ISI THERAPEUTIC FAMILY SERVICES, LLC
IRON SHARPENS IRON

isitherapy.com website
(334) 703-2095 phone
(334) 539-1971 fax
info@isitherapy.com email

REGISTRATION INFORMATION - MINOR

How did you hear about us?

CLIENT INFORMATION

CLIENT FULL NAME	DATE OF BIRTH	GENDER MALE FEMALE OTHER

MARITAL STATUS SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED OTHER	EMPLOYMENT STATUS FULL TIME PART TIME SELF-EMPLOYED RETIRED ACTIVE MILITARY OTHER	STUDENT STATUS FULL TIME PART TIME

ADDRESS	CITY/STATE/ZIP

HOME PHONE	CELL PHONE	WORK PHONE	INDICATE BEST # TO LEAVE MSG HOME CELL WORK

EMAIL ADDRESS	OK TO DISCUSS SCHEDULING VIA EMAIL? YES NO OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? YES NO

EMERGENCY CONTACT

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	RELATIONSHIP TO CLIENT

RESPONSIBLE PARTY 1 (IF DIFFERENT THAN CLIENT)

BILLING FULL NAME	RELATION TO CLIENT LEGAL GUARDIAN SPOUSE PARENT OF 18+ DEPENDENT OTHER

BILLING ADDRESS	CITY/STATE/ZIP

BILLING PHONE	LEAVE MSG? YES NO	EMAIL ADDRESS	OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? YES NO

RESPONSIBLE PARTY 2 (IF DIFFERENT THAN CLIENT)

BILLING FULL NAME	RELATION TO CLIENT LEGAL GUARDIAN SPOUSE PARENT OF 18+ DEPENDENT OTHER

BILLING ADDRESS	CITY/STATE/ZIP

BILLING PHONE	LEAVE MSG? YES NO	EMAIL ADDRESS	OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? YES NO

INSURANCE INFORMATION Copy of both sides of the insurance card(s) needed at intake.

Please file to my insurance as listed below I do NOT wish to file insurance (self-pay) I do NOT have mental health coverage (self-pay)

**Does your insurance require pre-certification, an authorization or referral from your Primary Care Physician? Yes No

PRIMARY INSURANCE COMPANY			SECONDARY INSURANCE COMPANY			**DOES YOUR EMPLOYER HAVE AN EMPLOYEE ASSISTANCE PROGRAM (EAP)?** YES NO
Policy Holder's Name & Date of Birth:			Policy Holder's Name & Date of Birth:			
COPAY: $	*DEDUCTIBLE: $	CO-INSURANCE: %	COPAY: $	*DEDUCTIBLE: $	CO-INSURANCE: %	**DO YOU HAVE HRA ACCOUNT ASSOCIATED WITH YOUR INSURANCE?** YES NO

ALL COPAYS AND BALANCES ARE DUE IN FULL AT THE TIME OF YOUR APPOINTMENT

***Please make all checks payable to: ISI Therapeutic Family Services, LLC**

My signature below gives ISI Therapeutic Family Services, LLC permission to use PayPal or Square to collect any fees or copays etc.

Cardholder Signature:	Date:

PRIVATE PAY and FILING to DEDUCTIBLE Payment due IN FULL at the time of service.

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IMPORTANT SIGNATURES

CLIENT FULL NAME	DATE OF BIRTH

if client is a minor, please print name of parent/guardian(s) signing on behalf of the client:

PRINT FULL NAME	RELATIONSHIP TO CLIENT
PRINT FULL NAME	RELATIONSHIP TO CLIENT

MISSED APPOINTMENTS

I am financially responsible for my attendance at all scheduled appointments, unless cancelled with at least 24 hour notice. Minimum charges of $65 will be applied to my account for a late cancel and $65 for a no-show. This charge is NOT covered by insurance.

INSURANCE BILLING

I authorize ISI Therapeutic Family Services, LLC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to ISI Therapeutic Family Services, LLC. I understand that I am responsible for payment for services rendered by ISI Therapeutic Family Services, LLC regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify ISI Therapeutic Family Services, LLC immediately whenever I have changes in my health plan coverage.

ACCOUNT RESPONSIBILITY

I am responsible for payment to ISI Therapeutic Family Services, LLC for all services rendered, due at the time of the visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. If I default on any payment obligations as called for in this agreement, ISI Therapeutic Family Services, LLC reserves the right to forward my information to collections, and an additional 30% may be assessed to my account to cover the costs of this action. There will be no obligation to provide continuing services to any client who names ISI Therapeutic Family Services, LLC as a creditor in any bankruptcy filing.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

RECORDS RELEASE – Primary Care Physician

- I do not have a Primary Care Physician
- I do not want ISI Therapeutic Family Services, LLC to release my information to my Primary Care Physician at this time
- I request ISI Therapeutic Family Services, LLC to release my information to my Primary Care Physician. If so, please complete the included Release of Information form.

CLINICAL STAFF RELEASE

I understand that as part of professional clinical consultation, my situation may be reviewed using general clinical information, and that my therapist will obtain a signed Release of Information (ROI) prior to discussing specific details of my situation.

INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES

I am consenting to treatment and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practices (HIPAA).

My signature below indicates that I have been offered a copy of, and that I fully understand & agree to all of the terms and conditions of the Counseling Policies. If I have questions, the information has been explained and/or summarized for me.

SIGNATURE(S) (CLIENT OR LEGAL GUARDIAN)	DATE
SIGNATURE(S) (LEGAL GUARDIAN)	DATE

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PRIMARY CARE PROVIDER NOTIFICATION OF CLINICAL SERVICES AND CONSENT FOR THE RELEASE OF INFORMATION

Continuity and coordination between physical and mental health is an important aspect in the delivery of quality health care, as mental and physical disorders can interact to affect an individual's health.

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	INTAKE DATE

PRIMARY CARE PROVIDER/CLINIC	
PHONE	FAX
ADDRESS	CITY/STATE/ZIP

MENTAL HEALTH PROVIDER INFORMATION

Dear Primary Care Provider,
I am sending this form to notify you that I am currently seeing your patient in a therapeutic setting and to provide our offices with a release of information to facilitate communication and to coordinate services in regards to client care. If further information is desired, please contact me at your convenience.
Sincerely,

Charles 'Chad' Smith, M.A., LMFT

MAILING ADDRESS:
ISI Therapeutic Family Services, LLC
2206 Executive Park Drive
Opelika, AL 36801

CLINICAL INFORMATION

REASON FOR REFERRAL OR CARE COORDINATION	
DIAGNOSIS	MEDICATIONS
TREATMENT PLAN(S) OR RECOMMENDATIONS	

CONSENT AND RELEASE

I authorize the exchange of information regarding my clinical care needed to coordinate treatment with my primary care physician.
I understand that my records are protected under the Federal and specific State confidentiality laws and 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 action has been taken in reliance on it (e.g., the provision of treatment upon consent to disclose third party payers) and that this consent expires automatically as described below. Information to be released includes diagnosis, treatment procedures and details of my condition which help to coordinate treatment. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. This release is valid for 1 year after last contact and I may cancel it in writing at any time.

SIGNATURE(S)	DATE
SIGNATURE(S)	DATE

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COUNSELING POLICIES

Please carefully read through the following Counseling Policies. This document contains important information about our professional services and business policies, as well as responsibilities and expectations of you as the client. When you sign the IMPORTANT SIGNATURES page of this document, it represents your understanding of all the rules and responsibilities of both the client and the therapist, in addition to understanding the financial terms and agreements.

Welcome to ISI Therapeutic Family Services, LLC!

I am grateful to have the opportunity to offer services to you and hope this form will assist your decision in pursuing counseling.

We are a professional mental health counseling group where your therapist maintains his or her private practice. Within this model, your therapist is your primary point of contact for scheduling & account management (payment, statement/receipt requests, & billing questions). Our business office provides administrative support to your therapist. To update your personal and/or insurance information or if you are having difficulty scheduling online, please contact Christy Lessley at christy@isitherapy.com.

What is therapy and how does it work?

The Counseling Relationship. Each person who seeks counseling comes with unique experiences and concerns. The relationship of counselor to counselee will be characterized by professional dignity, expertise, warmth, and acceptance. Therapy is a learning process and a process of change that seeks for the persons involved to better understand themselves and others as well as the interactions that occur between the participants and significant others. Equally important is to achieve enhanced functioning as an individual, couple, or family so that healthy interactions are established and greater satisfaction is attained. My therapeutic approach is eclectic, depending on the type of problem being addressed. While I am systemic in nature, I gravitate toward cognitive-behavioral therapy, solution-focused brief therapy, family systems, and structural family therapy. My approach is straightforward and based upon the counselee's goals. Techniques may involve visualizations and/or material drawn from spiritual disciplines. In addition, the holistic nature of my views concerning mental health recognizes a person's spirituality as a vital component and the central organizing principle around which lasting mental health and strong relationships may be achieved. Initially in the therapeutic process, we will explore the background of focal issues. Although it may be a painful process at times, success is dependent on client honesty. My hope early in therapy is to instill trust within the client/therapist relationship. Once this foundation has been adequately established, we will develop specific goals and a plan by which these goals will be achieved. We will jointly assess objective achievement on a regular basis to determine if significant change in the treatment plan needs to be made. Termination of therapy will result when the client and therapist agree the goals have been achieved, at the client's request, or when another therapist might better meet the needs of the client.

INTAKE APPOINTMENT

Since your therapist is your primary contact, you will not need to check in with a receptionist upon arrival. Please take a seat in our waiting area and your therapist will greet you for your appointment. Please bring the following REQUIRED items to your intake appointment:

- Completed and Signed Counseling Policies forms
- Completed Personal History form
- Photo ID (of legal guardian, if client is a minor)
- Insurance card(s)
- Payment for copay or other financial responsibility (cash, check, credit/debit card, or HSA card)

If you are unable to complete, or forget to bring your forms, please arrive a minimum of 15-20 minutes early to complete a new Personal History form located in the wall file in the waiting area. *The time allotted for the appointment cannot be extended due to incomplete forms.*

All forms will be reviewed during your intake session and the remaining time will be spent talking about what brought you in for counseling. Your therapist will focus on hearing your story and asking questions to better understand your particular struggle and/or situation. This is also a time to measure how comfortable this feels and if this is a good "fit" between you and your therapist.

By the end of your first session, you can expect some feedback from the therapist and both of you will agree on a "game plan" for therapy. If you have any questions, feel free to ask your therapist during your appointment.

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UNATTENDED CHILDREN

We are unable to provide supervision for children in the waiting room and cannot accept responsibility for their safety if left unattended.

For the safety and welfare of the children and out of consideration for others, please make arrangements for childcare during therapy sessions, or provide adult supervision for children while waiting in the waiting room.

Parents will be held responsible for any property damage caused by their child

CONFIDENTIALITY POLICY

The staff and therapists at ISI Therapeutic Family Services, LLC have an obligation to respect your right to confidentiality for the information you share within this clinical setting. Confidentiality of client information is governed by federal law (Health Information Portability and Accountability Act) and by state law.

The State of Alabama laws impose some limitations to your rights to confidentiality. The following is a list of situations in which you may lose your right to confidentiality:

- ✓ We are obligated to report any maltreatment of minors or vulnerable adults. This includes physical abuse, sexual abuse or neglect.
- ✓ We are obligated to report any prenatal exposure to controlled substances.
- ✓ We are obligated to report any serious harm you intend to inflict on yourself or another.
- ✓ We are obligated to share information if directed by Court Order to conform to state or federal law, rules or regulations.

If you are a minor, you have a limited right to privacy in that your parents may have access to your records. Minor clients have rights to complete confidentiality in obtaining counseling for pregnancy & associated conditions, sexually transmitted diseases, & information about drug and alcohol abuse. However, if the therapist believes that sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law.

There are instances in which administrative individuals associated with ISI Therapeutic Family Services, LLC have duties that require access to the information you may share for claim processing, scheduling, reports, consultations, etc.

In keeping with standards of practice, your therapist may consult with other mental health professionals within this group private practice regarding care and management of cases. The purpose of this consultation is to ensure quality of care. Your therapist will maintain confidentiality and protect your identity by not using real names or any identifying information. Therapists seeing members of your family or your significant others will obtain a signed Release of Information (ROI) prior to discussing specific details of your situation.

IN CASE OF EMERGENCY

Since I provide outpatient diagnostic and psychotherapy services only, I cannot guarantee around-the-clock availability. Phone calls made after hours will be handled by my voice mail system and returned the following day. Therefore, if you should experience an emotional or behavioral crisis, and I cannot be reached immediately by telephone, you should contact a local medical or psychiatric hospital or call 911. East Alabama Medical Center is located at 2000 Pepperell Parkway, Opelika, AL 36801. The crisis center contact is: 1-800-815-0630.

TELEPHONE & EMAIL COMMUNICATION

Voicemail is available between sessions. Messages will be returned as soon as possible during business days. Please do not rely on your therapist's voicemail in times of crisis or for an emergency.

A prorated charge is applicable to time spent with you on the telephone by your therapist beyond appointment scheduling or similar matters (lasting more than 5 min). Telephone sessions between sessions may be scheduled in advance, based on availability of both parties. **Therapy sessions conducted on the telephone are not billable to insurance.**

Email should ONLY be used for scheduling purposes and may not be checked on a daily basis. Email correspondence is not considered to be a confidential medium of communication and your therapist is not responsible for any information transmitted via email.

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INSURANCE BILLING: Please email us at christy@isitherapy.com to update insurance or registration information.

We are in-network providers for most major insurance companies. Please call your insurance company before your first appointment to verify if we are in-network and to see if you need prior authorization or a referral from your primary care physician. We are NOT in-network with Medicare or Medicaid. As a courtesy to you, we work directly with your insurance company.

You must notify us in advance of your first appointment if you intend to use an Employee Assistance Program (EAP). Once services have been provided under insurance, we will not bill your EAP.

Once we receive your in-take packet, we will verify your coverage and any necessary authorizations. If your insurance requires a referral from your primary care doctor, it is your responsibility to obtain a referral PRIOR to your first appointment with us. Verification of coverage is not a guarantee of claim payment. Coverage is subject to the terms and conditions (e.g. authorizations, network requirements) outlined in your member contract with your insurance company.

It remains your responsibility to understand your plan's limitations, deductibles and exclusions. For benefit coverage questions, please call the customer/member service number on the back of your insurance card. We have no authority to make specific representations to you regarding coverage of services.

It is your responsibility to provide us with updated information when your insurance policy changes or your coverage terminates. If the insurance information you provide to us is later determined to be inaccurate, resulting in denial of your claim, then you will be responsible for paying the amount of the denied claim.

If you attend any appointment without obtaining a referral, if required, you are responsible to pay the private pay fee for services at the time of your visit.

There may be instances in which you will need to communicate directly with your insurance company to ensure a smooth billing process. If your insurance requests information regarding Coordination of Benefits (CoB) or Pre-existing Conditions, please promptly return any forms or call your insurance company directly to follow up. Once they request this information from you, all claims deny, and become your full financial responsibility until you provide it. Please email us at christy@isitherapy.com to let us know you have resolved any CoB or Pre-existing Condition requests so that we can have your insurance reprocess the denied claims immediately.

ACCOUNT RESPONSIBILITY

Because we are a "fee for service" provider, billing statements from ISI Therapeutic Family Services, LLC will NOT automatically be sent - should you need a statement or itemized receipt, please inform your therapist, and we will provide this for you upon request within 7 business days.

Per your agreement with your insurance company, it remains your responsibility to *immediately* pay any copayments, deductibles, coinsurances or other amounts your insurance carrier determines as payable by you. This payment is to be collected by your therapist. We do not have the ability to waive copayments, deductibles, or coinsurance amounts due, as this is a violation of the contract we have with your insurance company.

Cost estimation tools provided by your insurance company allow the collection of coinsurance and deductible amounts **up front at the time of service**, rather than waiting until after the claim is processed. This collected payment is based on an *estimate* of your out-of-pocket costs for services provided. Actual coverage and member liability amounts are determined once the claim is processed and you receive an explanation of benefits (EOB). Any overpayments will be applied to ongoing balances or refunded within 90 days of claim processing. Any underpayments must be paid by mail, online at our website, or at your next scheduled appointment (if scheduled appointment occurs within 1 week of receiving your EOB).

To ensure proper credit, please make checks payable to ISI Therapeutic Family Services, LLC. There will be a **$40 fee for returned checks**. Thereafter, payment will only be accepted in the form of cash, credit card or money order.

You are responsible for charges not eligible and/or covered by your medical insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Should you default on any payment obligations, we reserve the right to forward your information to collections, and an additional 30% may be assessed to cover the costs of this action.

We are not obligated to provide continuing services in the event that ISI Therapeutic Family Services, LLC is named as a creditor in any bankruptcy filing.

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MISSED APPOINTMENTS

We realize that on occasion you will not be able to make a scheduled appointment. However, please remember that your therapist has reserved this time for you alone, so our policy is to charge **a minimum of $65 for missed appointments or for cancelations without a AT LEAST 24-hour advance notice**. It is up to your therapist's discretion to require *more* than a 24-hour notice or to charge a *higher* rate for missed appointments.

This charge is NOT covered by insurance and will be billed as your responsibility. Please help us serve you better by keeping scheduled appointments. *Clients with more than one missed appointment may be subject to same day scheduling and/or termination of care.*

PAYMENT FOR MINORS

Parents or guardians accompanying minors are responsible for payment of co-pays or balances at the time of service. If a minor is accompanied by an adult other than a parent or guardian, payment is still expected at the time of service. For unaccompanied minors, charges MUST be pre-authorized to an approved credit card, or paid by cash or check prior to, or at the time of service.

MAKING PAYMENTS

Please understand that payment of your bill is considered a part of your treatment. If mailing, please remit payment to:

ISI Therapeutic Family Services
2206 Executive Park Drive
Opelika, AL 36801

Online payments: Visit our website at ***www.isitherapy.com*** to pay using PayPal to isitherapybiz@gmail.com

FEES

Service/Insurance Code	Description	Unit	Rate
Not Billable to Insurance	Late Cancelation / No show	n/a	$65
Not Billable to Insurance	Returned Check (NSF)	n/a	$40
Not Billable to Insurance	Phone calls, Letters, & Reports	15 min	$25+
Not Billable to Insurance	Court Appearances	Day	$500

PREPARATION OF FORMS AND REPORTS

These require chart review and often, discussion with the client. A prorated charge is applicable to time spent and is not billable to your insurance.

RELEASE OF RECORDS

Most of the information a clinician collects about you will be classified as confidential. However, when insurance is involved ISI Therapeutic Family Services, LLC does not have control over and cannot assure its clients of confidentiality. That means employees of the insurer and employees of contracted organizations of the insurer have access to your chart. This is provided for in the insurance policy between you and your insurance company. The client record is legally the property of ISI Therapeutic Family Services, LLC. However, clients may have access to information contained in the file, except in those cases where the release of such information may be deemed harmful to the client's well-being. Information can be released to others only upon written informed consent of the client. In a few cases, information is unavailable to a client. Certain confidential data may be available only to the clinician and particular government agencies. Classified material falling into this category might deal with adoption, civil or criminal investigations, some medical data and the names of persons who report suspected abuse of children or vulnerable adults. In the event of request for transfer of records, the records will be forwarded upon completion of a Release of Information form and a payment fee based on the current AL Code Title 12 Courts 12-21-6.1*. Copies of records are available for $1 per page for the first 25 pages, not more than 50 cents for each page in excess of 25 pages and a search fee of $5, plus the actual costs of mailing the medical records.

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****COURT & LEGAL PROCEEDINGS**

ISI does NOT provide disability determination, custody studies, or handle court issues.

- ISI providers do not perform court evaluations nor do they appear in court on behalf of individuals, children or adults. ISI services are designed to assist in alleviating problems through individual or relational psychotherapy. ISI providers are not trained for, nor do they maintain records with the intended purpose of court involvement.

- In addition, the legal process is such that we may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your therapist. Because the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify whether factual or in an expert nature, in court or deposition.

- Should we be called to court by a judge court order, or our records court ordered or subpoenaed, we will charge the full amount applicable under law for our services.

- In the event that it is necessary, by court order or by subpoena, for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her services, (including but not limited to: travel, necessary expenditures (copies, parking, meals, and the like), time spent speaking with attorneys, reviewing records and preparation of reports) @ the rate of $500 per day.

- The client further agrees to pay a retainer fee of $1,000.00 two weeks prior to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.

- Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist at ISI to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. **My informed consent signature shows that this litigation limitation is clearly understood and agreed to.**

CLIENT BILL OF RIGHTS

ISI does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability or public assistance status.
Every client:

- shall be informed prior to, or at the time of, the intake appointment of services available at ISI and of any financial charges that are the client's responsibility to pay beyond the coverage of health insurance.
- can expect complete and current information concerning his or her diagnosis and individual treatment plan in terms he or she can understand.
- shall have the right to know by name, and the competencies of, the licensed mental health professional responsible for coordination of his or her treatment.
- shall have the freedom to place grievances and recommend changes in policies and services to ISI staff free from restraint, interference, coercion, discrimination, or reprisal.

In addition to the rights listed above, services offered by practitioners licensed by the State of Alabama have the right to: (a) expect that a practitioner has met the minimal qualifications of training and has the experience required by state law; (b) examine public records which contain the credentials of the practitioner; (c) obtain a copy of the rules of conduct.
Every client:

- has the right to be informed of and to refuse to participate in any experimental research.
- may expect courteous treatment and to be free from verbal, physical, or sexual abuse by RRC staff.
- has the right to a coordinated transfer of care when there will be a change of providers.
- may assert the client's right(s) without retaliation.
- has the right to choose freely among available mental health professionals and practitioners in the community and to change providers after mental health services have begun within contractual limits of the client's health insurance (if any).

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COMMENTS, QUESTIONS, CONCERNS

We value your opinion and strive to provide the best service possible. If you would like to share your comments, questions, or concerns, please contact our administrative department by phone 334-703-2095 or email at admin@isitherapy.com.

NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. Protecting our patients' privacy has always been important to this practice. A new state and federal law, the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At ISI Therapeutic Family Services, LLC, we are very careful to keep your health information secure and confidential. This law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W, Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our administrative department at admin@isitherapy.com or 334-329-9930 or to file a complaint in writing, addressed to: ISI Therapeutic Family Services, LLC 2206 Executive Park Drive, Opelika, AL 36801. If you choose to file a complaint, we will not retaliate in any way.

MINOR AGREEMENT

I understand that the normal procedure for discussing issues that are in my child's/children's therapy will be joint sessions including my child/children, the therapist, and me and perhaps other appropriate adults. If I believe there are significant health or safety issues, I will contact the therapist and attempt to arrange a session without my child/children present.

Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child/children. I understand that if information becomes known to the therapist and has a significant bearing on the child's/children's well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

Because of the role is that of the child's helper, the therapist will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. *Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.*

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I will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child prefers/children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child has/children have been abused or is/are a clear danger to self or others, the therapist will normally tell me only the following:

- ✓ whether sessions are attended
- ✓ whether or not my child is/children are generally participating
- ✓ +whether or not progress is generally being made

MINORS & SHARED CUSTODY

The best treatment for children with emotional and behavioral problems is within the context of their families. Children with unmarried or divorced parents have ongoing developmental needs for regular contact with both parents, unless it can be shown that this contact threatens the child's safety or mental health. Therapy is confidential, but not secret. Parents are entitled to understand the nature of their child's problem as well as the method and course of treatment. We welcome involvement of step-parents, siblings, grandparents, and others, but participation in therapy and access to the professional is determined based on the child's needs, the parents' wishes, and the family's circumstances. Only parents have access to their child's medical records. Both parents have this right of access, regardless of custody unless the custodial parent provides us with a court order limiting access or communication.

In cases where there is joint (split) legal custody between parents or guardians who are not married or cohabitating, we require both parents' authorization and signature for treatment of their minor child/children, prior to the child being scheduled for services. We believe it is best to identify and resolve potential parental conflicts or disagreements before treatment begins. If one parent is unavailable and we have a note from the child's medical doctor determining that it is appropriate to proceed with the consent of only one parent, the absent parent will maintain a right to the child's treatment records upon request while the child is a minor unless there is a court order to the contrary. In cases where one parent has sole legal custody of their minor child/children, only that parent is required to authorize treatment. In cases where the legal guardian is someone other than a parent, documentation must be provided.
We may request a copy of the custody decision for the mental health record, as well as a copy of any court order(s) regarding participation in therapy. We will attempt to involve both parents in the child's care except in cases of abuse or serious impairment on the part of one or both parents, or when the involvement would be detrimental to the child's mental health or would interfere with the child's treatment. Parents should understand that telephone, face-to-face, e-mail, or written communication from either parent may be shared as is clinically appropriate at the discretion of the therapist, with the other parent or with the child. Written communications, e-mails and telephone messages become part of the child's permanent record.

Alabama Law entitles parents with legal custody to information regarding their child's treatment and generally entitles parents to copies of their child's health records. However, Alabama allows for an exception to the release of copies of health records in the case of mental health. Mental health records are kept confidential to protect the child's ability to speak freely about their relationships and concerns regarding each parent. It is rarely in the child's best interest to have therapy records read by parents. Parents are encouraged to meet regularly with their child's therapist. Arrangements can be made to observe appointments, review records in the office, and freely share information regarding the child's health and treatment. If continuation of treatment becomes an issue, it is the responsibility of the parents to resolve the disagreement in court.

The role of your therapist is to provide psychotherapy services, not to assess fitness for custody, serve as an advocate on other issues or act as an expert witness. However you should be aware, if you should become involved in a legal matter and the therapist is subpoenaed to court, even by another party, you will be charged any and all applicable legal fees.

The parent/guardian who registers the child for services as a client is established as the guarantor and is responsible for payment of the account. When parents who are divorced have agreed to share health care expenses, it is the responsibility of the guarantor of the account to pay the fee and to collect reimbursement from the other parent if sharing expenses. If there is a communication problem resulting in a missed appointment, the guarantor is responsible for payment of the missed appointment fee. We expect parents to inform each other about scheduled appointments. The late cancel or no-show fee will apply if an appointment is missed regardless of which parent scheduled the appointment.

We are not responsible for routine communication with parents who do not attend appointments cannot routinely contact the non-custodial parent after each appointment. It is unrealistic to expect the therapist to send a summary letter, note, or e-mail after each appointment, unless payment arrangements have been made for this service. Expectation is that parents will communicate with each other openly regarding treatment and that each parent will cultivate a healthy relationship and open communication with their child.