Treatment Agreement **Julie Shewman, LPC**

Confidentiality

When working together the information you share with me is kept in strict confidence with a few exceptions. By law, I am required to report to the proper authorities any person who is a danger to themselves or to others, or who is gravely disabled as well as all instances of suspected physical, sexual abuse and neglect of children, the elderly, or the disabled. My records can be subpoenaed by a court of law in criminal liability cases and those involving child custody disputes. At times I consult with other therapists. I do not use names or other identifying information as part of the consultation. I will endeavor to release and disclose the minimum information necessary for payment from insurance. All other disclosures require a signed Release of Information (ROI) which I can provide you upon request.

Payment Policy

Initial intake sessions may last up to 90 minutes and the fee for an intake session is $325.00. Typical individual sessions lasting 55-60 minutes are $195.00 per session. At times I offer sessions lasting 45 minutes for $175 per session. You are responsible for any balance not covered by your insurance provider. As a Licensed Professional Counselor, my services are covered by most insurance providers, however it is your responsibility to determine if mental health services are covered and who is covered to provide the services. Any unpaid balances will be your responsibility. Unpaid balances will be turned over for collections after 90 days unless other arrangements are made. At that time I reserve the right to terminate services and to refer you for services elsewhere. Any and all fees associated with collecting unpaid balances will be added to the total amount owed. Session fees may change with two weeks verbal advance notice; current rates are shown on my website.

Cancellation Policy

When an appointment is made, that time is set aside for you. **I require a 24 hour notice (one business day)** for cancellations. If cancellation is made with less than a 24 hour notice a $50 fee will be charged. If the appointment is not cancelled, a no show fee of $100 will be charged. At my discretion I may excuse a late cancellation due to extenuating circumstances provided the appointment is cancelled before the scheduled appointment time. Insurance does not cover for missed appointments. I reserve the right to discontinue services if there are frequent last-minute cancellations or no-shows, regardless of the reason. Therapy work cannot progress without regular and consistent attendance.

Emergency and After Hours

Messages can be left 24 hours a day on my confidential voicemail (907.538.4622). I will attempt to return all calls within one business day Monday through Friday, unless I am out of the office. I am not able to provide 24 hour a day emergency care. If you have an after hours emergency, please call the crisis intervention hotline at 907.563.3200, call 911, or go to your nearest emergency room. If your need exceeds what I can provide, we will need to discuss alternative plans.

Consent for Treatment

By signing below, I acknowledge I have read & I understand these policies and consent to receive therapy services.

Client Signature	**Printed Client Name**	**Date**
Parent/Guardian Signature (<18)	**Printed Parent/Guardian Name**	**Date**
	Julie Shewman, LPC	
Witness Signature	**Witness**	**Date**

Client Information

Today's Date: _____ **Julie Shewman, LPC**

Client Name	Date of Birth	Contact Phone #: ☐ Ok to leave voice messages ☐ Ok to leave text messages
Address (Street, City, ST, Zip)	Client Social Security Number	Client Employer Name and Position
Emergency Contact	Emergency Contact Phone	Relationship to client

Payment Responsibility – Who is responsible for payment

Name ☐ Client (If client go to next section)	Relationship to Client	Date of Birth
Address	Social Security Number	Primary Phone Number

Insurance Information (Please fill this out and bring your insurance card to first session.)

Insurance Company	Plan Name	**Name of Policy Holder** (Insured's name) ☐ Client ☐ Other:		
Insured's ID #	Insured's Employer	**Insured's Date of Birth**		**Insured's SSN**
Address for Claims	Claims Phone Number	Deductible	Copay	Amt pd to deductible

Secondary Insurance Information

Insurance Company	Plan Name	Name of Policy Holder (Insured's name) ☐ Client ☐ Other:		
Insured's ID #	Insured's Date of Birth	Insured's Employer		
Address for Claims	Claims Phone Number	Deductible	Copay	Amt pd to deductible

Other Relevant Information

Referral Source (Name and relationship to client)
Medications (name, dosage, frequency, purpose)

Julie Shewman, LPC
Fax 907.868.8692

4141 B Street, Suite 206
Anchorage, AK 99503

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: CLIENT GIVING CONSENT

→ **Printed Name of client:** _____

(if client is a minor)
→ **Printed Name of parent/guardian:** _____

SECTION B: Important Information - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will be giving your consent for my use and disclosure of your protected health care information. This information will be utilized solely for the rendering of mental health treatment and associated payment activities.

Notice of Privacy Practices: You have the right to read my Notice of Privacy Practices before deciding whether to sign this Consent. My Notice provides a description of the uses and disclosures I may make of your protected health information and of other important matters about your protected health information. A copy of my Notice of Privacy Practices will be provided upon request. I encourage you to read it carefully before signing this Consent.

As circumstances may dictate, and within the limits of the law, I reserve the right to change my Privacy Practices. If changes are implemented, they will be provided for your review. Said changes may apply to your Health Care Information which was previously obtained.

You may obtain a copy of my Notice of Privacy Practices, including any revisions of my Notice, at any time by contacting me.

Right to Revoke: You have the right to revoke this Consent at any time by giving me written notice of revocation submitted to the above address or Fax number. Please understand that revocation of this Consent will not affect any action I took in reliance on this Consent before I received your revocation.

By signing below I indicate that I have had full opportunity to read and consider the contents of this Consent form and this office's Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I further acknowledge that I have, on behalf of myself and/or any minor or incapacitated dependents, read and understand this office's Notice of Privacy Practices.

→ **Client (or parent/guardian) Signature:**_____**Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Please let me know if you would like a copy.

Julie Shewman, LPC
4141 B Street, Ste. 206 Anchorage, AK 99503
Phone: (907) 538-4622 | Fax: (907) 868-8692
Julie@julieshewmanlpc.com

Electronic Communication Consent

Email and text communication can provide an efficient and effective way to communicate regarding issues that are administrative, non-emergent, and non-urgent. Email and text can be used to request a non-emergent appointment, communicate about an existing appointment, and cancel a future appointment (at least one full business day in advance).

The following summarizes the information that you need to know in order to determine whether you wish to supplement your experience at my practice through electronic communications.

General Considerations

To the extent I am able, email and text communication will be considered and treated with the same degree of privacy and confidentiality as written medical records. Standard email servers, such as Yahoo, Gmail, or Hotmail, and text message servers are not secure which means that, although the accounts may be password protected, the email and text messages are not encrypted. These messages can potentially be intercepted and read by unauthorized individuals. Your email and text will only be used as a means of communication between you and me, never for marketing or any other purpose.

Healthcare Office Responsibilities

Every attempt will be made to respond to your email or text message within 2 business days (Monday through Thursday, excluding holidays), unless I am out of the office for a vacation or illness. If you do not receive a response from me within 2 business days, please contact me by phone. Copies of the emails and texts that you send me, and that I send you, may be incorporated into your records with my office, unless they are purely administrative in nature as determined by me. You are advised to retain copies for your files as well.

Client Responsibilities

Email and text messages **should not** be used for emergencies or time sensitive situations. In the event of a medical emergency, you should immediately call 911. For other emergent or time sensitive situations, you should contact me by phone. Email and text messages should be concise and be used for only administrative purposes such as confirming or cancelling an appointment. For issues more complex or sensitive please arrange for an office appointment.

By signing below I acknowledge that I have read and understood the above description of the risks and responsibilities involved with electronic communications. I acknowledge that commonly used email and text services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.

In consideration of my desire to use electronic communication, I hereby consent to electronic communication over non-secure email and text services. I have read and acknowledge the "Client's" responsibilities.

I understand that I may revoke my consent to communicate electronically at any time by notifying Julie Shewman, LPC, in writing. If I revoke consent, the revocation will have no effect on any actions Julie Shewman, LPC, has already taken in reliance on my consent.

I agree and release Julie Shewman, LPC, and the practice from any and all liability that may occur due to electronic communication over a non-secure network.

→ **Authorized email address (please print):** _____

→ **Printed Client Name:** _____

→ **Client signature:** _____ **Date:** _____

Julie Shewman, LPC
4141 B Street, Ste. 206 Anchorage, AK 99503
Phone: (907) 538-4622 | Fax: (907) 868-8692
Julie@julieshewmanlpc.com

I can send you an appointment reminder by email and/or by text. The appointment reminder will include only the date and time of your appointment and your service provider name. The appointment reminder service will not encrypt the messages. Health care information sent by regular e-mail or regular text could be lost, delayed, intercepted, delivered to the wrong address or phone number, or arrive incomplete or corrupted.

If you understand these risks and would like to receive an appointment reminder by email and/or by text, I need you to confirm you accept responsibility for these risks and will not hold me responsible for any event that occurs after I send the message.

☐ I would like to receive email appointment reminders at the following email address:

Authorized email address (please print): _____

☐ I would like to receive text appointment reminders at the following phone number:

Authorized phone number (please print): _____

Julie Shewman, LPC
4141 B Street, Ste. 206 Anchorage, AK 99503
Phone: (907) 538-4622 | Fax: (907) 868-8692
Julie@julieshewmanlpc.com

CREDIT CARD AUTHORIZATON FORM

Please complete all fields. You may cancel this authorization at any time by contacting Julie Shewman, LPC. This authorization will remain in effect until cancelled for as long as you are engaging in services.

Please note the late cancellation fee/no show fee will be charged to this card on the date the services were to be rendered. Insurance does not cover this fee and will not be billed.

Credit Card Information

Card Type: □ MasterCard □ VISA

Printed Cardholder Name (as shown on card): _____

Card number: _____

Expiration Date (MMYY): _____

Card CVN# (3 digit code on back of card): _____

House or P.O. Box # where billing statement comes: _____

Zip Code where billing statement comes: _____

By signing below I authorize Julie Shewman, LLC to charge my credit card above for agreed upon services and (if applicable) the late cancellation/no show fee. I understand that my information will be retained on file for future transactions on my account.

Cardholder Signature:_____ Date: _____

Julie Shewman, LPC
4141 B Street, Ste. 206 Anchorage, AK 99503
Phone: (907) 538-4622 | Fax: (907) 868-8692
Julie@julieshewmanlpc.com

Telemental Health Informed Consent p. 1 of 2

Provision of mental health services over electronic communications, also referred to as Telemental Health or Distance Therapy Services, can provide an efficient and effective way to engage in therapeutic services that have traditionally occurred face-to-face in an office setting. Telemental health is the delivery of mental health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client who are not in the same physical location.

The following summarizes the information you need to know in order to determine whether you wish to supplement your experience at my practice through telemental health.

Risks: Telemental health is a new delivery method for professional services, and is not fully validated by research. There may be potential risks, including some risks not currently recognized. Among the known risks is the possibility the technology could fail during the session, the transmitted information could be unclear or inadequate due to technical issues, and the information could potentially be intercepted by unauthorized person(s). It is also possible that security protocols could fail, resulting in a breach of privacy of personal health information (PHI).

Unauthorized Access to Electronic Transmissions: To the extent Julie Shewman is able, telemental health sessions will be considered and treated with the same degree of privacy and confidentiality as in-office sessions. However, telemental health has some limits to confidentiality as a result of the electronic means required to provide the service. These services rely on technology which allows for greater convenience in service delivery. There are risks in electronic transmission of information including, but not limited to, breaches of confidentiality, theft of PHI, and disruption to sessions due to technical difficulties.

Location: Julie Shewman is a licensed professional counselor in the state of Alaska, license #106477. Practice is limited to clients in the state of Alaska at this time.

Records: In accordance with state law, client records are maintained and archived for a period of seven (7) years following termination of counseling services as identified by the last therapeutic session of record.

Limits of Confidentiality: Confidentiality is also as defined in the client treatment agreement.

Potential Limits Impacting Service Delivery: When providing distance therapy services, a variety of issues may impact service delivery. These include, but are not limited to: time zone differences (I am located in the Alaska Time Zone, GMT-9); differences in local customs, cultural and language differences may impact services delivered.

Insurance for Telemental Health or Distance Therapy: In 2016, Alaska enacted a law expanding the use of telemedicine in the state. This law authorizes the use of telemedicine (also known as telemental health and distance therapy) in certain clinical practices including counselors. In addition, Alaska enacted a law requiring insurance plans in Alaska to cover telemental health services the same as in-person mental health services and without the need for a prior in-person visit between the health care provider and patient. As a Licensed Professional Counselor, my services are covered by most insurance providers, however **it is your responsibility to determine if outpatient out of network mental health and telemental health services are covered by your insurance plan**. Ultimately you are responsible for any balance not covered by your insurance provider.

Client initials/date

_____/_____

Emergency or crisis procedures: In emergencies, in case of service disruption, or for other routine administrative purposes, it might be necessary to communicate by other (non-video) means.

Client alternative contact in emergency situations:

_____

Client alternative contact in non-emergency situations (if different):

_____

By signing below I understand my practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today. We will modify our plan as needed. As a result of the distance involved, some therapeutic interventions that my provider might provide in-person may not be available. I also recognize my provider will not be able to render any emergency assistance if I experience a crisis.

Emergency Care: I acknowledge that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

These are the names and telephone numbers of my local emergency contacts (including local physician; crisis hotline; trusted family, friend, or adviser).

_____ _____
Name and relationship Telephone Number

_____ _____
Name and relationship Telephone Number

_____ _____
Name and relationship Telephone Number

If a need for direct, in-person services arises, it is my responsibility to contact Julie Shewman's office for an in-person appointment or my primary care physician if Julie Shewman is unavailable. I understand an opening may not be immediately available in either office, or that due to distance involved it may be more appropriate for me to seek emergency care. Emergency care practitioners in my area I could contact include:

_____ _____
Name of emergency care provider in my community Phone number

I have discussed local support services that may be available in case of an emergency. I am aware my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

I acknowledge I have read and understood the above description of the risks and responsibilities involved with telemental health participation. With this knowledge, I voluntarily consent to participate in the telemental health treatment.

→ **Authorized email address (please print): _____**

→ **Printed Client Name: _____**

→ **Client signature: _____ Date: _____**