Psychological & Counseling Associates of the Lowcountry, LLC

23 Plantation Park Drive #202
Bluffton, SC 29910
(843) 290-6828

Dear _____,

Your initial appointment has been scheduled for

_____

Thank you for this opportunity to work with you. The following are some of the necessary details. The session will be held at the private practice offices of Psychological & Counseling Associates of the Lowcountry, LLC in Plantation Business Park.

Directions are:

From Highway 278, turn into the Plantation Business Park entrance. It's on the inland side of the highway between the Kroger's shopping center and Buck Island Road (behind the Dairy Queen). Go past the retail shops in the front until you come to Plantation Park Drive at the T in the road. Turn left onto Plantation Park Drive. Turn right at the second right into the 23 Plantation Park office building area. Bear left and park in front of the second building on the left. Look for #202. Please wait in the foyer waiting room for your clinician to greet you, as we have no receptionist, and your clinician may be in session with another client.

Please complete the enclosed forms and bring to the session. Charges vary by clinician, with full payment or co-payment expected at the beginning of the session. Your clinician will discuss financial arrangements with you. If you have insurance, you are only responsible for the deductible and co-pay/co-insurance, once the deductible has been met; we will help you determine your financial responsibilities under your insurance plan. If you plan to use your insurance, please record your deductible and co-payment/coinsurance amounts on the Insurance Intake form. We will bill your insurance company, if you have one. We can also obtain prior authorization for your mental health services, where one is required. <u>Medicare does not require prior authorization for outpatient mental health services.</u>

If you need to change or cancel the appointment, or have further questions, we can be reached at (843) 290-6828.

Sincere regards,

Helene Stoller, Psy.D.
Licensed Psychologist
Owner/Clinical Director

Jessica Joyce, Psy.D.
Licensed Psychologist

Alison Jedrick, MSW Janet Meyer, MSW Susan Knapp, MSW Daniel Riggs, MSW
Licensed Independent Clinical Social Workers

Steven Meinert, PhD.
Licensed Professional Counselor

Psychological & Counseling Associates of Lowcountry, LLC
Welcome Letter

WELCOME! The most important goal of mental health services is to help you feel and do better in your life. As a client, you can help with your treatment by keeping the following information in mind. We use solution-focused, goal-directed approaches to a wide variety of problems. It is especially important that you keep in close contact with family or supportive friends during a crisis and that you assume responsibility for helping yourself. If you are dissatisfied with your progress in therapy or with any services we provide, please discuss this openly.

Confidentiality. What you say is CONFIDENTIAL and will be discussed with other people only with your written permission (except in medical emergencies, under a court order, or as required by law, e.g., mandatory child abuse reporting and vulnerable adult abuse reporting). If there is a clear intention to do serious harm to yourself or to another person, that information will be shared in an attempt to prevent that harm from occurring. Information regarding services provided to minor children can be given to parents on request as a matter of state law. If a minor child is seen, issues regarding confidentiality will be discussed with the parents. Insurance providers often require more detailed information about your situation prior to approval of continued treatment or payment for treatment. If you wish to know the informational requirements of your insurance company, please ask.

Office Hours. Office hours are 8-8 Monday – Friday and 9-5 on Saturday. You can schedule or change appointment times by calling the office and leaving a message for the appropriate clinician or by contacting your clinician directly (preferred).

Fees, Phone Calls, and Reports. Fees vary between $125 and $275 per hour depending upon the service and the clinician and are subject to change with advance notice. Full payment (or co-payment if covered by insurance and the deductible has been satisfied) is expected at the beginning of the session. Phone calls, letters, and reports to facilitate scheduling, information sharing, etc. and requiring up to 10 minutes of time are free of charge. After 10 minutes, you are billed at a prorated hourly rate. Reports of findings are billed at a prorated hourly rate. Scheduling paid telephone sessions is welcome when a situation is particularly urgent or because of travel or geographical difficulties.

Consultation and Supervision. As independently licensed contractors, practice clinicians are solely responsible for the care of clients with whom they work. To provide the best possible service, your clinician may engage in consultation with other clinicians. When discussing clients, only first names are used for reference purposes to protect confidentiality.

Insurance and Bookkeeping. Psychological & Counseling Associates of the Lowcountry, LLC uses the insurance billing and bookkeeping services of Apple Billing. Please call (843) 757-7227 with questions about billing or statements you receive.

Cancellations and No Shows. The approximate cost of a session ($90 for counselors and social workers, and $115 for psychologists) is charged for appointments canceled with less than 24 hours advance notice and for failure to attend a scheduled appointment. Exceptions are for sudden illness or accidents and for Medicaid clients. This is standard practice and is intended in part to preserve the time for those who may need it. Please note that insurance companies do not pay for failed or canceled appointments. Please ask your clinician any questions you have about this policy.

Crisis Situations. Depending on the nature of the crisis situation, call your clinician, or call 911 for life-threatening emergencies. If necessary, your clinician will have discussed back-up systems for when s/he is unavailable.

Collections. In case you do not pay your bill, we reserve the right to seek payment through use of a collection agency or through other legal means. Interest charges of 1.5% per month to a maximum of 18% per year will apply.

I understand and agree to abide by the policies stated above. If I am not financially responsible for my bill, I have obtained consent from the payor on my account, indicated by his/her signature.

_____ _____

Client Signature Date

_____(Payor) _____(Date)

Psychological & Counseling Associates of the Lowcountry, LLC 23 Plantation Park Dr. #202 Bluffton, SC 29910
Office phone (843) 290-6828 Fax (843) 757-3993

Our responsibilities to you:
Psychological & Counseling Associates of the Lowcountry, LLC is required by law to maintain the privacy of your health information and to provide you with this notice of privacy practices in order to inform you of how your health information is used and disclosed. We reserve the right to change our practices regarding the health information we keep. If we make a material change in our privacy practices, we will give you a copy by mail or in person. Amended notices will also be posted in our offices. Unless otherwise required by law, your health record is the physical property of Psychological & Counseling Associates of the Lowcountry, LLC, but the information in it belongs to you, and you have the right to have your health information kept confidential.

You or a person legally authorized to act for you, have a right to:

- Obtain a paper copy of this notice upon request.
- Review or obtain a copy of your health information for a reasonable fee; if this request is denied, you have the right to request a review of the denial.
- Request amendments to your health information, and to be informed of the reason, if we do not agree to an amendment.
- Request limits on certain uses and disclosures of your health information, and to be informed of the reason if we do not agree to a limit.
- Get a list of our disclosures of your health information, as specified below.
- Request that communications of your health information be made by alternative means or at alternative locations (e.g., to maintain your confidentiality), if this request is reasonable.
- Revoke any special authorizations to use or disclose health information, except to the extent that the has already been made.

There are some restrictions on these rights, and special rules apply which restrict access to psychotherapy notes, HIV/AIDS information, and federally protected drug and alcohol information. You can exercise your rights or obtain additional information about your rights by contacting one of the persons listed in the last section of this notice.

General policy on use and disclosure of your health information. We will use and disclose your health information only with your authorization, or when we are required to do so by state or federal law, or in an emergency.

Permitted uses and disclosures: The uses and disclosures listed in the section below may be made with your one-time permission. We are not required to maintain a written accounting of the disclosures made for these purposes.

- **Treatment**. Information is used and disclosed to provide you with healthcare services. For example, we may talk with your physicians or other treatment providers about your care.
- **Payment.** Psychological & Counseling Associates of the Lowcountry, LLC may use and disclose to other parties (i.e., your insurance company, HMO, Medicaid, Medicare) your health information to receive payment for the healthcare services we provide to you.
- **Health care operations.** Health information is used and disclosed for operational reasons. For example, your information may be used to assess the quality of care provided to you, to improve services and facilities, or to train and evaluate staff.
- **To keep you informed.** We may use and disclose information in order to send you appointment reminders or information about your treatment or treatment alternatives.
- **Disclosures to friends and family.** With your permission, we may disclose your health information to friends and family who are involved in your care.

Disclosures without authorization. The HIPAA Privacy Rule states that Psychological & Counseling Associates of the Lowcountry, LLC may use and disclose your Protected Health Information without your authorization for the reasons listed below. However, if other state or federal laws provide you with more privacy protection than HIPAA, you will receive that added protection.

Psychological & Counseling Associates of the Lowcountry, LLC will use or disclose health information only in an emergency or when we are required to do so by state or federal law. When we determine that we must use or disclose information, unless prohibited by law, we will do the following:

1) Attempt to contact you before using or disclosing this information, if it is reasonable to do so;
2) Maintain an accounting of the disclosures and uses made for the purposes listed in the section below: and
3) Upon your request, provide you with access to that accounting.

Serious threats to health and safety. Your health information may be disclosed to avert a serious threat to public health and safety, as permitted by law.

As required by law. Psychological & Counseling Associates of the Lowcountry, LLC may use and disclose information for the mandatory reporting of child abuse and neglect; for judicial or administrative proceedings, if required by legal process; and as otherwise required by law.

Health oversight. Information may be disclosed when required to monitor the level and quality of care you receive, for example the State of South Carolina Department of Public Health.

Contracted or affiliated purpose. Our contractors and agents may be given health information if this information is necessary for them to perform certain services for us and if they agree to keep such information confidential.

Inmates and correctional facilities. Psychological & Counseling Associates of the Lowcountry, LLC may disclose inmate and detainee information to prison staff and law enforcement personnel, if necessary for health care or for security reasons, as permitted by law.

Research. Psychological & Counseling Associates of the Lowcountry, LLC may use health information for research, with your consent or when a review board has approved research which poses minimal risk and your privacy is ensured. No public disclosure of your name will be made without your consent.

Uses and disclosures with your authorization. If a use or disclosure is not covered in the two sections above, for example, if you request that we disclose health information to your employer, we will disclose information only if you authorize it in writing. We will maintain an accounting of uses and disclosures that you authorize in this manner.

For more information, to make a complaint, or to exercise your rights:

If you have questions, need information, believe your privacy rights have been violated, or wish to make a complaint or to exercise one of your rights described in this notice, you may contact the owner of Psychological & Counseling Associates of the Lowcountry, LLC, Dr. Helene Stoller at the practice's office: 23 Plantation Park Dr. #202, Bluffton, SC 29910 (843-290-6828).

If you are not satisfied with the response you receive from Psychological & Counseling Associates of the Lowcountry, LLC, you may contact:
Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F
HHH Building
Washington, D.C. 20201

I, _____ have received a copy of the "notice of privacy practices (HIPAA)" form from Psychological & Counseling Associates of the Lowcountry, LLC. It was reviewed by my therapist and any relevant questions have been addressed. I understand that I can obtain any additional copies as needed by contacting my therapist and requesting one.

_____ _____
Client Date

_____ _____
Parent/Guardian or legal representative (as applicable) Date

Registration and History

Date: _____

Client Identification Data					
Name (Last) (First) (M)			Age	Birthdate	Sex
Address (City) (State) (Zip)					
Social Security #		Home Phone		Work Phone	
Marital Status			Religion		
Single ☐	Married ☐	Divorced ☐	Separated ☐	Widowed ☐	
Education (Highest Grade Completed)		College Degrees		Veteran Yes ☐ No ☐	
Employer		Occupation		How long employed?	

Family History					
Family Members	**Age**	**Emotional Problems**		**Living?**	**Occupation**
		Yes	**No**	**Yes** **No**	
Spouse's Name					
Mother's Name					
Father's Name					
Stepmother's Name (if applicable)					
Stepfather's Name (if applicable)					
Other significant person responsible for raising you					
Number of children of person completing form	Age of oldest		Age of youngest		Number deceased
Number of brothers and sisters	Age of oldest		Age of youngest		Number deceased
Number of other persons living in current household	Relationship				

Notify in case of emergency (Name, relationship, phone number for contact)

Address	Home Phone

Please see reverse side

Health Data
Your Physician (Full Name):
Address (Clinic Name) (Street) (City) (State/Zip)

Do you have any current medical problems? Please describe. _____
Are your medical problems being treated? _____ If yes, by whom? _____

What medications and dosages are you now currently taking? _____
_____
Have you ever seen any of the following for help with a problem? Please circle all that apply:
Psychiatrist Psychologist Social Worker Counselor Minister Chemical Dependency Counselor
For what? _____ When? _____
Previous psychiatric or chemical dependency hospitalization? _____ Yes _____ No
If yes, where? _____ When? _____

Directions: Please answer the following questions from your personal perspective.
Who referred you to Psychological & Counseling Associates of the Lowcountry, LLC?
_____
What is the crisis or problem that brought you to see us? _____

Who is the person/issue you are most concerned about and why? _____
_____

PROBLEM LIST

Listed below are possible problems you or your family currently has. Please rate each by your degree of concern by circling the issue, rating it, and indicating why you are concerned.

1. Suicide potential or depression? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? _____
2. Alcohol/drug abuse? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? _____
3. Family/relationship problems? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? _____
4. Worry/Anxiety? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? _____
5. Verbal abuse/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? _____
6. Sexual abuse/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? _____
7. Physical abuse/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) Why? _____
8. Other problem/behavior? (Low) 1 2 3 4 5 6 7 8 9 10 (High) What and why? _____

ASSESSMENT and PROBLEM SOLVING

Why do <u>you</u> think there are these problems for you or your family? _____
_____
What is the main goal or need <u>you</u> have for the first session? _____
What are <u>your</u> ideas on how that goal can be accomplished? _____

Chemical Use History

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, what do you drink ☐Beer ☐Wine ☐Hard liquor

How often do you drink? ☐ Daily ☐ 3-5 times weekly ☐1-2 times weekly ☐Less frequently

Do you sometimes drink more than you had planned? ☐Yes ☐ No

Have family and friends ever expressed concern about your drinking? ☐Yes ☐ No

Have you ever been arrested for alcohol related charges: DWI, public intoxication etc.? ☐ Yes ☐ No

Have you ever been treated for drinking or gone to AA? ☐ Yes ☐ No

Have you ever had periods where you were unable to remember what happened when you were drinking?
Yes ☐ No ☐

What has been your experience with the following?	**Use currently**	**Used in past**	**Never used**
Tranquilizers: (for example) Valium, Librium, Tranxene, Azene, Miltown, Equanil, Xanax, Ativan			
Pain Pills/Narcotics: (for example) Darvon, Codeine, Percodan, Demerol, Dilaudid, Heroin			
Stimulants: Amphetamines, Speed, Dexedrine, Ritalin, White Crosses, Zip, Cocaine and its derivatives ie, crack, crank			
Sleeping Pills/Soporifics: Doriden, Placidyl, Dalmane, Seconal, Tuinal, Nembutal, Amytal, Phenobarbital, Noctec, Somnos			
Hallucinogens: Marijuana, Hashish, THC, LSD, Mescaline, Psilocybin, MDA, PCP, Angel Dust, Mushrooms			
Volatiles: Aerosols, Paint thinner, Glue, Lacquer, Amyl or Butyl, Nitrate "Poppers", Gasoline			
Others: Please list			

Have family and friends ever expressed concern about your use of drugs? ☐ Yes ☐ No

Have you ever been arrested for drug related charges? ☐ Yes ☐ No

Have you ever been treated for chemical dependency? ☐ Yes ☐ No

Have you ever overdosed? ☐ Yes ☐ No

Psychological & Counseling Associates of the Lowcountry, LLC (PCAL)

Telemental Health Services Informed Consent for Technology Treatment

I, _____, understand that by engaging in services delivered via the internet (telemental health) and/or telephone, I fully understand and am assuming all liability for the following:

1. Confidentiality. I am responsible for having adequately encrypted software and internet service, as well as a private environment to receive services. Adequate WIFI signal is strongly recommended of at least 50 MBPS for video services. PCAL makes reasonable efforts to secure my privacy in the environment from which services are delivered but assumes no liability for the protection of my privacy in the area where I am receiving services. PCAL is also not liable for breaches of data caused by malware, hackers, or other technical problems. PCAL uses HIPAA-compliant software (i.e., doxy.me, CounSol, Vsee) for teleconferencing.
2. Quality. I understand that it will enhance the quality of my teleconferencing experience if I perform tests in advance of the session to ensure video and sound are working, camera and microphone are enabled. Technical difficulties may result in a session being rescheduled at my request if they occur within the first 30 minutes. After 30 minutes, the session will be billed as a full session; rescheduling must be requested at the time of the compromised session. Missed sessions or sessions cancelled with less than 24 hour notice (except in event of an emergency) will be billed at the late cancellation rate (currently $115 for psychologists and $90 for LPCs/LISW-CPs), and are not covered by insurance.
3. Emergency Plan and Safety. At the beginning of each session I will be required to disclose my name, contact information, and physical location in the event that emergency services are needed. Services will not be delivered when I am operating a vehicle, under the influence of drugs or alcohol, or engaged in other operations that would place my safety at risk. Missed appointment fees may apply at the clinician's discretion in such cases. I contract that if I am experiencing dangerous symptoms and my PCAL clinician recommends that I seek emergency care, I will do so without hesitation by calling 911 or attending my local emergency room. If I fail to do this, I acknowledge that my PCAL clinician may contact local emergency services to assure my safety. I also agree to honor electronic signatures on any written contracts between myself and PCAL.
4. Email, Texts, and Security. **I understand that all texts and emails not related to scheduling may become part of my medical record.** PCAL has my permission to send me emails and/or texts regarding appointments and billing, which may not be encrypted. I understand that I may opt out of electronic appointment reminders at my request. I understand that my medical records are maintained on a secure electronic medical record platform and/or secured paper records. I recognize that PCAL makes reasonable efforts to protect my private health information and acknowledge that PCAL is not responsible for breaches in security by outside parties. I understand that some information may be shared with third parties (e.g., billing company) for purposes outlined in Consent for Privacy Practices.
5. Termination of Services. In the event that my symptoms become such that they cannot be safely managed through telemental health services, or services can no longer be provided to me by PCAL, I will be responsible for seeking services from another provider. I can request assistance in locating a provider by sending an email, letter, or text message to my clinician asking for such assistance. If I choose to no longer receive services from PCAL, I agree to notify my clinician in writing so that my file may be closed. In the event that no appointments are scheduled and/or no communication occurs for over 3 months, my file may be closed. Records will be maintained in accordance with state law.
6. Mandated Reporting. PCAL is a mandated reporter in the state of South Carolina, meaning that if my clinician has reason to suspect abuse or neglect of a child, person with disability, or other vulnerable person (i.e., elderly), terrorist activity, or knowledge of a person who is in immediate danger, s/he must report this to the local authorities. The report will be made to the location in which the client is located.
7. Billing. I agree to verify with my health insurance provider that telemental health services are covered under my plan. As of March, 2020, Medicare, TRICARE, BlueCross Blue Shield, Medicaid, and Aetna Medicare Advantage plans have indicated that they will cover telehealth services because of the coronavirus outbreak. This is expected and hoped to be a temporary measure, and subsequently verification of telehealth benefits for mental health services will be necessary. Any costs for services not covered by insurance will be my responsibility. I understand that telephone visits may not be covered even if video sessions are covered. If telephone is used for services, it must be with video in conjunction with sound or may be subject to different service codes, and I may be responsible for payment.

I have read and agree to the above terms and conditions.

_____ _____

Signature Date

Psychological & Counseling Associates of the Lowcountry, LLC
Client Intake

Client Information

Client Name:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____

Gender:_____Date Of Birth:_____Social Security#_____

Marital Status:_____Employer:_____

Insurance (where applicable)

Insurance Company:_____

Phone number: _____

Address:_____City:_____State:_____Zip:_____

ID#_____Policy#_____Group#_____

Co-pay amt:_____per visit. Deductible ☐Yes ☐No Amount:_____Effective Date:_____

Prior Authorization or Referral name and phone:_____

Policy Holder Information

Insured Person_____

Address_____City:_____State: _____Zip:_____

Date of Birth:_____Relation to Client:_____Employer:_____

Secondary Insurance (where applicable)

Company:_____

Address:_____City:_____State:_____Zip:_____

ID#_____Policy#_____Group#_____Phone_____

I assign all benefits from insurance or other third-party coverage to Psychological & Counseling Associates of the Lowcountry, LLC. Further, I understand that by signing this form I acknowledge that if my insurance carrier or HMO/PPO does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by Psychological & Counseling Associates of the Lowcountry, LLC. A photocopy of this authorization may be honored.

Authorized Signature:_____Date:_____

Payor Signature (if adult client is not responsible for bill):_____Date:_____

Psychological & Counseling Associates of the Lowcountry, LLC
Payment Policy Agreement

After many years of work as clinicians, we have learned that most people are responsible for themselves and promptly pay for their services. We have also unfortunately learned that a small number of people do not understand that their clinician is in business and needs to earn a living from the services s/he offers. These people miss appointments or cancel appointments with only a few hours notice, which means that the clinician will not be able to use that time-slot to see another client and will lose out on the revenue that comes from consultations with clients. As a result of these problems, and the difficulty we have sometimes experienced in getting paid for these missed or late-cancelled appointments, we have instituted a payment policy as described below. We apologize to those many clients who pay fully, promptly, and notify their clinician well in advance of any changes to their plans that affect their clinician's schedule for insisting that you adhere to these policies as well.

I understand that Psychological & Counseling Associates of the Lowcountry, LLC charges the full session fee for missed appointments and appointments cancelled or rescheduled with less than 24 hours advance notice. (This does not apply to Medicaid clients or to emergency situations.) I agree to allow my clinician to take an imprint of my active MasterCard, American Express, or VISA which s/he will use with my permission to charge me for any missed appointments or late cancellations that I might have. I understand that s/he will give me a copy of my credit card receipt for my own records. I know that I (the client) may question or contest any charges that I do not understand or deem unwarranted. I understand that I will be responsible for the cost of any credit card chargebacks that I do not discuss with the practice (currently $25).

Client or authorized representative signature **Date**

Payor signature, if adult client is not responsible for bill **Date**

I also understand that I am responsible for my unpaid fees, including deductible and co-pay/coinsurance amounts. I agree to allow my clinician to take an imprint of my active MasterCard, American Express, or VISA card which s/he will use with my permission to charge me for any fees that I do not pay while I am receiving services from Psychological & Counseling Associates of the Lowcountry, LLC. I understand that I will receive a copy of my credit card receipt for my own records. I know that I (the client) may question or contest any charges that I do not understand or deem unwarranted. I understand that I will be responsible for the cost of any credit card chargebacks that I do not discuss with the practice (currently $25).

Client or authorized representative signature **Date**

Payor signature, if adult client is not responsible for bill **Date**

Consumers of psychological services offered by psychologists licensed by the State of South Carolina have the right:

1. to expect that the practitioner has met the minimal qualifications of training and experience required by state law.

2. to examine the public records maintained by the Board of Psychology which contain the credentials of the practitioner.

3. to obtain a copy of the rules of conduct from the South Carolina Board of Psychology.

4. to report complaints to the practitioner, and if not satisfactorily resolved, to file a complaint with the South Carolina Board of Psychology.

5. to be informed of the cost of professional services before receiving the services.

6. to privacy as defined by rule and law. This means that no information will be released from the facility in which the practitioner works without the client's informed, written consent, except for the following:

   a. The practitioner is required by law to report instances of abuse or neglect of a child or a vulnerable adult.
   b. The practitioner is required by law and professional codes of ethics to notify proper persons and/or authorities if the practitioner believes there is a danger to a client or another identified person.
   c. The practitioner is required to report admitted prenatal exposure to harmful controlled substances.
   d. In the event of a client's death, the spouse or parents of the deceased have a right to access the client's records.
   e. The practitioner must produce records or testimony in response to a Court Order and potentially to a subpoena.
   f. Parents or legal guardians of a non-emancipated minor client have the right to access their child's records.

7. to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving psychological services.

8. to respectful, considerate, appropriate, and professional treatment.

9. to see information in his/her record upon request.

10. to be involved in the formulation of the treatment plan, the periodic review of plans and progress, and the formulation of the discharge plan.

11. to be informed of treatment options, expected outcome of treatment, expected length of treatment, and cost in language that he/she can understand.

12. to discuss needs, wants, concerns, and suggestions with the practitioner.

13. to be advised as quickly as possible if a scheduled appointment time cannot be kept due to illness or emergency.

Similar rights adhere to the recipients of services from Licensed Clinical Social Workers and Licensed Professional Counselors. Please consult their respective licensure laws for the State of South Carolina for details.

Each client has the responsibility to:

1. Refrain from physical (and other) abuse of self, others, and property. Clients are responsible for repair or replacement of any property they damage in the facility.

2. Devote reasonable energy and time to therapy work. Therapy is generally "hard (emotional) work." For progress to occur, we recommend making your therapy a high priority in your personal life. Your therapist may regularly assign homework that is intended to help you learn about yourself, and doing your homework is expected to expedite your therapy and decrease your costs.

3. Fulfill contracted behavior.

4. Be honest with your therapist concerning your thoughts and feelings about your therapy and treatment.

5. Keep appointments as made. Your appointment time is reserved for you. Therefore, you will be charged for the appointment unless you give at least 24 hours advance notice. Exceptions may be made for emergencies and other extenuating circumstances.

6. Keep current in paying your fees (deductibles, co-payments, fee-for-service payments). You are required to pay your fee at the beginning of each session. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that occurred prior to the first visit to my office), session fees credited toward the deductible will be collected at the time of the session until the deductible payment is verified by the insurance company or third-party provider.

7. Inform those involved in the treatment plan about any changes to physical health, insurance plan, or ability to pay for contracted services.

8. Parents or caregivers are responsible to supervise the activities of children with respect to use of facilities, material, etc.