Arrow Counseling Services, LLC
POLICIES & PROCEDURES

Welcome and thank you for choosing Arrow Counseling Services. Our desire is to provide professional counseling services to children, families, adolescents and adults. Please read the following information carefully and sign/initial where indicated. Your signature will provide us with your understanding of office policy and procedures as well as your consent for treatment.

INFORMED CONSENT, CONFIDENTIALITY & RELEASE OF INFORMATION

Information provided during therapy sessions is held in the strictest of confidence. Case notes will not be provided to a third party without written authorization from you. However, there are limits to confidentiality. These limits include:

> * **Duty to Warn & Protect** - When a client discloses intentions or a plan to harm another person, the mental health professional is required warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
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> * **Abuse of Children & Vulnerable Adults** - When there is suspicion of abuse or neglect of a child, elderly person or disabled person, the mental health professional is required to report this information to the appropriate social service agency and/or legal authority.
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> * **When a court order exists to release information**
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> * **Supervision and Treatment Purposes** - As Owner of Arrow Counseling Services, Carla Arrow or her designee, will have access to all medical treatment records, for the sole purpose of clinical consultation and administrative audits. No information in the records will be released without prior written authorization.

PARENTS & MINORS

* For parents of minors, please understand that therapy being provided is not for custody purposes or disputes. Therefore, you knowingly and freely waive your right to request the release of information to your attorney or any other officer of the court/or custody purposes. Please be aware that we are not custody experts.

* Patients under the age of 18 who are not emancipated from their parents should be aware that the law may allow parents to review their child's treatment record. Due to privacy in psychotherapy being essential to successful progress especially with teenagers, it is at times, our policy to request an agreement from parents that they provide consent to waive access to their child's records. If agreed, at scheduled appointments parents will only be provided with general information regarding the progress of the child's treatment. A summary of the child's treatment will also be provided at the conclusion of the child's treatment. Any other communication will require the child's consent, unless the therapist feels that the child is in danger or is a danger to someone else, in which you as the parent would be immediately contacted. Prior to communicating any information with parents, we will discuss the matter with the child and handle any objections as appropriate.

PROVISION FOR CRISIS MANAGEMENT

* When crises occur that require hospitalization and stabilization of an extreme nature or of extreme distress, sessions may run longer than the normal 50-60 minutes. A provision has been established that after the first 60

minutes of crisis therapy additional sessions can be added on in 30 minute increments. This would typically be used when immediate hospitalization is required, or following a traumatic event that has destabilized the family or client. This is a provision by the insurance companies to reimburse for these unexpected crises. Billing will be processed according to each individual's insurance carrier's procedure.

* After hour emergency phone calls can be directed to our on-call emergency phone line at 717-758-8075. This phone number should only be used after normal business hours (M-F 8am-8pm and Saturday-Sunday) for emergencies that are not life threatening and do not require medical or crisis management. This phone number should not be used to reschedule appointments or contact your therapist to discuss matters that can be handled during the next business day.

TELEPHONE CALLS

* Occasionally the need to talk to your therapist may arise between normally scheduled sessions. Your therapist will respond to your call within 48 hours during his or her normal business hours. If you require more than a brief (e.g., 5 minute) conversation and you decide your issue or concern cannot wait until your next scheduled session, you will be billed $2.00/minute.

LENGTH OF SESSIONS

* Psychotherapy sessions are 54 minutes in length beginning at your appointed time and concluding after 54 minutes. Since your therapist has sessions scheduled after yours, the sessions must end at the appointed time regardless of when you arrive, and the full session fee will be charged. Therefore, it is to your benefit to be on time. Additionally, due to the nature of the work we do, there may be times when crisis arises and may result in the need to reschedule your appointment. We will make every effort to reschedule your appointment at a mutually agreed upon time. We ask your understanding when these rare occasions occur.

FEES

All services are billed at a per session rate. All co-payments, co-insurance payments, or private payments are due at the time of services. The current fee schedule is as follows:

* Initial Assessment Session: $200

* Individual Session (60 minutes): $150

* Couple or family session $150

* A sliding scale is available for those with financial difficulties, who do not have insurance (based on gross income and number of household members)

* No Show or late cancellation fee is $70 per session missed.

* Emergency cancellations less than 24 hours in advance will result in a $70 cancellation fee.

* Phone Calls from a client regarding clinical treatment content will be $2 a minute.

* For copies of medical records that are not able to be sent electronically via secure email fees will be: $.10 per one sided page and $1 per minute records preparation fee. The therapist will inform the client of the amount due for copies of medical records and payment will need to be received before copies of records are released.

* Any forms such as Disability, FMLA, etc., that are not filled out during the client's session will be charged at $2 a minute. The therapist will inform the client of how long it took to fill out the forms and payment will need to be received before forms are released.

* Court appearances are billed at $250 per hour that the therapist is required to be present.

* If the court hearing is outside of the York County Court area, the therapist's time to travel to the court hearing will be paid at $60 per hour. Any mileage over the amount that it would take the therapist to get from their home to Arrow Counseling Services will be paid at $.56 a mile.

* Any letters outside of coordination of care will be billed at $2 minute.

***NOTE:** When an appointment is scheduled, that time is reserved for you. If the appointment is missed or cancelled without sufficient notice, the therapist is unable to make use of that time. Please note that most insurance carriers do not reimburse fees for cancellations or missed appointments. Therefore, it will be the client's financial responsibility to make late cancel or no show fee payments.

SCHEDULING POLICY

In most cases, issues are not resolved in one therapy session. At the time of the initial appointment the therapist will usually establish the next appointment within one week. Appointment frequency is based on the therapist's assessment of what will be most effective and productive for you. During the initial phase of therapy, ongoing appointments are generally scheduled weekly or bi-weekly. Please note:

*If you cancel two appointments within a 3 month period, we will only be able to schedule one appointment at a time.

*If you late cancel or no show 2 or more times within a 6 month period, you will not be able to schedule in advance and you may be discharged from services. You will be placed on a cancellation list and will be called when your therapist has openings in his or her schedule.

If you cancel any appointment with less than 24 hours notice, the cancellation fee always applies.

BILLING & FINANIAL RESPONSIBILITY

* For health insurance holders, Arrow Counseling Services participates with a number of insurance providers. Please contact your insurance carrier prior to your first appointment to verify the following information:

* ls my Arrow Counseling Services therapist a participating in network provider?

* Does my insurance policy provide mental health benefits?

* Do I have a co-pay or co-insurance?

* Do I have a deductible that needs to be met?

* Do I need pre-authorization for services?

Please be able to provide this information prior to your first appointment. If your insurance requires a preauthorization, please make sure that the authorization information is given to the office staff prior to your first appointment to ensure your eligibility to be seen at your scheduled intake appointment time.

INSURANCE BILLING

* We will bill your provided healthcare insurance company and follow the contractual obligations that exist between your healthcare insurance company and our agency. Our office will only file an insurance claim if our office is a participating provider. Otherwise, it will be your responsibility to seek reimbursement from your insurance company, and you will be responsible for payment in full to Arrow Counseling Services. You have a responsibility to be aware and understand the provisions of your healthcare insurance policy. Please remember that insurance and behavioral health plans are a method of reimbursement for services, and not a substitute or guarantee of payment. Please understand that insurance is a contract between you and your insurance carrier. Therefore, in the event that your insurance company does not reimburse for services rendered as anticipated, you will be responsible for all incurred fees and expenses and will be billed accordingly.

* For seIf-pay clients, or those with non-participating or out-of-network plans, full payment is expected at the time of service. Our office will be glad to provide you with an invoice to potentially obtain reimbursement.

* Payment for services may be made by cash, check, credit card or HSA account cards. Please make all checks payable to Arrow Counseling Services, and provide payment to the office manager before your session starts. If the office manager is not on site, please have your check written ahead of time so that your full session time can be designated for therapy. Please make every attempt to have exact amount for cash payments. Change may not be able to be provided. Returned checks will result in a charge of $35.00 to cover bank charges and processing fees.

***NOTE:** Again, all payments are expected at the time of service. If you do not have your payment on the date of service, we reserve the right to reschedule your appointment.

EMERGENCY TREATMENT

* In the event of a psychiatric emergency, do not phone your therapist or Arrow Counseling Services office. Instead, call 911 or go immediately to your local emergency room. Then you should call your therapist. If your therapist is unable to be reached, please leave a message and your therapist will contact you as quickly as possible.

*In case of an emergency during a therapy session, if you become unable to communicate or need medical assistance, the person you have indicated as your emergency contact on your Intake Form will be contacted, and by signing this form, you authorize Arrow Counseling Services to do so.

TERMINATION

* In the event you choose to terminate counseling with ACS it is our policy to consider anyone terminated if, the therapist or the office has not had any contact with you by phone, email or written correspondence and you have not continued with the therapy process for 30 calendar days after your last scheduled appointment. If after the 30 days you would like to schedule a follow up appointment, please call the office.

*If we do not hear from you by the end of the 60 day period as prescribed, we will assume that you are not interested in pursuing counseling at this time and we will close your file.

*If after file closure, your circumstances change and you wish to pursue counseling, we would welcome the opportunity to work with you. However, once your file is closed, you will have to go through the intake process again in order to schedule an appointment.

Community Resource Guide and Re-engagement with Services if needed

* The Community Resource Guide is a handout that each client receives which helps give them other options for support within the community. You are able to access these resources and opportunities at any time during and after treatment. Specific instructions are also given on how to reengage in services at Arrow Counseling Services LLC if needed. By signing this form, you are signifying that you were given a Community Resource Guide with instructions on how to reengage in services if needed.

NOTICE OF PRIVACY PRACTICES

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

l. My Duties

* The privacy and confidentiality of your health information is very important and I am committed to protecting it to the extent that I can, consistent with law and ethical standards. Your health information includes records that I create and obtain in order to provide care to you. For example, it includes a record of your symptoms, examination and test results if applicable, diagnoses, summary of treatment and referrals. Bills, insurance claims and other payment information is also included in the record of your health information.

* This Notice tells you about the different ways I may use and disclose your health information. lt also describes your rights and my obligations. I am required to: maintain the privacy of your protected health information as required by law; provide you with this Notice of my legal duties and privacy practices with respect to your health information that I collect and maintain; and follow the terms of my Notice that is currently in effect.

ll. Uses and Disclosures of Protected Health Information - Payment, Treatment and Health Care Operations

* Under federal law, I am permitted to use and disclose personal health information without authorization for treatment, payment and health care operations. However, state law or the ACA's Code of Ethics may require me to obtain your express authorization before disclosing certain portions of your record and protected health information. I may also choose to require your release of information in certain circumstances. Treatment: For example, I may discuss certain aspects of your counseling with your psychiatrist in order to provide the best treatment and medication for you. Likewise, your psychiatrist may discuss certain medication management issues with me so I can collaborate in treatment. Payment: If your health insurance company needs more information for payment than what is printed on your receipt, I will provide only the minimum amount of information necessary for the insurance company to process the claim. This may include the diagnosis and explanation of care provided.

III. Other Uses and Disclosures of Protected Health Information

Besides use and disclosure for treatment, payment and health care operations, I may use and disclose your personal health information without authorization for the following purposes:

> * **Abuse, Neglect or Domestic Violence**: I may disclose protected health information about you to a state or federal agency if I am required or permitted by law to report child or vulnerable adult abuse or neglect or domestic violence. When possible, and as consistent with my professional judgment in order to avoid harm to you or others, I will inform you of the need to make such a disclosure.

* **Judicial or Administrative Proceedings:** I may disclose health information about you in the course of a judicial or, administrative proceeding as required by law. For example, if a court orders me to release information, I must generally comply with the order. In some circumstances, I may be required to turn over information in response to a subpoena. If I receive a subpoena for your records, I will attempt to contact you and/or your attorney if that is feasible. Your attorney may be able to file a motion which will lead to a court order.

* **Law Enforcement:** If authorized or required by law, I may release health information to law enforcement officials. For example, I may release information to help identify a suspect or fugitive or report a crime related to a medical emergency.

* **Health Oversight Activities:** I may disclose health information about you to governmental, licensing, auditing or health care accrediting agencies where authorized or required by law. For example, information may be released to the state licensure board if a complaint is filed against me.

* **Appointment Reminders and other Health Services:** I may contact you to remind you of appointments or to inform you of treatment alternatives or other options and services that may be of interest to you.

* **Prevention of Serious Threat to Public Health or Safety:** In accordance with law and ethics, I may use and disclose health information about you to prevent or minimize the risk of a serious and imminent threat to your health and safety or to the health and safety of another person or the public.

* **Minors:** If you are an unemancipated minor under the law of the state of Pennsylvania, I may, in certain circumstances, disclose health information about you to a parent, guardian or other authorized person, in accordance with law and ethics.

*** Parents:** If you are the parent of an unemancipated minor, I may disclose health information about your child to you in certain circumstances. For example, if I must legally obtain your consent in order to treat your child, when you are acting as your child's "personal representative" under law, I may disclose health information about your child to you. In other circumstances, such as when your child is legally authorized to consent to treatment without a separate consent from you, and where the child does not request that you act as his/her "personal representative", I may not disclose health/mental health information about your child to you without your child's authorization.

*** Personal Representative:** If you are an adult or emancipated minor, I may disclose health information about you to a "personal representative" authorized to act on your behalf in making health care decisions.

*** Research and Related Activities:** I may disclose health information about you for research purposes in accordance with my legal and ethical obligations. Additionally, federal law allows us to create a "limited data set" which does not include information such as your name, address, Social Security number. This limited data set may be shared with those who have signed a contract promising to protect the privacy of the information and to use it only for research, health care oversight and health care operations.

*** Worker's Compensation/ Employee Assistance Program:** I may disclose health information about you for worker’s compensation or employee assistance program as authorized or required by law. These programs provide benefits for certain work-related illnesses and injuries or employee related mental health issues.

*** Required by Law:** I may disclose information about you when required to do so by federal, state or other applicable law.

*** Authorization Required for Other Uses or Disclosures:** I will obtain your written authorization for any other use or disclosure of your protected health information. You have the right to revoke any authorization, in writing and in accordance with this Notice, to the extent that action has not been taken in reliance on the authorization. Psychotherapy notes are not among the records that you may, by law, review or copy unless I believe it is in your best interests to access them. I will be happy to discuss the issue of psychotherapy notes with you if you have any questions.

IV. Your Rights Regarding Health Information

You have certain rights regarding health information that I create and maintain about you. These rights include:

*** Right to Inspect and Copy**. With certain exceptions (such as psychotherapy notes as described above, information collected for certain legal proceedings and health information restricted by law), you have the right to inspect and/or receive a copy of your records. If I am unable to accommodate your request, I will inform you in writing of the reason for the denial and your right if any, to request a review of the denial. I may charge you a reasonable fee for copying your records.

*** Right to Request Communication by Alternative Means**. If you would like me to communicate with you in a certain way (e.g., by leaving a message on your office phone number) or at a certain location (e.g., home only), I will make efforts to accommodate such requests for confidential communications as long as they are reasonable. I may request that you give me an alternative means to reach you if there is an emergency. If I am unable to contact you using your requested means, I may contact you using any information I have.

*** Right to Request Restrictions.** You have the right to request that I restrict or limit certain uses and disclosures of information. You may be asked to submit this request in writing. However, I am not required to agree to your request. I will let you know whether I am able to honor your request.

***Right to Receive a Paper Copy of this Notice**. You have the right to request a paper copy of this Notice at any time, even if you have agreed to receive it electronically.

In order to make any requests or exercise any rights set forth above, you must submit your request in writing to:

Carla V. Arrow, MS LPC NCC
1427 East Market Street
York, PA 174O3

You may also contact Carla Arrow by phone or e-mail during normal office hours.
717-755-O011 (ph) or Carrow@ArrowCounselingServices.com (email)

V. Questions or Complaints

* If you believe that your privacy rights have been violated, you may file a written complaint and address it to Carla V. Arrow (listed in section IV above). If that does not satisfy your concern, you may complain to the Secretary of Health and Human Services (HHS). Instructions for filing a complaint with the appropriate office for your region can be found at http://www.hhs.gov/ocr/howtofileprivary.pdf. Alternatively, you may call 1-800-368-1019 and request instructions for filing a complaint. There will be no retaliation for filing a complaint.

VI. Future Changes to this Notice and My Privacy Practices

* I reserve the right to amend the terms of my privacy practices and policies and this Notice. If this Notice is revised, the changed terms will apply to all health information about you, including information obtained before the effective date of the revised Notice. Any materially revised Notice will be distributed to all clients, posted in my waiting area and posted on my website.

CLIENT RIGHTS AND RESPONSIBILITTES

As a client of Arrow Counseling Services, you have the following rights:

* To be treated with dignity and respect at all times. You will not be subjected to harsh or unusual treatment or be deprived of any civil rights while a client at Arrow Counseling Services;

* To expect that a licensee has met the minimal qualifications of training and experience required by state law;

* To examine public records maintained by the Board and to have the Board confirm credentials of a license.

* To obtain a copy of the Code of Ethics;

* To report complaints to the Pennsylvania State Board of Social Workers, Marriage and Family Therapists and Professional Counselors;

* To be informed of the cost of professional services before receiving the services;

* To be assured of privacy and confidentiality while receiving services as defined by rule and law, excluding the following exceptions:

* A Reporting suspected child abuse;

* Reporting imminent danger to client or others;

* Reporting information required in court proceedings or by client’s insurance company, or other relevant agencies;

* Providing information concerning licensee case consultation or supervision; and

* Defending claims brought by client against licensee;

* To be free from being the object of discrimination on the basis of race, religion, gender; or other unlawful category while receiving services.

As a client of Arrow Counseling Services, you have the following responsibilities:

* To provide accurate and complete information concerning your present complaints, present/past medical/personal history and other matters relating to your current condition and life circumstances.

* To make it known to the therapist whether he/she comprehends clearly the course of treatment and what is expected from him/her.

* To read all handouts: Policies & Procedures, Client Notice of Privacy Practices, Client Rights and Responsibilities, and Client Release of Information Forms.

* To keep appointments and notifying the therapist at least 24 hours in advance if you are unable to make your appointment.

* To adhere to treatment recommendations. While entering into therapy is voluntary during the course of your care, your therapist will make recommendations that are specific to your presenting problem and circumstance. While there are benefits to following these recommendations, choosing not to adhere to

them could result in consequences. Those consequences will be discussed in greater detail during the session.

* To pay all fees incurred for treatment services at the time of service.

Our desire is that your experience with Arrow Counseling Services will be helpful and productive for you. If you have any questions regarding these policies and procedures or other aspects of your relationship with us, please discuss them with your therapist or call the office at 717-755-0011.

As a client of Arrow Counseling Services, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Arrow Counseling Services. I also acknowledge that I have read and have been given a copy of all Policies and Procedures including my consent for treatment by Arrow Counseling Services.

Client Signature: ____ Date: __________________

Client Signature: ____ Date: __________________

This Notice was effective from 11/1/2007 and updated 01/01/2019.