Capital Valley Counseling Associates, LLC
8 Centre Street, Suite 2, Concord NH 03301
603-228-7300 Fax 603-228-7301
www.cvcanh.org

Registration Packet

Welcome to Capital Valley Counseling Associates, LLC. We are pleased that you are interested in our services and look forward to the opportunity of working with you. We know that counseling can be beneficial, and we strive to create a welcoming and comfortable environment here.

The first visit with your therapist will consist of both a basic overview of how we work professionally, and allow you the opportunity to discuss the issues leading you to treatment. To allow us to make your first visit most productive, **we ask that you please take the time to complete the following**:

- Complete, sign and bring this Registration Packet and the Adult or Child Intake Forms packet with you to the first appointment. All are available on our website under the Forms tab.
- Contact your insurance carrier to ensure you understand your benefits and coverage including your copayment, deductible and Medical Spending/Health Savings Account balance.
- Please bring the Intake packets, insurance information, insurance card and copayment to your first appointment.

Your therapist will explain our policies including payment procedures during your first appointment. **Payments for deductibles and copayments are due at the time of service. Capital Valley Counseling accepts personal checks, cash or credit card.**

Parking is available on Centre Street in front of our office and on Main Street. Free parking is available on State Street. Although Capital Valley Counseling does have a small parking lot, this lot is reserved for building tenants. We encourage you to allow time to locate a parking space prior to your appointment.

**The entrance to our office is located on the side of the building, adjacent to the parking lot. We are located on two floors. There is a staff directory in the hallway upon entering the building. Unfortunately, our offices are not handicapped accessible – there are stairs both outside and inside the building.

We sincerely welcome you and hope your experience with us is rewarding and fulfilling.

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Consent to Treatment

I do hereby seek and consent to take part in treatment with the CVCA therapist named below (and/or provide my consent for my child to receive psychotherapy from the therapist named below). I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my (or my child's) best interest. I agree to play an active role in the treatment process.

I understand and accept the following:
Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, and frustration, loneliness, or helplessness. Psychotherapy often requires recalling or processing unpleasant aspects of your life. Psychotherapy has also been shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, to better relationships, and resolution of specific problems. Although your CVCA therapist will work hard to help you achieve your goals in therapy, there can be no guarantees made about the success of treatment.

I am aware that I may stop my treatment with this therapist at any time. I understand that in some circumstances there may be adverse consequences for me if I choose to stop treatment. For example, if my treatment has been court-ordered, I will have to answer to the court. I understand that my therapist will help me transfer to another therapist if I so choose.

NOTICE OF PRIVACY PRACTICES

This notice describes how you can access your personal medical information and how we may use and disclose it to provide you with services. *Please review it carefully*. If you have any questions about this notice, or the practices it describes, please discuss them with your therapist, or contact our Privacy Coordinator, at (603) 228-7300.

Our Commitment to Privacy

The therapists at Capital Valley Counseling Associates, Inc. (CVCA) are committed to ensuring the privacy and confidentiality of the Personally Identifiable Protected Heath Information (PHI) that is created in the course of your treatment. Confidence in the privacy of the sensitive information that clients share with us promotes partnership, honesty, and open dialogue, and facilitates treatment success.

The therapists at CVCA take steps to ensure that only those individuals who have a legitimate need to access your health information may do so. All CVCA staff and consultants are required to follow the policies contained in this notice. CVCA is required by law to maintain the privacy of your personally identifying health information. Any revision of the law or of the policies contained herein will effect the health information already contained in the record, as well as any information we receive in the future. Any revisions of this notice will be posted in our offices and will be made available for you upon request.

How We Will Use and Disclose Your Health Information

The following describes in general the different ways we may use or disclose your health information.

• **Treatment**: We will use and disclose your health information to provide and coordinate your treatment. CVCA may, at times, disclose your health information among members of its staff in order to carry out professional consultation so as to ensure quality treatment and, if necessary, in order to provide crisis services. For example, if you have called in crisis and your therapist is not available to take your call, another therapist may need to assist you and access your record.

• **Payment**: We may use or disclose your health information so that the services you receive are billed to, and payment is collected from, you, your health plan, or another third party. For example, we may need to disclose health information to your health plan to obtain authorization for additional visits with your therapist.
• **Operations**: We may use and disclose health information about you as is necessary to run our organization and make sure that clients receive quality care. For example, we may use and disclose information in the contexts of individual or group supervision of staff.
• **Quality Assurance**: We may use and disclose health information within our staff as necessary to review the quality of the records the therapists maintain and the clinical quality of the services provided. For example, your therapists record of your treatment may be reviewed by other CVCA staff for accuracy, completeness, and clinical appropriateness.
• **Business Associates**: We may use and disclose your information to companies and professionals such as our accountants, bookkeeper, or attorneys that assist us in running our operations. Contracts with these associates assure that the privacy of your health information is protected.
• **Individuals Involved in Your Care**: We may provide health information about you to someone whom you have identified as a caregiver or emergency contact. In an emergency, we may use and disclose your health information to notify a family member or other person responsible for your care of your location, general condition, or death. We may also use or disclose your health information to an entity assisting in disaster relief to inform you family about your condition.
• **Disclosure Required by Law**: We will disclose health information about you when required to do so by federal, state, or local law such as a court order or search warrant, or a report of abuse, neglect, or exploitation.
• **Averting a Serious Threat to your Health or Safety**: We may use or disclose information about you when necessary to prevent a serious threat to your health or safety or to the health or safety of others.
• **Public Health Activities**: We may disclose health information about you as necessary for public health activities. For example, we may be required by law to make a report to public health authorities to prevent or control a disease.
• **Health Oversight Activities**: We may disclose health information about you to a state or federal health oversight agency for monitoring, licensing, auditing, inspection, or investigation activities which are authorized by law.
• **Law Enforcement Activities**: We may disclose health information to a law enforcement official for law enforcement purposes when the information is needed to identify or locate a missing person, to report a death that may be the result of criminal conduct, or to report criminal conduct occurring on our premises.
• **Medical Examiners or Funeral Directors**: We may provide health information about clients to assist in identifying deceased persons and to determine the cause of death in certain circumstances. We may also disclose health information about our clients to funeral directors as necessary to carry out their duties.
• **National Security**: We may provide health information about you to authorized federal officials for intelligence and other national security activities authorized by federal law. We may also disclose health information about you to authorized federal officials so they may conduct special investigations or protect the President or other authorized persons.
• **Workers Compensation**: We may disclose health information about you to comply with the state's Workers' Compensation Law.
• **Other Uses You Authorize**: Uses and disclosures not described above will generally only be made with your written permission, called an "authorization." You have the right to revoke your authorization at any time. If you revoke your authorization, we will not make any further uses or disclosures of your health information under that authorization, except to the extent that we have already taken an action you previously authorized.

<u>Your Rights</u>
• **Right to Read and Copy**: You may read or copy your health information including clinical and billing records and records from other providers included in CVCA's records. You may submit your request to your therapist or the Privacy Coordinator.
• **Right to Request Amendment**: For as long as CVCA keeps records about you, you have the right to ask us to amend any health information used to make decisions about your treatment. A request for amendment must be made in writing to your therapist or to the Privacy Coordinator indicating what information you believe to be inaccurate and why. If your request is granted, we will annotate the heath information in question. *Under no circumstances will we remove or destroy original documents in your clinical record.* We may deny your request if you ask us to amend health information that was not created by CVCA, that is not part of what we must maintain to make decisions about your care, that is not part of the information that you would be permitted to inspect of copy, or that is already accurate and complete.
• **Right to an Accounting**: You have the right to request that we provide an accounting or list of disclosures we have made after April 14, 2003, excluding disclosures that you authorized or which were for treatment, payment, or healthcare operations. You may submit your request in writing to your therapist.
• **Right to Request Restrictions**: You have the right to request a restriction on the health care information we use or

disclose about you for treatment, payment, or health care operations. You may also ask that any part or all of your health information not be disclosed to family or friends who may be involved in your care. You must request these restrictions in writing. *We are not required to agree to a restriction that you may request.* If we do agree, we will honor your request unless the restricted health information is needed to provide you with emergency treatment.

• **Right to Alternative or Confidential Communications**: We will normally communicate with you in person, by phone, by email, or by first class mail. We will accommodate all reasonable requests that we communicate with you only in a certain location or with a certain method. You may request such manner of communication in writing.

• **Right to Paper Copy of this Notice**: You can obtain a paper copy of this Notice of Privacy Practices at any time from your therapist or the Privacy Coordinator.

• **Confidentiality of Substance Abuse Records**: For individuals who have received treatment for substance abuse, the confidentiality of such treatment is protected by federal law and regulations.

• **Retention of Protected Health Information**: CVCA retains client records for 7 years following the termination of services. Retained records may be kept in their original format or may be transferred and stored on electronic media. Following the 7 year period, CVCA may absolutely destroy all files, notes, evaluations, and other client data without further notice to the client.

Questions, Concerns, or Complaints

If you have a question or believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services.

CVCA, LLC
8 Centre Street, Suite 2
Concord, NH, 03301
(603) 228-7300

Secretary, HHS
U.S. Department of HHS
Office of Civil rights
200 Independence Ave. SW
Rm. 515 F HHH Bldg.
Washington, D.C. 20201

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Capital Valley Counseling Associates, LLC.'s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact my therapist or Capital Valley Counseling Associates, LLC.

I acknowledge that I have read, understand and am in agreement with the above Consent to Treatment

Client Signature_____ Date _____

Therapist _____ Date_____

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Clients' Rights

Confidentiality

All communication between therapist and client is held in strictest confidence unless:

1. The client authorizes release of information to a specific person or treatment facility.
2. The therapist is ordered by a court to release information.
3. The client is believed to be a danger to self or others (e.g. actively planning suicide, homicide, or other damage to a person or to property).
4. Abuse/neglect of a child, incapacitated adult, or elder is suspected.

In 3 and 4, the therapist is required by law to inform legal authorities and/or potential victims.

5. If a client chooses to use his/her insurance, the insurance carrier is legally entitled to receive any and all records at its discretion. In order to bill and receive payment, we are required to provide a diagnosis and often to report a treatment plan, and progress toward stated goals.
6. The therapists at Capital Valley Counseling meet regularly for peer supervision and occasionally seek outside supervision. Any information shared in those meetings is subject to the same rules of confidentiality as in any therapy session.
7. In treatment of a minor, parents or legal guardians may have the right to review all records. This can often be counterproductive to treatment. Our policy is to discuss this with the parents and their children at intake and determine how such information will be shared.

Emergency Coverage

Clinicians at Capital Valley Counseling Associates, LLC. provide outpatient psychotherapy services. No face-to-face emergency services are offered after hours. Crisis related phone calls will generally be responded to within sixty minutes, either by your therapist or the on-call clinician. If you are experiencing a potentially life-threatening mental health crisis, you will need to contact the emergency service of your local community mental health center or proceed to the nearest hospital emergency room.

Your Relationship with Your Therapist

All members of our staff adhere to the code of ethics of their profession. Dual relationships (for example business, social, romantic and/or sexual) are ethical violations. Sexual contact between a psychotherapist and a client is never appropriate.

If a client has a problem with his/her therapist which cannot be resolved with the therapist, the client may request a consultation with members of the Capital Valley Counseling clinical team and/or may choose to end therapy. If requested, the client's therapist or members of the Capital Valley Counseling clinical team will offer appropriate referrals to other therapists. Unresolved complaints may also be addressed to the appropriate professional organization or to the New Hampshire Board of Mental Health Practice, 105 Pleasant Street, Concord, NH 03301.

I acknowledge that I have read, understand and am in agreement with the above.

Client Signature_____ Date _____

Therapist _____ Date_____

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Financial Contract / Fee Agreement

Client Name _____ Date of Birth _____ Date_____
Primary Insurance Co. _____ ID Number _____
Group Number _____ Authorization # _____
Secondary Insurance Co. _____ ID Number _____
Group Number _____ Authorization #_____
Subscriber _____ Subscriber's DOB _____
Subscriber's Address _____
Subscriber's Phone_____ Employer _____

Client Agreement: I agree to pay for the clinical services provided by Capital Valley Counseling Associates, LLC as listed in the attached **Fee Schedule.** **I agree to pay my co-payment/co-insurance/deductible at the time of service as stated below**. I understand that the amount I am paying is an estimate based on information regarding my insurance coverage and that I am responsible for knowing my insurance eligibility and benefits. I agree that I am responsible for payment of services not covered and/or not paid for by my insurance. I authorize payment of benefits to the provider or providers of services at Capital Valley Counseling Associates, LLC. I authorize the release of any medical or other information necessary to process my insurance claim.

I agree to pay the following Copayment/Deductible payment at each appointment: _____

Authorization for additional sessions on managed care insurance policies and payment of insurance claims requires that your therapist release to your insurance company or to its designated care manager clinical information about you, in writing or verbally, to substantiate the medical necessity of treatment. This information may include, but is not limited to, complete diagnosis, presenting problems and symptoms, relevant social and mental health history, goals of treatment, and progress toward achievement of goals. You may choose that this information not be revealed in which case your insurance company will cease covering your treatment and you will become personally responsible for the cost of your continued treatment.
A charge may be made for missed/cancelled appointments unless one business day's notice is given. This charge may be an amount up to the full fee for the session. Insurance companies do not pay for missed or cancelled appointment charges.

The fee for a missed/broken appointment is _____, payable prior to the next scheduled session.

There is a $20.00 fee for all checks returned for insufficient funds.

Any outstanding fees/overdue accounts of 90 days or more (from the date of service) may be reported to a collections agency and/or credit bureau or be addressed in court/legal proceedings. By signing this agreement, I consent to the release of any necessary information to such institution(s) as needed to seek reimbursement for overdue accounts.
I have read, understand and agree to abide by the provisions, terms and conditions of this agreement.

Client/Guardian: _____ Date: _____

Client/Guardian:_____ Date:_____

Therapist: _____ Date: _____

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Fee Schedule

Services covered by health insurance companies are usually paid at a contracted rate different than the rates stated below.

Therapist's Credentials …….. Master's Level (LCMHC, LICSW)

60 Minute Diagnostic Evaluation (initial session.) ……..…..…… $180.00

30 Minute (16 – 37 minutes) Individual or Family Psychotherapy …..……..….. $ 85.00

45 Minute (38 – 52 minutes) Individual Psychotherapy ….…… $150.00

45 Minute (38 – 52 minutes) Family Psychotherapy ……..……..……..... $150.00

60 Minute (53 – 60 minutes) Individual or Family Psychotherapy ……..$170.00

60 minute (53 – 60 minutes) Crisis Psychotherapy …….…..... $225.00

Missed / Cancelled Appointment with less than 1 business day's notice ……... $130.00

Case Management Services …… $ 30.00 per 15 minutes
- Case Management includes but is not limited to research, phone calls of a clinical or administrative nature, writing letters, offsite meeting preparation, consultation with third parties. **Most insurance companies do not cover this service**.

Offsite meetings with third parties (school meetings, etc.) ……..….. $150.00 / hour
Most insurance companies do not cover this service.

Court/Legal Matters …… $200.00 / hour
This fee applies to, but is not limited to case preparation, research, phone calls travel time, meetings, depositions, waiting time in any legal proceeding. (Your therapist reserves the right to require a retainer for services prior to engagement in any court/legal matters.) **Insurance companies do not cover this service**.

This Fee Schedule does not obligate a Capital Valley Counseling Associates, LLC. therapist to perform any/all of the above services. The performance of such services is at the sole discretion of the therapist and Capital Valley Counseling Associates, LLC. Therapist reserves the right to charge a pro-rated rate for sessions exceeding the scheduled appointment time.

I have read, understand and agree to abide by the provisions, terms and conditions of this Fee Schedule and the attached **Financial Contract**.

Client / Legal Guardian Signature: _____ Date: _____

Client / Legal Guardian Signature: _____ Date: _____

Therapist: _____ Date: _____

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TELEMENTAL HEALTH INFORMED CONSENT

I, _____, hereby consent to participate in telemental health with, **CAPITAL VALLEY COUNSELING ASSOCIATES, LLC** , as part of my psychotherapy.
I understand that my therapist will use the teleconferencing platform, Doxy.me, Zoom, or Psychology Today, I give my therapist permission to use my unencrypted email: _____ for telemental health, scheduling appointments, appointment reminders and between session contact. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at **603-228-7300** to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

8) I understand that my therapist is only licensed to practice in the state of NH.

Emergency Protocols

Please provide your location in case of an emergency. You agree to inform me if your location changes during your treatment with Capital Valley Counseling Associates, LLC. Please provide an emergency contact person who I may contact on your behalf in a life- threatening emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone:_____
_____
_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____
Signature of client/parent/legal guardian date

_____ _____
Signature of therapist date

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Credit Card Authorization Form

Please complete all fields.

Credit Card Type: VISA_____ AMEX_____ MASTERCARD____ DISCOVER ____

Card #_____

Name on Card: _____

Expiration Date:_____ Security Code: _____

Zip Code of Cardholder: _____

I, _____, authorize **Capital Valley Counseling Associates, LLC** to charge my credit card above for agreed upon expenses / charges as outlined in the Capital Valley Counseling Associates, LLC Financial Contract and the CVCA, LLC Fee Agreement - such charges including insurance deductibles, co-payments, co-insurance payments, missed appointments / last minute cancellations and any and all other fees as outlined in the Financial Contract and Fee Agreement. I understand that my information will be saved in a secure place for future transactions on my account.

Upon expiration of this credit card, I agree to immediately provide to Capital Valley Counseling Associates, LLC active credit card information. I acknowledge and agree that an expired credit card and / or overdue payments can result in cessation of counseling services until such time as these financial matters are rectified. I further acknowledge and agree that payments for all services are due and payable at the time of service.

Signature of Cardholder:

_____

Signature of Client (Parent / Legal Guardian):

_____

Date:

_____