Integrative Counseling, LLC
REGISTRATION FORM

Client Name (First, MI, Last): _____ **Sex**: □ **M** □ **F**

Address: _____ **City**: _____ **ST**: _____ **Zip**: _____

Date of Birth: _____ **SSN**: _____ **Email**: _____

Phones:* Mobile: (_____) _____ Mobile Carrier: _____

Your appointment reminder may be sent by text (if you provide your carrier) or email. Also, please circle preferred number for calls.

Home: (_____) _____ Other: (_____) _____

Race: __White __Black __Asian __Alaskan __American Indian __Other: _____

Ethnicity: __Puerto Rican __Mexican __Cuban __Other Hispanic __Not Hispanic

---

Parent/Guardian Name (*or additional responsible party*): _____ □ M □ F

Social Security Number: _____ Relationship to client: _____

Date of Birth: _____ Home Phone: _____

Address: _____ Mobile Phone: _____

_____ Email: _____

Emergency Contact: _____ Relationship to client: _____

Address: _____ Home Phone: _____

_____ Mobile Phone: _____

Referral Source: _____ Phone Number: _____

Agency: _____ Fax Number: _____

May we contact your Referral Source? ( ) yes ( ) no If yes, please be sure to complete a ***Release of Information***

Probation Officer/Monitor: _____ Phone Number: _____

Agency: _____ Fax Number: _____

May we contact your P.O./Monitor? ( ) yes ( ) no If yes, please be sure to complete a ***Release of Information***

Lawyer: _____ Phone Number: _____

Agency: _____ Fax Number: _____

May we contact your Lawyer? ( ) yes ( ) no If yes, please be sure to complete a ***Release of Information***

Financial Policy and Authorizing Signature:

Note that payment of services is considered part of your treatment, and payment is due at the time service is provided. All charges you incur are ultimately your responsibility. Upon request, we will provide a statement you may use for third party reimbursement; ***Integrative Counseling does not participate with any insurance. Integrative Counseling does not submit claims***.

Consent: *The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. Telephone, Internet, and Email communications carry an inherent risk to privacy;* ***by providing my email address above, I give permission to receive communication – such as reminders and account statements – through email****. By signing below, I indicate acceptance of these conditions.*

_____ _____ _____

CLIENT/GUARDIAN SIGNATURE **PRINTED NAME** *(if not client)* **DATE**

Administrative use only **Treatment Recommendations**

( ) Group Counseling ( ) Individual Counseling ( ) Family Counseling ( ) _____

( ) Referred to: _____

Counselor: _____

Group Days: M T W Th F Sa Su Time: _____

Michigan Alcohol Screening Test

Client Name:_____ Score: _____

	Yes	No
1. Do you feel you are a normal drinker?		
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember part of the evening before?		
3. Does your spouse or do your parents ever worry or complain about your drinking?		
4. Can you stop drinking without a struggle after one or two drinks?		
5. Do you ever feel bad about your drinking?		
6. Do your friends or relatives think that you are a normal drinker?		
7. Are you always able to stop drinking when you want to?		
8. Have you ever attended a meeting of Alcoholics Anonymous?		
9. Have you gotten into fights while drinking?		
10. Has drinking ever created problems between you and your spouse?		
11. Has your spouse or other family member ever gone to anyone for help about your drinking		
12. Have you ever lost friends or girlfriends/boyfriends because of your drinking?		
13. Have you ever gotten into trouble at work because of drinking?		
14. Have you ever lost a job because of drinking?		
15. Have you neglected your obligations, your family or your work for 2 or more days in a row because of drinking?		
16. Do you ever drink before noon?		
17. Have you ever been told you have liver trouble or cirrhosis?		
18. Have you ever had Delirium Tremens (DTs), severe shakes, heard voices, or seen things that weren't there after heavy drinking?		
19. Have you ever gone to anyone for help about your drinking?		
20. Have you ever been in a hospital because of your drinking?		
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem?		
22. Have you ever been seen at a psychiatric or mental health clinic or gone to a doctor, social worker, or clergy for help with an emotional problem in which drinking had played a part?		
23. Have you ever been arrested, even for a few hours, because of drunk behavior?		
24. Have you ever been arrested for drunk driving or driving after drinking?		

Integrative Counseling, LLC

Release of Information

_____

I, _____ hereby authorize Integrative Counseling, LLC

to exchange information with: _____.
Name of Program, Agency, or Individual

_____ _____
Phone Fax

The following information may be exchanged:

_____ Full client record
_____ Progress and attendance reports
_____ Admission and discharge diagnosis and recommendations
_____ Reason for termination of treatment and discharge summary
_____ Urinalysis/Breathalyzer results
_____ Immunization and physical records
_____ Other _____

The above information will be exchanged for the following reason(s):

_____ To coordinate treatment
_____ As a condition of probation, parole, or adjudication
_____ As required by my employer or EAP
_____ To assist my attorney
_____ Other _____

This consent will expire one year from the date of signature unless otherwise noted:

_____.

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that the information has already been disclosed in reliance with this consent.

Prohibition of Re-disclosure: This information has been disclosed to you from records protected under Federal Law. Federal Regulations (42CFR Part II) prohibit you from making further disclosures of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ _____
Client Signature Date

_____ _____ _____ _____
Parent/Guardian Signature Date Witness Signature Date

Integrative Counseling, LLC

Fee Schedule and Policies

Intake and Assessment	$150	Medication Authorization	$20	No Show Fee Group	$40
Group Therapy or Education	$45	Written Report (*per half hour*)	$50	No Show Fee Individual	$60
2hr DWI Education	$80	Psychiatric Assessment - MD	$300	No Show Fee Psychiatric Svc	$100
2hr Adolescent Education	$100	Psychiatric Assessment	$200	Disability/Workers Comp Report	$300
Family Group/Parent Ed	$45	Medication Management - MD	$120	Psychiatric Report (*per half hour*)	$100
Weekend Alcohol Ed	$400	Medication Management	$100	Letters/Forms	$25
Relationship Therapy	$110	Suboxone Evaluation	$215	Crisis Session	$45
Consultation Only	$110			Urine Screen – THC or Panel	$35

**This is not a comprehensive list of all possible charges.*

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It is office policy to charge for missed appointments not canceled at least 24 hours prior to the scheduled appointment. This includes groups – unless prior arrangements are made, you will be expected at the next scheduled group meeting. In the event a courtesy reminder is not made, it *does not excuse* a missed appointment.

Fees and Payment

Fees will be collected at the time service is rendered. Payment may be made by cash, check, or credit card. Checks returned for non-payment will result in a $25 bounced check charge, and may result in checks no longer being accepted from the client. Integrative Counseling does not accept insurance payments. ***Statements are not regularly mailed, and are provided only upon request***.

Failure to Pay

The client agrees that failure to pay the expected service fee within ten business days of the service date may, at the option of Integrative Counseling, be construed as a discharge of services by the client. ***Client accounts sent to collections for non-payment will be charged the amount owed plus any and all associated collection fees***. The client agrees that information pertinent to the collection of any amount due be released to a third party collection agency or attorney. The client further agrees that in the event that legal action is taken to collect any money under this agreement, the client shall pay the amount due as attorney collection fee as well as any cost of any legal action; and consents to legal action being held in Howard County, Maryland, and waives any right to claim improper jurisdiction and/or venue.

Court Appearances and Associated Costs

Congruent Counseling Services charges $400 per hour with a minimum of $3,200 for any court appearance whether requested or summonsed, regardless of requesting party. Clients will also be charged per hour for any travel time, consultation time, preparation time, and any time spent waiting. Costs incurred by the company for associated legal fees will be passed on to the client. In the case of minors, the signing parent is responsible for this fee unless otherwise pre-arranged with the non-signing parent. A deposit of $3,200 is due 10 days prior to any court appearance. If a court appearance is canceled or rescheduled, staff must be given ten business days' notice. If ten business days' notice is not given, then Congruent Counseling Services may still charge up to $3,200 for each day if unable to reschedule appointments and for any preparation time, administration time, and reports completed.

Understanding of Separate Practices

The client recognizes and understands that although they share space, Integrative Counseling, LLC (IC) and Congruent Counseling Services, LLC (CCS) are separate practices, and as such may require the opening of a separate client chart. The client understands that *any insurance benefits utilized with CCS cannot be utilized with IC*. IC accepts no third party payers of any kind and has no insurance contracts. Clients may continue to receive services from either or both programs. Additionally, the client understands that each program may exchange information with the other and the client signature below serves as a release for the programs to exchange such information as needed to ensure appropriate treatment.

Medication Changes or Refills between Appointments

We understand you may sometimes need a brief refill to get you through to your next appointment. Refills between appointments will be billed at $35. These refills will be for no longer than two weeks or until you are able to see your psychiatrist in person. You may choose to schedule a Telepsychiatry appointment if the next appointment is too far away.

Statement about Supervision

The client received information regarding Supervision of Services. Release of information is provided to the Supervisor for a period of one year from the date signed (refer to Statement of Supervision).

Infectious Disease Education

The client received education and risk reduction education about TB, STDs, HIV/AIDs, and Hepatitis.

Your signature below indicates understanding of the fees and policies as delineated here.

Client Signature	Date	Parent/Guardian Signature	Witness Signature	Date

Integrative Counseling, LLC
Telephone, Email and Teletherapy Policies

Communication, Reminders, Statements

We wish to communicate with you in the most efficient way possible. That may be by phone, email, or text message. Telephone, email, and text messaging communications carry an inherent risk to privacy. Please do not use email for an emergency or rapid response request, or for sensitive information. We may use your email, mobile phone text messaging, or home phone for appointment reminders, statement delivery, or general information. By signing below, the client acknowledges recognition and acceptance of risk to privacy in the use of email and text message.

Telephone and Internet Session – Teletherapy or Telepsychiatry

In order to meet the needs of busy people, we can regularly schedule phone or Internet counseling. This way you can work on your goals from anyplace. Teletherapy and telepsychiatry are not covered by insurance and are therefore billed at our standard rates. Clients regularly seen in the office for sessions under insurance can schedule teletherapy/telepsychiatry appointments to bridge some gap with the understanding these sessions will not be billed to insurance. Teletherapy and telepsychiatry clients will be billed via credit card at the time of service. Credit cards must be must be kept on file with Congruent Counseling Services. Clients may choose to receive 10% discount by prepaying for a block of ten sessions. Initial sessions must be done in person and are not billable to insurance if telephone or teletherapy/telepsychiatry sessions are the primary mode of treatment.

Missed Appointment/Brief Phone Sessions

As noted on the Fee Schedule and Policy page, missed appointments are charged for sessions not canceled 24 hours in advance. We must charge for these missed appointments because we have reserved the time for you and cannot fill your appointment with another client if we have less than 24 hours to do so. This can be very expensive as insurance does not cover missed appointments. However, we understand sometimes life gets in the way. In order to help stay on track in counseling, and to save the full missed appointment fee, therapists may opt to conduct a 15-30 minute phone session during your already scheduled individual, family, or couples appointment time. This session will be charged at a rate of $50, far less than the full missed appointment charge. This session will allow you to stay focused on your treatment and schedule your next session at a better time. The missed appointment phone option may only be used once in a 30-day period. Second missed appointments will be charged at the full rate.

Therapist and Counselor Contact Outside of Sessions

It is our goal to provide you with the best treatment we can provide. In order for our counselors and therapists to help you, they need to be healthy themselves. If there is an emergency please call emergency services or 911. Your counselor or therapist has provided you with personal contact information to help address your needs. If you would like to talk with your therapist, and cannot wait until the next appointment, please be respectful of their time. In cases where you need the help, we want to help. Please note calls, texts, or emails taking over five minutes will be charged as crisis session at a rate of $45. Crisis sessions are not billable to insurance and are the responsibility of the client or parent.

Psychiatrist Contact Outside of Sessions

It is our goal to provide you with the best treatment we can provide. In order for our psychiatrists to help you, they need to be healthy themselves. If there is an emergency please call emergency services or 911. If you are calling to make or change your appointment or to address billing issues, please call the office. If you are calling with a therapy or mental health concern, please call your individual therapist. Your psychiatrist has provided you with personal contact information to help you address your needs. If you would like to talk with your psychiatrist regarding medication issues, and cannot wait to schedule an appointment, please be respectful of their time. Calls, texts, or emails to clarify or change medication(s) within seven days of your last appointment are acceptable. Medication calls, texts, or emails outside of this seven day window will be charged as a Crisis Session at a rate of $45. Crisis Sessions are not billable to insurance and are the responsibility of the client or parent.

I have reviewed and understand these options and I have received a copy of the Telephone, Email and Teletherapy Policies.

Client Signature	Date
Parent/Guardian Signature	Date
Witness Signature	Date

Integrative Counseling, LLC

Notice of Privacy Practices (HIPAA), Client Bill of Rights and Confidentiality of Client Records

Client Bill of Rights

Each Client has the right to:

1. Be treated with consideration, respect, and full recognition of the client's human dignity and individuality;
2. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;
3. Not be physically or mentally abused by the program staff;
4. Be free from discrimination;
5. Be free from restraints;
6. Privacy and confidentiality; and
7. Refuse participation in any experimental research unless the research complies with 45 CFR Part 46. 45 CFR Part 46 is the Code of Federal Regulations Protection of Human Subjects.

Confidentiality of Patient Records

The Federal Law and Regulations protect the confidentiality of patient records maintained by this program. Generally the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug user unless:

1. The patient consents in writing;
2. The disclosure is allowed by court order;
3. The disclosure is made to medical personnel in an emergency or to qualified personnel for research, audit, or program evaluation.

Violation of Federal Law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state and local authorities.

Acknowledgment and Consent Regarding Notice of Privacy Practices

Our Notice of Privacy Practices is posted on the wall and is available upon request. The Notice of Privacy Practices of Integrative Counseling (IC) provides information about how IC may use and disclose your protected health information (PHI). The Notice of Privacy Practices states that IC reserves the right to change its terms. Should this happen, understand that IC will make the changed notice available in its office. You have the right to revoke this consent, in writing, except where IC has already made disclosures in reliance on your prior consent. Understand that you have the right to request restrictions on how your PHI may be used or disclosed for treatment, payment and health care operations. IC is not required to agree to your restrictions, but if it does, it is bound by its agreement with you. By signing below, you consent to the use and disclosure of your PHI for treatment, payment and health care operations as described in the Notice of Privacy Practices. You specifically consent to IC communicating with you using the contact information you provide, as further described in the Notice of Privacy Practices.

Discharge

Clients who choose to terminate services will be discharged immediately. Clients who have not attended sessions for 30 days or more and who do not have an appointment scheduled will be discharged at the discretion of the doctor or therapist with no prior notice. Discharged clients are no longer under the care of Congruent Counseling Services, Integrative Counseling, a therapist, or a doctor. Discharged clients may be re-admitted at the discretion of the practice upon request.

I have reviewed and understand these rights and I have received a copy of this Notice.

Client Signature	Date

Parent/Guardian Signature	Date	Witness Signature	Date

Credit Card Recurring Payment Authorization Form

As a courtesy to you, we can now schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started. Once a month, with this authorization, we will charge the balance due on your account to the credit card you list on file.

You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged once each billing period for the total amount due for that period. The charge will appear on your credit card statement.

Please complete the information below:

I, _____, authorize Congruent Counseling Services, LLC and/or Integrative Counseling, LLC (as indicated above) to charge the credit card indicated below once between the 15th and 20th of each month for payment of any balance due for _____.
(name of client or clients)

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email: _____

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Is this for a(n): ☐ HSA ☐ FSA ☐ Other Consumer Spending Account?

***For all consumer spending accounts, be advised that if the card cannot be processed, you will be billed and should seek reimbursement from them directly.**

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

_____ _____

CLIENT/GUARDIAN SIGNATURE DATE

Integrative Counseling, LLC
Notice of Privacy Practices (HIPAA), Client Bill of Rights and Confidentiality of Client Records

Client Copy

Client Bill of Rights

Each Client has the right to:

1. Be treated with consideration, respect, and full recognition of the client's human dignity and individuality;
2. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;
3. Not be physically or mentally abused by the program staff;
4. Be free from discrimination;
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Integrative Counseling, LLC
Expectations and Rules

Client Copy

Counselor: _____

Group Days: M T W Th F Group Time: _____

Client Expectations and Rules

1. A client who makes a threat or becomes violent will be discharged.
2. A client who brings a weapon will be discharged.
3. A client who becomes verbally abusive will be discharged.
4. All state, county and federal laws will be observed. Violators will be turned in to the appropriate authorities. (Confidentiality – 42 CFR, part II will be observed.)
5. If a client misses three appointments, the client will be discharged.
6. If a client chooses to not actively participate in treatment, he/she may be discharged.
7. A client's refusal to pay for a service is grounds for discharge.
8. Each session will begin and end on time. If a client is more than 10 minutes late, he/she will be considered as a no-show.
9. Clients may be asked to give random urine drug screens or alcohol breathalyzer screens on a weekly basis. If the client refuses, he/she may be discharged at the discretion of the program directors. Clients receiving two positive urine or breathalyzer screens may be discharged from the program at the discretion of the program directors. Clients will be monitored while giving urine.
10. If a client appears to have used illicit drugs or alcohol, staff will ask to speak with the client in private, a urine screen may be required and the client may be asked to leave treatment for the day. Clients will not be treated when under the influence of any illicit drug or alcohol.
11. All clients are expected to maintain the confidentiality of other clients.

Client Grievance Procedures

Clients have the right to discuss treatment issues, and if necessary to review with the Director, disagreements about treatment, discharge, or change in status. No retaliation will be taken against clients who present a grievance. Clients will first be asked to discuss concerns with his/her counselor. The counselor will attempt to resolve the client's concerns. If the client is unsatisfied, he/she can write his/her complaint to the Program Director and the Director will investigate. The Director will write a response to the client within five days. The Director will offer possible remedies and discuss with the client. If the client is dissatisfied with the response from the staff, they can write the following impartial agency: Equal Employment Opportunity, 111 Market Place, Baltimore, MD 21201, phone number 410.962.3932.

Integrative Counseling, LLC
Fee Schedule and Policies

Client Copy

Intake and Assessment	$150	Medication Authorization	$20	No Show Fee Group	$40
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Infectious Disease Education

The client received education and risk reduction education about TB, STDs, HIV/AIDs, and Hepatitis.

Integrative Counseling, LLC
Infectious Disease Education

Client Copy

Tuberculosis

Tuberculosis (TB) is an infectious disease that usually infects the lungs, but can attack almost any part of the body. Tuberculosis is spread from person to person through the air. When a person with TB in their lungs or throat coughs, laughs, sneezes, sings, or even talks, the germs that cause TB may spread through the air. If another person breathes in these germs, there is a chance that they will become infected with tuberculosis.

It is not easy to become infected with tuberculosis. Usually a person has to be close to someone with TB disease for a long period of time. TB is usually spread between family members, close friends, and people who work or live together. TB is spread most easily in closed spaces over a long period of time.

If it is not treated, TB can be fatal. But TB can almost always be treated and cured if you take medicine as directed by your healthcare provider. Once you begin treatment, within weeks you will no longer be contagious. That means you can't spread the disease to others. If you take your medicine just as your healthcare provider tells you, all the TB germs should be killed.

Risk Reduction: Travelers should avoid close contact or prolonged time with known TB patients in crowded, enclosed environments (for example, clinics, hospitals, prisons, or homeless shelters). If you think you have been exposed to someone with TB disease, contact your healthcare provider or local health department to see if you should be tested for TB. Be sure to tell the doctor or nurse when you spent time with someone who has TB disease.

American Lung Association, http://www.lung.org/lung-disease/tuberculosis/

CDC: http://www.cdc.gov/tb/topic/infectioncontrol/

Tobacco Smoking

Cigarette smoking has been identified as the most important source of preventable morbidity (disease and illness) and premature mortality (death) worldwide. Smoking-related diseases claim an estimated 443,000 American lives each year, including those affected indirectly, such as babies born prematurely due to prenatal maternal smoking and victims of "secondhand" exposure to tobacco's carcinogens. Smoking cost the United States over $193 billion in 2004, including $97 billion in lost productivity and $96 billion in direct health care expenditures, or an average of $4,260 per adult smoker.

Risk Reduction: Quitting smoking is the single most important step a smoker can take to improve the length and quality of his or her life. Stopping smoking can be tough but smokers don't have to quit alone. The American Lung Association has lots of options to help adult and teen smokers quit smoking for good.

American Lung Assocation, <http://www.lung.org/stop-smoking/how-to-quit/>

HIV/AIDS

HIV is the human immunodeficiency virus. It is the virus that can lead to acquired immune deficiency syndrome, or AIDS. HIV damages a person's body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases. Within a few weeks of being infected with HIV, some people develop flu-like symptoms that last for a week or two, but others have no symptoms at all. People living with HIV may appear and feel healthy for several years and can still spread the virus. HIV is spread primarily by not using a condom when having sex with a person who has HIV, sharing needles, and being born to an infected mother. If you believe you may have been exposed you need to see a doctor and get tested. Early treatment can reduce the spread of HIV and allow you to start treatment early to reduce the impact of the disease on your body.

Risk Reduction: Use condoms consistently and correctly. Reduce the number of people you have sex with. Talk to your doctor about pre-exposure prophylaxis (PrEP). PrEP should be considered if you are HIV-negative and in an ongoing sexual relationship with an HIV-positive partner. Talk to your doctor right away (within 3 days) about post-exposure prophylaxis (PEP) if you have a possible exposure to HIV. Get tested and treated for other sexually transmitted diseases (STDs) and encourage your partners to do the same. If your partner is HIV-positive, encourage your partner to get and stay on treatment.

CDC: http://www.cdc.gov/hiv/topics/basic/index.htm

AIDS.Gov: www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/sexual-risk-factors/

Congruent Counseling Services, LLC
Infectious Disease Education

Client Copy

STDs

Sexually transmitted diseases, or STDs, can be painful and embarrassing. Unfortunately, they are especially common when safe-sex precautions are not taken. Luckily, most STDs are easily treatable by your doctor. If you're afraid you might have an STD, consider these seven warning signs: painful urination; painful intercourse; open sores or bumps near the mouth or genitals; unusual discharge from the genitals/unusual odor; itching or swelling in the genital area; changes in menstruation; high fever, fatigue, or nausea. These can all be symptoms of an STD. If you feel as if you might be coming down with something shortly after having unprotected sex, don't assume that it's just a common cold. If you believe you might have an STD, you should make an appointment with your doctor as soon as possible.

Risk Reduction: There are several ways to avoid or reduce your risk of sexually transmitted infections: Abstain from sex; Stay with 1 uninfected partner; Avoid vaginal and anal intercourse with new partners until you have both been tested for STDs; Get vaccinated. Vaccines are available to prevent human papillomavirus (HPV), hepatitis A and hepatitis B. Also, Use condoms and dental dams consistently and correctly; Don't drink alcohol excessively or use drugs. Communication: Teach your child that becoming sexually active at a young age tends to increase a person's number of overall partners and, as a result, his or her risk of STDs. Consider male circumcision.

Reference: http://www.cdc.gov/STD/

Mayo Clinic: www.mayoclinic.org/diseases-conditions/sexually-transmitted-diseases-stds/basics/prevention/con-20034128

Hepatitis

Hepatitis is an inflammation of the liver. The condition can be self-limiting or can progress to fibrosis (scarring), cirrhosis or liver cancer. Hepatitis viruses are the most common cause of hepatitis in the world but other infections, toxic substances (e.g., alcohol, certain drugs), and autoimmune diseases can also cause hepatitis. There are 5 main hepatitis viruses, referred to as types A, B, C, D and E. These 5 types are of greatest concern because of the burden of illness and death they cause and the potential for outbreaks and epidemic spread. In particular, types B and C lead to chronic disease in hundreds of millions of people and, together, are the most common cause of liver cirrhosis and cancer.

Risk Reduction: Good personal habits will help reduce the spread of hepatitis A and hepatitis E. If you're in a place where you're not sure things are clean, boil water. Cook all food well and peel all fruit. If you're a healthcare worker or caregiver for someone who has a contagious form of hepatitis, take extra steps to stay clean. Wash your hands, utensils, bedding, and clothes with soap and hot water. To prevent the spread of hepatitis B, stay away from the blood or body of someone who has it. That means no kissing or sex. Don't share razors, scissors, nail files, toothbrushes, or needles. If you plan to travel to countries where hepatitis is widespread, get protected. You can get vaccinations for hepatitis A and B. In the U.S., all children are advised to receive a series of hepatitis B vaccine before they start school. Kids who live in places with a lot of hepatitis A should get that vaccine. There isn't a vaccine for hepatitis C.

WHO: www.who.int/features/qa/76/en/

Web MD: www.webmd.com/hepatitis/understanding-hepatitis-prevention

For Treatment or Testing

See your doctor, or we recommend Dr. Patel, Family Health Center, 10632 Little Patuxent Pkwy, Suite 111, Columbia, MD 21044. Phone: 410.997.9751.

Integrative Counseling, LLC

Client Copy

Telephone, Email and Teletherapy Policies

Communication, Reminders, Statements

We wish to communicate with you in the most efficient way possible. That may be by phone, email, or text message. Telephone, email, and text messaging communications carry an inherent risk to privacy. Please do not use email for an emergency or rapid response request, or for sensitive information. We may use your email, mobile phone text messaging, or home phone for appointment reminders, statement delivery, or general information. By signing below, the client acknowledges recognition and acceptance of risk to privacy in the use of email and text message.

Telephone and Internet Session – Teletherapy or Telepsychiatry

In order to meet the needs of busy people, we can regularly schedule phone or Internet counseling. This way you can work on your goals from anyplace. Teletherapy and telepsychiatry are not covered by insurance and are therefore billed at our standard rates. Clients regularly seen in the office for sessions under insurance can schedule teletherapy/telepsychiatry appointments to bridge some gap with the understanding these sessions will not be billed to insurance. Teletherapy and telepsychiatry clients will be billed via credit card at the time of service. Credit cards must be must be kept on file with Congruent Counseling Services. Clients may choose to receive 10% discount by prepaying for a block of ten sessions. Initial sessions must be done in person and are not billable to insurance if telephone or teletherapy/telepsychiatry sessions are the primary mode of treatment.

Missed Appointment/Brief Phone Sessions

As noted on the Fee Schedule and Policy page, missed appointments are charged for sessions not canceled 24 hours in advance. We must charge for these missed appointments because we have reserved the time for you and cannot fill your appointment with another client if we have less than 24 hours to do so. This can be very expensive as insurance does not cover missed appointments. However, we understand sometimes life gets in the way. In order to help stay on track in counseling, and to save the full missed appointment fee, therapists may opt to conduct a 15-30 minute phone session during your already scheduled individual, family, or couples appointment time. This session will be charged at a rate of $50, far less than the full missed appointment charge. This session will allow you to stay focused on your treatment and schedule your next session at a better time. The missed appointment phone option may only be used once in a 30-day period. Second missed appointments will be charged at the full rate.

Therapist and Counselor Contact Outside of Sessions

It is our goal to provide you with the best treatment we can provide. In order for our counselors and therapists to help you, they need to be healthy themselves. If there is an emergency please call emergency services or 911. Your counselor or therapist has provided you with personal contact information to help address your needs. If you would like to talk with your therapist, and cannot wait until the next appointment, please be respectful of their time. In cases where you need the help, we want to help. Please note calls, texts, or emails taking over five minutes will be charged as crisis session at a rate of $45. Crisis sessions are not billable to insurance and are the responsibility of the client or parent.

Psychiatrist Contact Outside of Sessions

It is our goal to provide you with the best treatment we can provide. In order for our psychiatrists to help you, they need to be healthy themselves. If there is an emergency please call emergency services or 911. If you are calling to make or change your appointment or to address billing issues, please call the office. If you are calling with a therapy or mental health concern, please call your individual therapist. Your psychiatrist has provided you with personal contact information to help you address your needs. If you would like to talk with your psychiatrist regarding medication issues, and cannot wait to schedule an appointment, please be respectful of their time. Calls, texts, or emails to clarify or change medication(s) within seven days of your last appointment are acceptable. Medication calls, texts, or emails outside of this seven day window will be charged as a Crisis Session at a rate of $45. Crisis Sessions are not billable to insurance and are the responsibility of the client or parent.

Statement of Supervision

Clinical Supervision Provisions

Services may be provided by an LG, a State of Maryland Certified Counselor, or ADT under the supervision of the Clinical Director Mark D. Donovan, LCPC, LCADC who can be reached at 10630 Little Patuxent Pkwy, Ste 209, Columbia, MD 21044, 410-740-8066. Counselor names and certification details can be viewed at www.integrative-counseling.com, or by request from your counselor. Certification can be verified at https://mdbnc.dhmh.md.gov/pctVerification/default.aspx. The client agrees to release such information as is required for supervision to the Clinical Supervisor for a period of one year.