outstanding copayment or co-insurance payment amounts due for Group Therapy services.
- After violation of the practice's cancellation policy for the fee associated with a ***late cancelation or missed appointment***.

Confidentiality in Group Services:

Trust is extremely important in any therapeutic relationship. In a group setting, that trust is extended beyond the individual client-therapist relationship to the relationships among all clients participating in the group. By signing the group consent, you agree to keep all information that is shared in group sessions confidential, meaning that you agree not to share any information that has been discussed by other group members with anyone outside of the group.

In order to protect your confidentiality, we adhere to the following procedures:

1. Inquiries about you made in person, in writing, or by telephone will not be acknowledged by any of our staff members without your authorization. You must sign our Authorization to Release Information form before any information about you will be given to any party outside New Directions Counseling Services, LLC, unless it meets the exception criteria outlined below in sections two and three.
2. Pennsylvania state law requires exceptions to confidentiality including but not limited to:
    a. If you express a serious threat or intent to kill or seriously injure yourself or an identifiable person or persons.
    b. If we have reasonable cause to suspect abuse or neglect of a child or vulnerable adult.
    c. When we are required to do so by legal order of a court.
3. New Directions Counseling Services, LLC is a group practice and providers at the practice share administrative resources. This means that other providers at the practice may have indirect access to your information (e.g., your name). On occasion, your provider may also engage in collaboration or consultation with other providers at the practice with the aim of providing the highest quality treatment to you. Further, your clinical record may be utilized by more than one treatment provider in the event that you are receiving treatment with our therapeutic and/or psychiatric practitioners. Our administrative staff members also have access to your information strictly for administrative purposes. All clinical and administrative staff members adhere to our Privacy Practices.

Regarding sections two and three above, providers will, whenever possible, inform you of their intent to share information with a third party. If you express thoughts about harming yourself or someone else, every effort will be made to resolve the issue through treatment before information is released to an outside party.

Emergencies:

If you need to contact us regarding an urgent matter, please try reaching your group therapist at 724-934-3905 using their extension. If you are having an emergency and you are not able to reach your therapist, you should immediately proceed to the emergency room of the medical facility that is nearest to you at the time of the emergency.

Notice of Privacy Practices - Abbreviated*

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

Uses and Disclosures for Treatment, Payment, and Health Care Operations
We may **use** or **disclose** your **protected health information (PHI)**, for **treatment**, **payment**, and **health care operations** with your consent. **PHI** refers to identifying information in your health record. **Treatment** is when we provide or manage your health care. **Payment** is when we obtain reimbursement for your healthcare. **Health care operations** relate to the performance and daily routines of the practice. **Use** applies to activities within the practice. **Disclosure** applies to activities outside of the practice.

Uses and Disclosures Requiring Additional Authorization
We may also use or disclose your PHI for purposes outside of treatment, payment, and health care operations, however, you must sign a separate Authorization to Release Information form to allow this. You may revoke any authorizations of PHI at any time, but you must do so in writing. You may not revoke an authorization to the extent that we have already relied on the authorization and third party insurers have a right to contest this claim.

Uses and Disclosures with Neither Consent nor Authorization
We may use or disclose your PHI without your consent or authorization in the following circumstances. There may be additional disclosures of PHI that we are required or permitted by law to make without your consent, but the ones listed below are the most common.

- If you express a serious threat to kill or injure yourself or an identifiable person or persons, we must notify the potential victim or victims and others (such as law enforcement personnel) to keep you or others safe.
- If we have reasonable cause to suspect abuse of a child or vulnerable adult.
- When we are required to do so by legal order of a court.
- For worker's compensation, disability, and other similar programs.

Client's Rights

- You have the **right to request restrictions** on certain uses and disclosures of your PHI.
- You have the **right to receive confidential communications by alternative means and at alternative locations**. For example, you could ask us to send your bill to a different address or call you only at home and not at work.
- You have the **right to review** your PHI. There may be a charge if copies are requested.
- You have the **right to amend** your PHI by written request if you believe your record is incorrect.
- You have the **right to notification** if there is a privacy breach of your PHI.
- You have the **right to an accounting** of disclosures of your PHI.
- You have the **right to a paper copy** of this notice.
- You have the **right to file a complaint** if you feel your privacy rights have been violated. Complaints must be in writing and sent to our compliance officer (listed below). You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for exercising this right.

Health Care Provider's Duties

- We are required by law to maintain the privacy of your PHI and to notify you of our legal duties and privacy practices regarding your PHI.
- We are required to abide by the terms of this notice, although we have the right to change the privacy policies and practices described here as long as we provide proper notification.
- We are required to provide proper notification if we revise the policies and procedures listed here.

If you have any questions or concerns related to this notice or additional rights which may be granted to you by the laws of Pennsylvania, please contact our compliance officer, Dr. Michael Schneider, by phone at 724-934-3905x31 or by email at mschneider@newdirectionspgh.com.

***This abbreviated version provides the basic information about your privacy rights and what we do to protect your privacy rights. A longer, more detailed version is available in our waiting room, on our website, or from any staff member.**