Melissa R. Tower, MA, LLP, CPC **Phone: 616-805-3255**
4829 East Beltline NE
Building 3, Suite 303
Grand Rapids, MI 49525

www.melissa-tower.com
Email: melissatowertherapy@gmail.com

Therapy Agreement

~ Therapist and Client Responsibilities and Expectations ~

I am glad you have chosen to come to therapy. I hope my office will become a place of refuge and solitude for you, a place where you feel safe to express who you are. I have found that counseling is most effective when it is a collaborative process. Together we will work to develop therapy goals so that you will be able to track the progress you have made. We will make adjustments to your treatment plan, goals, and methods as needed. An important part of these goals is that you be yourself. When in my office you do not need to be anyone other than who you really are.

You can expect that I will provide compassionate, empathic, and sensitive care that is specific to your needs. This may include recommendations for you to meet with other healthcare providers such as another mental health provider or medical professional who may provide interventions that I am unable to provide. I expect that you will complete any tasks we agree upon, and you will do your best to discuss concerns, behaviors, thoughts and feelings that are bothersome. If anything about what occurs in our sessions or about the counseling process itself troubles or disappoints you, I strongly encourage you to talk about that in our sessions so we can address your concerns.

You will be asked to work both in and outside of the sessions. Most likely, you will find that our sessions provide a safe place to share thoughts and feelings, act out and practice behaviors, and plan for your future. You may find that therapy provides rapid relief or that work is arduous and painful. You need to be informed that in most cases while in therapy you may feel worse before feeling better. At times, you may feel that progress has been made and then later feel that nothing has been resolved. Please understand this is normal. My goal is that your counseling experience provides you with an opportunity for growth and healing.

For therapy to be successful, we must both be committed and open. I promise to do my best to support you, understand your point of view, and respect you. I also hope that you will come to therapy on a regular basis, be open to new possibilities and be devoted, even when you do not feel like it.

Please take note of the following:

- Evaluation will be 50-60 Minutes and **follow up Sessions will be approximately 45 Minutes**. I see clients back to back so there is strict adherence to scheduled times.
  Rates per Session: Evaluation=$150, 53-60 minutes=$130, 38-45 minutes=$100
- Please arrive for your appointment on time and give more than 24-hours notice if you need to change or cancel an existing appointment. I can be reached at 616.805.3255 (office) or via **email: melissatowertherapy@gmail.com**
- When timely cancellations occur, it is possible to offer your appointment time to other clients in need. I sincerely appreciate your cooperation and understanding.
- Unfortunately, if you do not cancel your scheduled appointment more than 24 hours in advance, you will be charged for your appointment (which your insurance carrier will not cover). **My policy is 1st & 2nd miss = $50, 3rd miss = $100** (charge for session). If an emergency arises, please call as soon as possible and let us know. Exceptions to a charge may be waived or reduced per therapists discretion.
- If you no show or cancel future appointments, this therapists duty of care is terminated and/or treatment is considered completed and your case will be closed.
- If I do not hear from you within 30 days from your last session with me, my duty of care is terminated 30 days from our last contact.
- In case of a crisis (not life threatening) call 616.805.3255. If there is imminent danger to anyone, call 911 first and then contact me. After hours please call my emergency service 616.732.9943. You may also contact Network180 24-hour helpline at 616.336-3909, Forest View Psychiatric Hospital 616.942-9610, Pine Rest Christian Mental Health Hospital 616.455-5000.

~ Confidentiality ~

With few exceptions everything clients say in counseling is confidential. Those exceptions required by law are as follows(Please also read and review closely the Privacy Policy Document):

- If the information given by a client indicates a clear and imminent danger to the client or others, therapists are required by law to disclose the danger to the appropriate authorities and/or family members.
- If therapists learn of abuse or neglect of or by a client, they are required by law to disclose to appropriate authorities.
- Therapists may be required by law to release confidential information if clients are involved in legal matters and records are subpoenaed.
- If clients use insurance to cover the cost of treatment, treatment notes, including diagnostic information, may be requested and reviewed by insurance companies.

I do accept emails at melissatowertherapy@gmail.com but you know and agree by signing this form that this form of contact is not encrypted so therefore is not confidential and you are at risk to jeopardizing your confidentiality. I do offer encrypted communication via APP MedTunnel should you desire.

~ Payment Policy and Fees of Services ~

We are entering into a fiduciary contract. Clients are responsible for payment at the time of service. If insurance is involved, we will bill the insurance company as a courtesy to clients. Short telephone calls (under 5 minutes) are not billed. If you would like to talk with me over the phone for over 5 minutes a fee of $1.25 per minute will be agreed upon and expected upon arranging this type of call. Telephone contacts are not reimbursed by insurance companies and are patient responsibility. Additionally, I am most willing to write letters to help advocate for clients as needed for court hearings, medical appointments, disability, FMLA, school board meetings, etc. I am not able to bill your insurance company for this service. I ask respectfully that I be compensated for my time for these services; lengthy telephone conversations, letters, appearing for court hearings, and attending professional / collaborative meetings. Should you discontinue paying for services, I have the right to discontinue treating you and my duty of care will be terminated.

~ Ending Therapy ~

How therapy ends is an important part of service. If clients engage in therapy, I expect to have at least one session in which the client and therapist know at the beginning of the hour that it is the last session.

Check this box:

- □ I have read and understand this therapy agreement and understand the fee notice information and will use my medical insurance. I understand that I am responsible for all co-insurance, co-payments, no-show/late cancellation charges, and fees for advocacy or all other services rendered by Melissa R. Tower, MA, LLP. I also understand that I am responsible for payment of fees for services described above in the event that my insurance company denies coverage. If I am not using my insurance, I understand the fee schedule and will pay the current standard rate for services out of pocket. I also understand that I am responsible for all no-show/late cancellation charges.

By signing this document, I indicate that I have reviewed, understand, and agree to comply with the policies in this disclosure statement/agreement.

Signature:_____ Date: _____

Client or Legal Guardian / Parent of Minor

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CONSENT FOR TREATMENT / NOTICE OF RECIPIENT RIGHTS & PRIVACY PRACTICES

NAME:_____ DATE OF BIRTH:_____

1. I am requesting an evaluation and treatment for the concerns noted in my Initial paperwork and treatment plan, which may include mental health and/or substance abuse issues, adjustments to life changes, and various other stressors.

2. I voluntarily consent to participate in psychotherapy treatment and agree to follow through on the goals that we set during the treatment process. I understand that during treatment I may feel worse before feeling better and that success with treatment is not guaranteed.

3. I understand that all clinicians in this office location, including Melissa R. Tower, MA, LLP, are independent practitioners/counselors/therapists and are not part of a group practice even though all clinicians work in the building under "Counseling Suite". While all providers rent office space in the "The Pines" offices, they are independent counselors and that in no way are they legally responsible for other independent therapists in the building.

4. I understand and agree that relevant service information, which may include substance abuse assessment or treatment information, will be shared with my authorized insurance health plan and unless I request otherwise with my physical health care provider (primary care physician) for the purpose of coordinating my physical and emotional health care.

5. I understand that I may ask questions about the risks and benefits of any treatments, procedures, and/or recommendations made for me.

6. My consent for treatment is freely given and I understand that it may be withdrawn at any time.

7. I understand that any information shared during my treatment is confidential as stated in the Michigan Mental Health Code and Federal Law and Regulations (42CFR.2) protecting alcohol and drug abuse treatment records. However, unless I request otherwise, summary information will be shared with my authorized health plan and my physical health care provider. In circumstances involving abuse or neglect with children or with vulnerable adults information will be shared with officials as required by law.

8. I have received a copy of HIPPA/Privacy Practices to read and review.

Signature:_____ Date:_____
Client or Legal Guardian / Guarantor or Financial account/ Parent of Minor

Release Obtained by:_____ Date:_____

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Primary Care Physician Coordination of Care Form

~ Purpose is for Therapist and your Doctor to be able to communicate about your care~

Patient Name_____Date of Birth_____

Insurance Health Plan_____

I_____(circle) DO Authorize DO NOT Authorize
Patient's Name

_____Melissa R. Tower, MA, LLP, CPC_____ my behavioral health provider and my doctor,
Therapist's Name

_____
Doctor/Primary Care Physician Name, Address, OR Phone Number

to exchange information regarding my mental health/substance abuse treatment and medical healthcare; for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment (as protected under 42 CFR Part 2) such as diagnosis and treatment plan and medical information, including information regarding the presence of absence of HIV/AIDS. I understand that this authorization shall remain in effect for one year from the date of my signature below, or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to my behavioral health provider. I also understand that it is my responsibility to notify this provider if I choose to change my Primary Care Physician.

_____Date:_____
Patient's (Parent/Guardian) Signature

_____Date:_____
Clinician's Signature

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To be completed by the clinician

ICD 10 Diagnosis Code and Name:_____

Treatment Modalities: Individual, Family, or Group Psychotherapy Frequency of Visits:_____

Other Information regarding Coordination of Care and Treatment:

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HIPPA Privacy Practices

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

I. **Uses and Disclosure for Treatment, Payment, and Health Care Operations**

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations pursoses with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations" - Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment twould be when I consult with another health care provider, such as your family physician or another mental health professional, such as my direct supervisor. - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when i disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordinations.
- "Use" applies only to activities within my office, such as sharing, employing, applying utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. **Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. I typically do not make or keep these notes. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (fo PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage (the law provides the insurer to right to contest the claim under the policy).

III. **Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* - If I have reasonable cause to suspect child abuse or neglect, I must report this suspicion to the appropriate authorities as required by law.
- *Adult and Domestic Abuse* - If I have reasonable cause to suspect you have been criminally abused, I must report this suspicion to the appropriate authorities as required by law.
- *Health Oversight Activities* - If I receive a subpoena or other lawful request from the Michigan departments of Health or Consumer and Industry Services, I must disclose the relevant PHI pursuant to that subpoena or lawful request.
- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law and I will not release information without your written authorization or court order. The privilege does not apply when you

are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* - If you communicate to me a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, I may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If I believe that there is an imminent risk that you will inflict serious physical harm on yourself, I may disclose information in order to protect you.
- *Worker's Compensation* - I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

IV. **Patient's Rights and mental health Profession's Duties**

Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You are the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decision about you for as long as the PHI is maintenined in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the rights to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Mental Health Professional's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in the notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedure, I will provide you with a revised notice in person or by mail

V. **Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact my clinical Ph.D Supervisor who can provide you with information about your options or you may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. **Effective Date, Restrictions, and Changes to Privacy Policy**

This notice is updated and will go into effect September 1st, 2018

I have reviewed and requested a copy of HIPPA Privacy Policies if desired:

Signature: _____Date: _____

Witness: _____Date: _____

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PATIENT INFO NEEDED FOR BILLING FOR MELISSA R. TOWER, MA, LLP, CPC

Patient Name: _____
Date of Birth: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Email Address: _____

If child or someone will pay for services other than client:

Guarantor's name: _____
Address: _____
Phone: _____

Insurance information:
Must have a copy of insurance card (front and back).
Must have a copy of pre-authorization, if applicable.
Policyholder's name: _____
Date of birth: _____
Address/Phone: _____
Relationship to patient: _____
Policy #: _____
Group #: _____

I agree that Melissa R. Tower, MA, LLP, Therabill/OfficeAlly, and support staff working with Melissa R. Tower, MA, LLP are authorized to submit insurance claims and follow up on insurance payments on behalf of Melissa R. Tower, MA, LLP, CPC.

Circle, Yes or No

May we phone, email, or send a text to you to schedule or confirm appointments? YES NO

If yes, list cell phone number _____

and cell phone carrier service provider(Sprint,Verizon, AT&T)_____

May we email you billing statements? YES, email:_____ NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

If yes, list what number is okay to leave messages_____

Patient Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE RECORD OF:
Note anyone else you would like to be able to speak with me about your care

NAME: _____ DATE OF BIRTH: _____

I hereby authorize: Melissa R. Tower, MA, LLP, CPC 4829 East Beltline NE to release specific information from my record to / and receive referral information **from:** (Name, position, address)

_____

I understand that my continued or future treatment by or payment to Melissa R. Tower, MA, LLP, CPC is not conditioned upon my providing or signing this authorization. The information to be released is all of the records specified by description and date, and may include information about drug/alcohol usage.
EXCEPT:
_____

The information to be released is to be used ONLY for the following authorized purpose:
Coordination of Care_____

The authorization is effective for the following period of time:

From _____ To _____

My authorization can be withdrawn upon my request or if any of the following occur:

EVENT: _____

CONDITION: _____

I understand that I may withdraw this release at any time by notifying the agency holding my records.

Signature: _____ Date: _____
Client or Legal Guardian / Parent of Minor

Release Obtained by: _____ Date: _____

Further release of information disclosed by the above authorization is prohibited by the Michigan Mental Health Code (Public Act 258 of 1974 as amended section 748 (3). This means that the released information may not be copied, shared, or released except as consistent with the authorization purposes stated above. This release is in compliance with Title 42 of the Code of Federal Regulations, Part II, which also prohibits re-disclosure. Information concerning HIV status must be specifically requested.