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OUTPATIENT SERVICE CONTRACT AND INFORMED CONSENT

Welcome to Anchor Counseling Centers (ACC)! This document contains important information about our professional services and business policies. Please read it carefully. Feel free to ask any questions that you might have so that you can enter into the agreement fully informed. Once you sign this, it will constitute a binding agreement between you and ACC.

ACC's Services
ACC offers mental health services, medication management, and speech therapy specifically designed to help you. Our expertise includes problems ranging from birth to death, and we are committed to providing the highest quality of services to our clients. Our purpose is to help you process and manage mental health symptoms and speech symptoms.

Appointments and cancellations
You are encouraged to schedule an appointment whenever you feel it will be useful for you to do so. Additional times will be negotiated with you as part of our treatment plan or at the time of your session.

Sometimes a therapist's schedule will change. We work to accommodate you, and if we are not able to, we will give you referrals internally (when possible) and outside of ACC.

Except for rare emergencies, we will see you at the time scheduled. The length of a typical session is about 45-50 minutes. Because this time is set aside just for you, it is important that you keep this appointment. Cancellations are accepted up to 48 hours prior to the time of the appointment. This will allow us to offer the time to another client. If a cancellation has not been arranged, the session will be a loss for someone else wishing to use that therapy time. These missed appointments will be billed at the rate of $75.00 per session. The No Show fee does not apply to Medicaid patients.

If you log in late to your scheduled appointment, your provider may not be able to accommodate a late appointment start and you may be subject to the $75 no-show fee. If you are having difficulty logging on for a telehealth appointment, it is the patient/guardian's responsibility to contact the therapist prior to the session start time. It is recommended that you log on 5-10 minutes early to account for troubleshooting technical difficulties.

Insurance
ACC is paneled with most major insurances. It is your responsibility to inform your therapist and/or ACC of insurance changes. If we notice your insurance has expired, we will email you asking for new insurance. If we do not hear back from you within 5 business days, you will be considered self-pay and a fee of $175 will be assessed for each denied session.

You are responsible for payment if insurance denies the claim or you choose not to use insurance. A fee will be assessed at the usual hourly rate for letters, reports, forms, etc. requested by the client.

By signing this Informed Consent, you assign any and all insurance benefits due and payable to you by any insurance policy to ACC for services rendered. Further, you authorize ACC to release to your insurance carrier any medical records or other documents requested by the carrier which are deemed necessary by the carrier to process payments of a claim. As a guarantor, you fully accept the services provided to the above-named client as full consideration for my signing of this document.

Costs for Services (Self-Pay)
In order to keep costs as low as possible, it is requested that you make payment at the time of each session, that is when services are rendered. Payment for services is the direct obligation and responsibility of the client. The fee for services is $175 per hour and this is considered "self-pay." This fee is charged for documentation, diagnosis, printed materials, reports, letters, consultation, travel time for "out of office" services, and telephone calls lasting longer than five minutes.

You will be billed for all the time spent with you or on your behalf. A credit card will need to be uploaded to the Patient Portal and will be charged at the time of the service.

Any legal consultation will be billed at $300 an hour directly to the patient. This includes phone calls, court appearances, letters, or providing documentation for legal purposes.

If you experience financial problems, please talk to us so that a mutually satisfactory payment schedule can be arranged.

Disabilities
The Bel Air, Cumberland, Eldersburg, Stevenson, and Sykesville offices are ADA accessible. While the Columbia and Frederick offices are on the second and third floors, we will make reasonable accommodations to ensure accessibility (telehealth).

Translator services are available upon request. If you need accommodations, please let the intake coordinator know at the time you schedule an intake to ensure your experience with ACC is comfortable.

Client Rights and Responsibilities
As a client of Anchor Counseling Centers, you have the right to seek alternate treatment at any time which can, and should be discussed with your provider. You also have the right to withdraw from treatment at any time, but potential risks such as depression, anxiety, and anger may occur. Other potential risks for engaging in therapy are sadness, anger, irritability, difficulty sleeping, and anxiety due to the therapeutic process. You also have the right to decline treatment, if part or all of your treatment is to be recorded for research or reviewed by another person.

ACC does not permit the recording of sessions by therapists or clients. Maryland is an All-Party Consent State. ACC will never record without explicit written consent (such as in the case of interns) and ACC does not consent to any recording (audio or visual).

ACC Responsibilities
It is the responsibility of ACC and the therapists to create a kind, open environment where clients and their families can feel safe to be themselves. ACC does not discriminate against sex, gender, race, religion, ability, etc. If you feel you have encountered any discrimination, please contact the owner of ACC, Whitney Thompson at WhitneyThompsonLCPC@gmail.com.

Confidentiality
Counseling/therapy services are best provided in an atmosphere of trust. In fact, according to the laws of the state of Maryland, whatever you tell a licensed provider cannot be revealed to anyone else without your written consent. The only **exceptions** to confidentiality are:

1. Court order,
2. You threaten harm to another person,
3. You threaten suicide or self-injury,
4. Indicate you are a perpetrator or victim of sexual and physical abuse.

In these instances, we are mandated to file a report or intervene in the situation to protect you or other potential victims. A client's case may be reviewed by colleagues for professional consultation purposes.

We also have the legal right to collect past due fees that are owed through collection agencies or small claims courts. In such instances, you will be notified in advance, and only information specifically pertinent to the collection process will be released.

Please feel free to ask for more detail about any of these policies. Please ask before signing if you have any questions about psychotherapy, medication management, or office policies. Your signature indicates that you have read the office and business policies and agree to enter therapy under these conditions.

I hereby assign any and all insurance benefits due and payable to me by any policy insurance to Anchor Counseling Centers (ACC) for services rendered. Further, I authorize ACC to release to my insurance carrier any medical records or other documents

requested by the carrier which are deemed necessary by the carrier to process payments of a claim. I understand that I personally guarantee to be financially responsible to pay Anchor Counseling Centers for any and all charges not covered by this assignment unless other arrangements have been made. As a guarantor, I fully accept the services provided to the above-named client as full consideration for my signing of this document. A copy of this document can be used in place of the original.

I understand by signing this contract I abide by the information laid out above.

Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Anchor Counseling Centers (ACC) mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. This is the same as an in-office visit.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. ACC utilizes secure, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to services through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my

request or at the direction of my counselor, I may be directed to “face-to-face” psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The above-mentioned people will all maintain the confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
8. I understand that my express consent is required to forward my personally identifiable information to a third party.
9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented healthcare facility in my immediate area.
11. I understand that different states have different regulations for the use of telehealth. In Maryland, telehealth may proceed if one or both of the involved parties are physically located in Maryland.
12. I understand it is my responsibility to ensure I am in a safe and private environment for the telehealth appointment. I understand that if I am in an environment with others present or within hearing distance, then I am putting my confidentiality at risk.
13. I understand that I will provide the technology to engage in telehealth.

Payment for Telehealth Services

Anchor Counseling Centers will bill insurance for telehealth services when these services have been determined to be covered by an individual’s insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, there is a fee of $175 per session. We will provide you with a statement of service to submit to your insurance company if you wish.

Patient Consent to the Use of Telehealth

I have understood the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client Email/Phone/Texting Informed Consent Form

You may give permission to your provider to communicate with you by email, phone, and text message (also known as SMS). This form provides information about the risks of these forms of communication, guidelines for email/phone/text communication, and how we use email/phone/text communication. It also will be used to document your consent for communication with you by email, phone, and text message.

1. **Risks of using email/texting:**

The transmission of client information by email, phone and/or texting has a number of risks that clients should consider prior to the use of email, phone and/or texting. These include, but are not limited to, the following risks:

A. Emails, phone calls/voicemails, and text messages can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

B. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.

C. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.

D. Employers and on-line services have a right to inspect emails sent through their company systems.

E. Emails, phone calls, voicemails, and texts can be intercepted, altered, forwarded or used without authorization or detection.

F. Emails, voicemails, and texts can be used as evidence in court.

G. Emails, phone calls, voicemails, and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party

2. **Conditions for the use of email and texts:**

The provider cannot guarantee but will use reasonable means to maintain the security and confidentiality of email, phone, voicemail, and text information sent and received. The provider is not liable for improper disclosure of confidential information that is not caused by the provider's intentional misconduct.

Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

A. ***The provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.*** The provider will respond to text messages, voicemails, and emails Monday-Thursday during the hours of 9AM-5PM, unless otherwise specified. Voicemails, text messages, and emails will not be answered outside of these hours or on the weekends/holidays.

B. Email and texting is not appropriate for urgent or emergency situations. ***If you experience a mental health emergency, please go to your nearest emergency room and/or call 911.***

B. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.

C. Email communication will usually be uploaded into the client's medical record. Texts may be uploaded and filed as well.

D. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.

E. The provider is not liable for breaches of confidentiality caused by the client or any third party.

F. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

G. Non-face-to-face evaluation and management of services provided by the provider to a client via telephone are subject to billing if initiated by an established client, or guardian of an established client.

H. It is the client's responsibility to update any changes in demographic information.

3. <u>Client Acknowledgement and Agreement</u>

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of cell phones, email, and/or texts between my provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that my provider may impose to communicate with me by email or text. By signing this form, I authorize the provider to send text messages to my cell phone regarding scheduling and treatment. I understand that standard text messaging rates will apply to any messages received. I also understand that I or the provider may revoke this permission in writing at any time. I agree not to hold the provider liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my cell phone number and or cell provider changes I will inform my provider.

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this

carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risks). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [other Therapists] and other patients) safer from exposure, sickness, and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Signing this form indicates that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom-free.
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time.
- You will wash your hands or use an alcohol-based hand sanitizer when you enter the building.
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit
- You will wear a mask in all areas of the office.
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or Therapists].
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID.

- If you have a job that exposes you to other people who are infected, you will immediately let me know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know.
- If a resident of your home tests positive for the infection, you will immediately let me know and we will then [begin] resume treatment via telehealth.

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
The practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, the other therapists, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or the other Therapists] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.