Ann Arbor Counseling Associates
Phone: (734) 956-0051
Fax: (888) 976-6019
www.annarborcounselingassociates.com

PRACTICE DISCLOSURES

Client/Patient Rights

- Attending counseling is voluntary
- You have a right to terminate counseling at any time for any reason
- You have a right to work with a counselor who suites your needs and purposes

Some of the Risks of Counseling

- You might feel worse before you feel better
- Your current relationships might change
- Counseling doesn't work for everyone

What to Expect From Your Clinician

A professional counselor, Psychologist, or Social Worker can help provide insight, help identify problem areas, work with you to come up with solutions, and support you through your changes. Counseling is tailored to the individual and to the successful attainment of your goals. Your therapist might draw from various styles of therapy in order to help you reach your goals including Family Systems Therapy, Person Centered, and Cognitive Behavioral Therapy. Your therapist may also highlight strengths and encourage exploration of solutions to help you maintain your changes long term while developing confidence in your ability to solve problems in the future.

What We Expect From Our Clients/Patients

- Achieving your goals will be based on several factors. Some of these include:
- Your willingness to work in session and outside of sessions towards achieving your goal
- Willingness to explore, problem solve, and try new skills
- Being honest in sessions
- Following through with mutually agreed upon treatment recommendations or discussing barriers to doing so
- Attending sessions as recommended and starting on time
- Trust and connection with your counselor
- Focus and your goals or revision of goals if necessary
- Giving and receiving feedback about our time together, progress, goal evaluation, and attendance

Appointments

Sessions are scheduled based on the recommendation of your therapist and your goals. A time slot will be selected by mutual availability. It is important that you commit to a time slot that works for you. Regular rescheduling or cancellation will be discussed in session with your therapist to determine if this relationship is effective. If you cancel an appointment with less than 24 hour notice or fail to show up for a scheduled session without notice you will be charged the full rate for the session as insurance cannot be billed. By signing this form you agree to this term.

Confidentiality and the Exceptions

Everything we discuss in session is confidential with a few exceptions. Michigan Law requires your therapist to disclose the following types of communication to ensure your safety or safety of others:

- Threatening to harm yourself or others
- Suspicion that you are abusing a person in a vulnerable population such as children, elderly, disabled, cognitively impaired.
- If you are using insurance to pay for your sessions, identifying information will be disclosed to the medical biller to process your claims however the content of our sessions will not be shared
- Ann Arbor Counseling Associates, LLC participates in coordination of care with other clinicians that belong to this practice. This means that your therapist might consult with

other members of the team and utilize their experience or expertise to assist in determining best treatment strategies.
- If you decide to communicate or subscribe to the AACA's social media pages your confidentiality cannot be guaranteed. Please use these methods of contact sparingly and cautiously.

Contact Information

AACA main phone number is (734)956-0051. Your call will be returned within 2 business days. If you are an existing client you can call our main number and press 4 to access a dial by name directory. You may also email us through the website or send a secure message through the client portal.

For emergencies go to your nearest ER
Suicide Prevention Hotline 1-800-273-8255

Education and Experience

All clinicians at AACA have a minimum of a Master's degree in their clinical field and hold a license through the State of Michigan. These licenses can be verified with LARA on the MI.GOV site.

Billing and Fees

- Any appointment that is not cancelled 24 hours in advance will be charged directly to the client at $85 per missed/late cancelled appointment.
- Sessions range from $85-$250 per session, depending on the type or length of session, type of session, provider, and insurance, etc.
- Copies of records can be requested in writing to your therapist and will be provided after an administrative fee is paid along with a fee per page and postage.
- Individual letters for non-legal matters will be provided at your therapist's approval at their cash rate minimum for 30 minutes of time .
- A detailed explanation of legal costs is available at annarborcounselingservices.com
- Insurance benefits are verified as a courtesy and we do not guarantee the accuracy of the information we receive from your insurance company.
- You will be responsible for any balances due as a result of no-shows, late cancellations, copays,deductibles, denied claims, or returned checks.
- If you choose to be a private pay client and not use your insurance policy or do not have one, you agree not to submit receipts to your insurance for reimbursement at a later date and understand we cannot bill your insurance for sessions occurring during the time frame in which you opted to pay out of pocket rather than use your insurance.

Legal Requests for Custody or Testimony

- We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings.
- If we get subpoenaed by your request or your lawyers, we will require an advanced paid $1500 retainer to deliver the requested services. This payment must be made by cash or certified check in advance of any court appearances, documents requests, or conversations with lawyers. Insurance does not cover these fees and the client or guarantor will be fully responsible for this fee. This fee is non-refundable if the court appearance is cancelled or rescheduled.

Complaints

If you have a concern or complaint about your treatment or about your billing statement, please talk to us about it. We will take your criticism seriously, openly, and respond respectfully.

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HIPAA NOTICE OF PRIVACY PRACTICES

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

1. WE HAVE A LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU. We are required by law to protect the privacy and confidentiality of health information about you, which we call "protected health information," or "PHI" for short. We are required to explain how we may use PHI about you and when we can give out PHI to others. You have rights regarding PHI about you as described in this Notice. We are required to follow the procedures in this Notice. We have the right to change our privacy practices and to make new Notice provisions effective for all PHI that we maintain by posting the revised notice at our location, making copies of the revised notice available upon request, and posting the revised notice on our website.

2. HOW WE USE OR DISCLOSE PROTECTED HEALTH INFORMATION.
We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative).
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.
- Where required by law.
- We have the right to use and disclose health information to pay for your health care and operate our business, and for your treatment by your health care providers.

For example, we may use your health information:
To provide healthcare treatment to you.

- We may use and disclose PHI about you to provide, coordinate or manage your health care and related services.For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.
- To obtain payment for services. We may use and give your medical information to others to bill and collect payment for the treatment and services provided to you. o For health care operations. We may use and disclose PHI in performing business activities that allow us to improve the quality of care we provide and reduce health care costs. Examples include: reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients; reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you; providing training programs for students, trainees, health care providers or non-healthcare professionals to help them practice or improve their skills.
- To provide healthcare treatment to you. We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.
- To obtain payment for services. We may use and give your medical information to others to bill and collect payment for the treatment and services provided to you.
- For health care operations. We may use and disclose PHI in performing business activities that allow us to improve the quality of care we provide and reduce health care costs. Examples

include: reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients; reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you; providing training programs for students, trainees, health care providers or non-healthcare professionals to help them practice or improve their skills.

- We may use or disclose PHI without your permission in the following limited circumstances:
    - When required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding. ANN ARBOR COUNSELING ASSOCIATES, LLC
    - When necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition. o For reporting of victims of abuse, neglect or domestic violence.
    - For health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency which is authorized by law to oversee our operations.
    - For judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal. o For law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
    - When the use and/or disclosure relates to decedents. For example, we may disclose PHI about you to a coroner or medical examiner as necessary to carry out their duties.
    - To manage or coordinate your health care. This may include telling you about treatments, services, products and/or other health care providers. 3. MORE STRINGENT LAW Highly Confidential Information. Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal and State law governing alcohol and drug abuse information as well as state laws that often protect information such as that dealing with HIV/AIDS.

4. YOU HAVE THE RIGHT TO OBJECT TO CERTAIN USES AND DISCLOSURES OF PHI AND, UNLESS YOU OBJECT, WE MAY USE OR DISCLOSE PHI IN THE FOLLOWING CIRCUMSTANCES.
We may share with a family member, relative, friend or other person identified by you, PHI directly related to that person's involvement in your care or payment for your care. We may share with a family member, personal representative or other person responsible for your care PHI necessary to notify such individuals of your location, general condition or death. If you would like to object to our use or disclosure of PHI about you in the above circumstances, please call our Privacy Officer listed below on this Notice.
5. ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION.
Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose PHI about you. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing. If you cancel your authorization in writing, we will not disclose PHI about you after we receive your cancellation, except for disclosures which were being processed before we received your cancellation.

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CONSENT FOR SERVICES
SIGNATURE FORM

Please initial each:

____ I have been given an opportunity to review the Health Insurance Portability and Accountability Act (HIPAA) regulations form.

____ I have received a copy of the Professional Disclosure statement and understand its contents especially the limits of confidentiality, the cancellation fee, and my rights as a counseling client. I also understand I can ask my therapist questions about this form anytime.

____ I agree at this onset of services to pay any balance that is deemed my responsibility by my insurance company or agreement with Ann Arbor Counseling Associates, LLC including copays, deductibles, co-insurances, denied claims, "no-show" fees, or if I have opted not to use insurance, the agreed upon rate between Ann Arbor Counseling Associates, LLC and myself.

By signing below, I authorize AACA, LLC to use this signature on all of my insurance submissions, if I am choosing to use insurance, and I am also consenting to receive counseling services at this time until I revoke authorization in writing.

Client Signature :_____

Date: _____ Printed Name: _____

Legal Guardian: _____ Date: _____

Printed Name: _____

Legal Guardian: _____ Date: _____

Printed Name: _____

Witness:_____

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GUARANTOR FOR SERVICES

The signer below agrees to take final and full responsibility of any balances that accrue and understand that any fees that are not covered by insurance will be billed to this Guarantor for prompt payment. The signer of this form cannot designate a third party as the guarantor. If the Guarantor is someone other than this client then Ann Arbor Counseling Associates reserves the right to contact this person to resolve financial matters while not releasing any clinical information. This form is required to establish services at Ann Arbor Counseling Associates.

This agreement will supersede any other agreements that were made between the client and their therapist or payment agreements made outside of Ann Arbor Counseling Associates.

Payment is due at the time of service. Delay in payment for balances due at the time of service may result in an immediate disruption of services and/or submission to collections. Payment plans are available and can be arranged by contacting our office at (734) 956-0051.

Patient Information
Name of Client: _____
Date of Birth of Client:_____

Guarantor Information

Name of Guarantor/party financially responsible for balances: _____

Relationship to client:_____

Date of birth of Guarantor:_____

Last 4 SS:_____

Phone:_____

Address:_____

Email:_____

"By signing this form I understand that I am fully responsible for any balances that this patient accrues with Ann Arbor Counseling Associates. I understand that Ann Arbor Counseling Associates verifies insurance policies as a courtesy and does not guarantee the information provided by my insurance company and I have the ability to verify my benefits independently."

Guarantor Signature_____ Date:_____

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CREDIT CARD AUTHORIZATION FORM

It is the policy of Ann Arbor Counseling Associates to have a valid credit card on file if you choose to pay for any balances with a credit card. You may avoid this by paying for balances due with either cash or check. All payments are due at the time of service and delay in paying balances due could result in a disruption of service or collections. The signor below, authorizes Ann Arbor Counseling Associates to charge the credit card listed below for all co-pays, outstanding balances,"no-show" fees, and other charges associated with services from Ann Arbor Counseling Associates from now until such time as I revoke this authorization in writing. We do offer payment plans upon request. Please contact our office at (734) 956-0051 to ask about a payment plan.

Name of Patient:_____

Name of Cardholder:_____

Card Number:_____

Card Expiration Date:_____

3 Digit Security Code _____

Billing Zip Code _____

"My signature authorizes Ann Arbor Counseling Associate to store this card and charge it for any outstanding copays, deductible payments, no-show or late cancellation fees, or balances due as designated by my insurance company or the agreement made between myself and Ann Arbor Counseling Associates until this authorization is revoked by me in writing."

Signature of Cardholder:_____ Date:_____

Revocation of Card on File

"I want this card to replace any other card on file and this serves as my notice in writing to revoke the use of previous cards"

Signature of Cardholder:_____ Date:_____
