# Art Therapy for Healing, LLC

## Rosemary Barnes Pratt, ATR-BC, LPC

**2510 S. Brentwood Blvd., Suite 305 . Brentwood, MO 63144 . 314-403-2384 . www.arttherapyforhealing.com**

**Date of Authorization:** _____ **Counselor/Therapist:** _____

**AGREEMENT FOR PAYMENT/CONSENT FOR SERVICES**

The Standard Fee for a 45-50 minute therapy session is $120, and the Standard Fee for a 60 minute therapy session is $150. We have limited adjusted fees for those whose income cannot support the Standard Fee. There is a 24 hour cancellation policy and you will be charged a late Cancellation Fee. The Standard Cancellation Fee is $60, or your Adjusted Fee, if it is below $60. This is necessary because a late cancellation does not allow sufficient time to fill the cancelled hour. Please complete the following information on all pages, including the signature and date as requested, and return to your therapist.

Client Name_____ Date of Birth_____
Address_____
City_____ State _____ Zip_____
Phone (cell) _____ May we leave a message? ____ YES ____NO
(cell/work/other) _____ May we leave a message? ____ YES ____NO
Email: _____ May we leave a message? ____ YES ____NO
**Please note, Email correspondence is not considered to be a confidential medium of communication.*
Place of Employment: _____ Marital Status: _____
If Client is Minor, Guardian: _____ Person Responsible for Payment: _____
If Client is Student: ____ Full Time Student ____ Part Time Student ____ Employed Student
Who Referred you: ____ Friend/Relative ____Pastor ____Insurance ____Physician ____ Attorney ____Other: _____
Reason for referral
_____
_____
**Emergency Contact** _____ **Phone** _____ **Relationship**_____

Physician name_____Phone_____
Medications_____
Current Physical Health Issues_____
Psychiatrist name_____Phone_____
Current Medications_____
Past Medications (include dates)_____
Allergies _____
Have you worked with another therapist in the past? Yes or No
If yes, who and for what and how long? _____
Name _____ Phone_____ Service provided/Diagnosis_____
Name _____ Phone_____ Service provided/Diagnosis_____
(Note: I can only contact that person if you complete a release of information form; they will also need a signed release of information form to share information with me, per HIPAA.)

**Abuse/Neglect**

Do you have minor children? Y or N
Legal Guardian? Biological parents/ Mother/ Father/ Adoptive Are parents Married/ Divorced/Separated/ Other _____
Who does your child live with? _____
Does the Father have legal rights? _____ Does Mother have legal rights? _____
Have you ever been investigated by Division of Family Services? _____ If so, why?_____
Do you have a current open case with DFS? _____ Why? _____
If yes, Who is your caseworker?_____ Phone_____

**Additional Concerns**

What brings you in for therapy? _____
_____
_____
Describe any past or current significant issues in other immediate family relationships, medical concerns, emotional or behavioral concerns (sexual, physical, emotional abuse, drug, alcohol abuse)._____
_____
_____
_____
Please list any sleep problems: _____

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Please list any appetite/eating problems: _____
Please list types and amount of exercise per week: _____
Are you currently experiencing overwhelming sadness, grief, or depression? _____
If yes, for how long? _____
Are you currently experiencing anxiety, panic attacks, or have any phobias? _____
If yes, for how long? _____
Are you currently experiencing any chronic pain? _____
How many alcoholic drinks do you consume per week? _____
How often do you engage in recreational drug use? _____
If you are currently in a romantic relationship, how would you rate it (1-10, with 1 being poor and 10 being exceptional)? _____
What significant life changes or stressful events have you experienced recently? _____
If employed, do you enjoy your work? Is there anything stressful about your current work? _____
Do you consider yourself to be spiritual or religious? _____ If yes, describe your faith or belief. _____
What do you consider to be some of your strengths? _____
What do you consider to be some of your weaknesses? _____
What would you like to accomplish out of your time in therapy? _____
_____

Any other information you would like to share about yourself?

_____
_____
_____

**Payment Information:**

***Payment is due at time of service*** * Or, if monthly payments are arranged, payment is due at the beginning of each month. A $60 charge will be assessed for missed appointments or appointments cancelled with less than 24 hour notice. *Please give 24 hour notice to cancel an appointment. If no notice or cancellation is given your time slot may not be held and/or your therapy services may be terminated.

I agree to pay the established fee. Please refer to the "Financial Agreement" if interested in details about rates. The client (or guardian) is responsible for paying the agreed upon fee at the start or end of each session. If my insurance company covers out-of-network benefits, the client can be submit a receipt for possible reimbursement.

Adjusted Fee: In order to be considered for an Adjusted Fee, you will need to provide household income information in order to demonstrate financial need. This figure to include all sources of income (salary, child support, maintenance).

Gross Household Income: _____ Number in Household: _____

I would like to be considered for an Adjusted Fee: YES / NO. Based on your income, your Adjusted Fee is: $_____

Financial Responsible Party Name _____
Address: (if different from above) _____
Phone (home)_____ (cell)_____ (work) _____

**Insurance Information, if using**. (The office will need a copy of both sides of your insurance card.)

Primary Insurance _____

Insured Name_____DOB_____SSN#_____

ID# _____ Group _____ Employer_____

**Authorizations # (if required by insurance company):_____

**If I fail to obtain authorization, I am responsible for payment to Art Therapy for Healing, LLC for the denied session.

Secondary Insurance _____

Insured Name_____DOB_____SSN#_____

ID# _____ Group _____ Employer_____

**Authorizations # (if required by insurance company):_____

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**If I fail to obtain authorization, I am responsible for payment to Art Therapy for Healing, LLC for the denied session.

**INSURANCE BILLING:** ____**YES, ART THERAPY FOR HEALING, LLC WILL BILL MY INSURANCE, AS OF _____.**
____**NO,** I AM CHOOSING **NOT** TO HAVE INSURANCE BILLED, NOR WILL I SUBMIT IT TO INSURANCE AT A LATER TIME FOR REIMBURSEMENT.

**TERMS OF SERVICE**

1. I am responsible for obtaining all authorizations and for all charges not covered. I will communicate with the Insurance Company and Insurance Billing Representative of Art Therapy for Healing, LLC to verify benefits. I understand that I am responsible for charges not covered or reimbursed by the abuse agents. I understand there is a $25 fee for returned checks, along with paying for the amount of the returned check. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required and waive confidentiality for this purpose). If I have provided a credit/debit card on file with Art Therapy for Healing, LLC, I give permission to submit remaining charges not covered by Insurance, until further notice in writing.
2. I authorize Art Therapy for Healing, LLC staff to communicate with my Insurance Company for the purpose of claim verification and authorization for services, including a diagnosis code, and for my insurance carrier to release information regarding my coverage to Art Therapy for Healing, LLC. I authorize the release of any medical or other information necessary to process this claim.
3. My right to payment for all services is hereby assigned to Art Therapy for Healing, LLC. This assignment covers any and all benefits under private insurance, Medicare, other government sponsored programs, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Art Therapy for Healing, LLC.
4. Statement of Confidentiality: It is the policy of Art Therapy for Healing, LLC to protect the privacy of every client. Generally, no one will be given any information about either you or services furnished to you without your prior written authorization or consent. There are; however, some circumstances which require the disclosure of information without your consent. Briefly, these are:
    a. When mandated by State or Federal Law. (i.e. Suspicion or knowledge of child abuse/neglect or elderly/disabled abuse/neglect)
    b. When there is an imminent risk of serious threat of physical harm to self or others.
    c. When specifically ordered by a court of law.
5. I consent to all reasonable and ethical treatment deemed necessary and appropriate to address my current needs, as determined by my reported symptoms and/or treatment goals. I have agreed to treatment on a strictly voluntary basis, with the understanding that I may terminate treatment at will. I give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgement indicates. This consent is given by me for myself or me/us as parent(s) and/or guardian(s) of said client. I/We have legal power to consent to medical, psychological, and mental health assessment and treatment of myself or said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.
6. I agree to not hold the office space(s) of Art Therapy for Healing, LLC liable in any way.
7. **IN CASE OF EMERGENCY, CALL BEHAVIORAL HEALTH RESPONSE: 314-469-6644, LIFE CRISIS SERVICES: 314-647-4357, GO TO THE NEAREST EMERGENCY ROOM, OR CALL 911.** Your therapist will discuss these details with you as well.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read the terms of services, and agree to accept the terms.

_____ _____

Client Signature Date

_____ _____

Legal Guardian Signature Date

_____ _____

Witness Signature Date

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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HIPAA PRIVACY PRACTICES**

My signature acknowledges that I received a copy of the Notice of Privacy Practices for Art Therapy for Healing, LLC.

It is your right to refuse to sign this document. If you refuse to sign this authorization, your provider has the right to decide not to treat you or accept you as a client in this practice.

Client's Name: _____ Date of Birth: _____

Client's Signature: _____Today's Date: _____

Parent/Guardian Signature: _____ Relationship to Client: _____

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Client's Name: _____ Date of Birth: _____

**ACKNOWLEDGMENT OF RECEIPT OF CLIENT RIGHTS**

**ACKNOWLEDGMENT OF RECEIPT OF SOCIAL MEDIA POLICY**

My signature acknowledges that I received a copy of the Client Rights Document and the Social Media Policy for Art Therapy for Healing, LLC.

Client's Signature: _____Today's Date: _____

Parent/Guardian Signature: _____ Relationship to Client: _____

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## RELEASE OF INFORMATION AUTHORIZATION

Client Name: _____Date of Birth: _____ Age: _____

I authorize Art Therapy for Healing, LLC to release and obtain information with: _____

Address: _____

_____

Telephone: _____ Fax Number: _____

Information shall consist of duplicate records and/or verbal consultation concerning treatment and/or education.

Specifically:

_____All Clinical Records _____ Psychological Evaluation _____Medical History

_____Social History _____Discharge Summary _____PCP Contract Form

_____Treatment Plan _____Psychiatric Evaluation _____Mental Health Info

_____Intake Summary _____Other: _____

_____Health care information related to the following treatment or condition: _____

_____Health care information for the following date(s) of service: _____

The information is needed for the purpose of adopting a more comprehensive and integrated approach to my health care and maintaining continuity of care for this purpose only, unless otherwise permitted or required by law. This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. This authorization is terminated one year from the date of signature below, or from termination of services, whichever occurs first.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy of it. My initials indicate I have been offered a copy of this authorization to release medical records.

I understand that I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.

_____**I do** give my mental health provider permission to have contact with my primary care physician, psychiatrist, therapist or other provider.

_____**I do not** give my mental health provider permission to have contact with my primary care physician, psychiatrist, therapist or other provider.

Client Signature: _____ Date: _____

Witness: _____ Date: _____

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**HIPAA Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

**Your Rights: You have the right to:**

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act on your behalf
- File a complaint if you believe your privacy rights have been violated

**Your Choices: You have some choices in the way that we use and share information as we:**

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

**Our Uses and Disclosures: We may use and share your information as we:**

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

**Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. Under certain circumstances, I may feel I must deny your request, but if I do I will give you, in writing, the reasons for the denial. I will also explain your right to have our denial reviewed.

**Ask us to correct your medical record**

If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than myself. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and the denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

**Request confidential communications**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper or electronic copy of this notice at any time.

**Choose someone to act on your behalf**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

**Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

**Our Uses and Disclosures**

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you. For example, I may use PHI to diagnose and provide counseling service to you. I may also disclose your information in order to remind you of appointment times. I may disclose your information to any family members or significant others that you voluntarily decide to bring to and include in a therapy session. I may disclose your PHI, with the exception of identifying information, during professional clinical supervision and/or consultation, in order to ethically provide you the highest quality services.

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Your consent is not required if you need emergency treatment, provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent, but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you could I may disclose your PHI. We can also use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options or other health care services or benefits I offer.

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities. For example, I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**To avoid harm**

I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds). **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger. If disclosure is compelled or permitted by the fact that you tell me of a serious/ imminent threat of physical violence by you against a reasonably identifiable victim or victims.**

**Do research**

In certain circumstances, I may provide PHI in order to conduct medical and psychological research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement.** For example, I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel, and/or in an administrative proceeding. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**

**Report suspected abuse or neglect**

**If disclosure is mandated by the Missouri Child Abuse and Neglect Reporting Law.** For example, if I have a reasonable suspicion of child abuse or neglect. **If disclosure is mandated by the Missouri Elder/Dependent Adult Abuse Reporting Law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**Other Instructions for Notice**

- Effective Date January 1, 2016

Privacy Official: Rosemary Barnes Pratt, ATR-BC, LPC, www.arttherapyforhealing.com ; 2510 S. Brentwood Blvd., Suite 305, Brentwood, MO 63144; (314) 403-2384

- We never market or sell personal information.
- We will never share any treatment records without your written permission unless required to do so by law.
- We will request your permission to display your artwork in office or at other venues. Your identifying information will be covered up to protect your privacy.
- We do not do fundraising
- This notice applies to Art Therapy for Healing, LLC for art therapy and counseling services.

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**FINANCIAL AGREEMENT**

The following delineates information regarding payment for services rendered by Art Therapy for Healing, LLC.

**Standard Fees for Services**

Initial Telephone Consultation (15 minutes) ..... No Charge

Individual Session (45 minutes)..... $120.00

Individual Session (60 minutes) ..... $150.00

Late Cancellation Fee/Missed Session..... $60.00

Each client is responsible for managing the finances of the therapy relationship. Payment is due before the beginning of each session, or at the beginning of each month, for monthly billing. A receipt will be provided for each payment received. If there is any concern about the standard fees, please consult with me.

If requested, a monthly statement can be provided. This statement will delineate the following information regarding rendered services: provider name, provider license number, date, fee and payment, CPT code, and diagnosis (if you want this listed).

If you have a health insurance policy, it could provide some coverage for mental health treatment. It is strongly recommended that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administrator. Insurance companies require that I assign you a diagnosis in the course of treatment. I am not an in-network provider on all insurance company panels; thus, you (not your insurance company) are responsible for the full payment of my fees. You may choose to submit the monthly statement to your insurance company for possible out-of-network reimbursement. I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled, though I cannot guarantee the receipt of any benefits. A yearly statement will be presented or mailed to you, if requested.

24 hour notice is required to cancel an appointment without the assessment of a Late Cancellation Fee. If less than 24 hour notice is given, then the client will be responsible for the Late Cancellation Fee. Emergencies or exceptional circumstances will be considered. You may cancel an appointment by calling (314) 403-2384 and leaving a voicemail.