Michele McColligan LLC, LPC, CAMS, CCATP
(678) 584-3989

CONSENT FOR TREATMENT

This document contains important information about my professional services and business policies. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have acted in reliance on it; if there are obligations imposed on me by your health insurer to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Psychological Services

Psychotherapy is the process where mental health distresses and disorders are assessed, prevented, evaluated, and treated. There are a variety of techniques that can be used to deal with the challenges that brought you to therapy. Psychotherapy has both benefits and risks. Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events in your life. Potential benefits include significant reduction in feelings of distress, better relationships, better problem-solving and coping skills, and resolutions of specific issues. Given the nature of psychotherapy, it is difficult to predict what exactly will happen, but I will do my best to make sure you will be able to handle the risks and experience at least some of the benefits. However, psychotherapy remains an inexact science and no guarantees can be made regarding outcomes. Before we begin working together, it is important to understand that I cannot guarantee that you or your child will benefit from therapy. No therapist can make such a guarantee because each client responds differently to this experience.

Therapy usually starts with an evaluation. This evaluation begins with an intake interview and may last more than one therapy session. During the evaluation, several decisions must be made. I must decide if I can provide the services needed to treat your presenting problem. You as a client must decide if you are comfortable with me. Both of us must decide on your goals for therapy and how to best achieve them. Therapy generally involves a large commitment, so it is your right to be careful about the therapist you select. If you have questions about any of the procedures recommended, feel free to discuss these openly with me. If you have doubts about me as your therapist, I will be happy to help you make an appointment with another mental health professional.

Sessions

Individual counseling sessions and family sessions are 50-minutes in length. Yoga-Cognitive Behavioral sessions are 60 minutes in length. Please arrive on time to your sessions. To respect other appointments, if you arrive late, the session will still end at the same time.

Contacting

My office hours vary. You can cancel and/or reschedule sessions by calling me, texting me or leaving me a voice message. If you have an emergency, please go to the emergency room at your nearest hospital or dial 9-1-1. Please note that the office does not have emergency services or facilities. Due to my work schedule, I am often not immediately available by telephone. I probably will not answer the phone when I am with a client. I will make every effort to return your call as soon as possible. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your primary care physician, call 911, or call the nearest emergency room.

Confidentiality

The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information to others about your treatment (or your child's treatment) if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. You should know that I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel it is important for our work together. I will note all consultations in your Clinical Record.

There are some situations where I am permitted or required to disclose information without either your consent or authorization: If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the therapist/patient privilege law.

I cannot provide any information without your written authorization, or a court order. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient to defend myself. If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills. If a patient threatens to harm himself / herself, I may be obligated to seek hospitalization for him/her and/or to contact family members, or others who can help provide protection. If I have reason to believe that a child, elderly, or disabled person has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Children Services (DFCS) or an agency designated by the Department of Human Resources.

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me will be different from most relationships. It may differ

in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways outside sessions, that would be considered a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between my interests and your interests, and then the client's (your) interests might not be put first. To offer all my clients the best care, my judgment needs to be unselfish and purely focused on your needs. Therefore, your relationship with me must remain professional in nature. You should also know that by law and ethically I am required to keep the identity of my clients a secret. As much as I may like to, for your confidentiality I will not address you in public unless you speak to me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, I cannot accept friend requests from social networking sites. After your therapy is complete, I will only respond to emails that are about your treatment. Please note that all email correspondence will become a part of your clinical record.

Record Keeping Procedures

Both law and the standards of the counseling profession require that I keep treatment records. You are entitled to receive a copy of these records unless I believe that seeing them would be emotionally damaging to you. If this is the case, I will be happy to provide your records to an appropriate mental health professional of your choice. Because client records are professional documents, they can be misinterpreted and can be upsetting.

If you insist on seeing your records, it is best to review them with me so that we can discuss their content. All records will be maintained for 7 (seven) years from the termination of service, as required by law. In most situations, I can charge a copying fee. If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request. In addition, I also keep a set of psychotherapy notes. These notes are for my own use and are designed to assist me in providing you or your child with the best treatment. While the contents of psychotherapy notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your or your child's therapy. They also contain particularly sensitive information that you or your child may reveal to me that is not required to be included in your clinical record and information supplied to me confidentially by others. These psychotherapy notes are kept separate from your clinical record. Your psychotherapy notes are not available to you. They also cannot be sent to anyone else, including insurance companies without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Consent for Minors

Clients under 18 years of age who are not emancipated, as well as their parents should be aware that the law allows parents to examine their child's treatment records unless I

believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is typically my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Insurance, Billing and Payments

My fee is $100.00 per session for Individual and Family sessions. Sessions run 50 minutes. Yoga-Cognitive Behavioral sessions are $125.00. Sessions run 60 minutes.

You will be expected to pay for each session at the time it is held, unless you have insurance coverage, or we agree otherwise. Credit Card Authorization will be held on file and usually ran 1-3 business days after the session. There is a 3% fee for credit cards. You can also pay cash or check. If you are paying by check, please make payments out to ***The Barden Group, LLC.*** There is a $25.00 fee for any returned checks or declined credit card transaction.

If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. If such legal action is necessary, its costs will be included in the claim.

Other services include report and letter writing, telephone or email conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. These services are not covered by your insurance company. No records (written or verbal) will be released to you or on your behalf if you have an outstanding balance

You will be charged the session fee for any sessions missed or cancelled with less than 24 hours' notice unless due to an unavoidable emergency. You may leave a message on my voicemail on weekends or after hours to cancel an appointment. Please note that insurance companies do not pay for missed or cancelled appointments, so you will be responsible for the missed visit fee. Additionally, if you (or your child) miss more than two appointments and do not give at least a 24-hour notice for those missed appointments, that counseling services may be discontinued, and you will receive an appropriate referral.

Court Attendance

For Court Attendance, On-Call, and Communication with Attorneys/Other Professionals I bill at the rate of $200.00 per hour for court attendance. The hourly rate begins when I leave the office location. A fee for two hours will be paid prior to court attendance, ($400.00) and is non-refundable if less time is needed. If the court attendance exceeds two hours, your credit card will be billed for the remaining time. Payment is for the therapist's time and not necessarily their testimony. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not. If you request for me to be on-call for court attendance, I bill at the rate of $1000.00 per hour for on-call. The hours requested for the therapist to be on call will immediately be charged to your credit card on file and is non-refundable.

Communication with Attorneys/Other professionals/Report writing:

I bill at the rate of $100.00 per hour for any type of communication with attorneys/other professionals/report writing (phone calls, letter writing, email, etc). You are responsible for providing credit card information prior to any communication I will have you're your attorney/other outside professional. A minimum of 30-minute increments will be billed to your credit card on file and is non-refundable.

Records Request

For records to be copied and faxed/given to the client, there is a flat rate of $25. If records need to be mailed, an additional fee of $10 is assessed to cover certified mail and postage. After payment is received and processed, please allow up to 7 business days for copies to be provided and/or mailed.

I _____, (client or legal guardian) have read, understand and agree to the terms of the Consent for Treatment.

_____ _____

Name of Client Date

_____ _____

Signature of Client Date

_____ _____

Name of Parent/ Guardian Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Michele McColligan LLC, LPC, CAMS, CCATP Date

Michele McColligan LLC, LPC, CAMS, CCATP
(678) 584-3989

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU M AY BE USED AND DISCLOSED BY MICHELE MCCOLLIGAN, LPC AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice is effective May 20th, 2015. It is provided to you pursuant to provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and related federal regulations. If you have questions about this notice, please contact me at (678)584-3989. Both federal and state laws establish strict requirements for most programs regarding the disclosure of confidential information, and I must comply with those laws. For situations where more stringent disclosure requirements do not apply, this Notice of Privacy Practices describes how I may use and disclose any Protected Health Information PHI for treatment, payment, health care operations and for certain other purposes. This notice relates only to health information. It describes your rights to access and control any PHI and provides information about your right to make a complaint if you believe I have improperly used or disclosed any PHI. Protected health information is information that may personally identify you or the child(ren) and relates to any past, present or future physical or mental health or condition and related health care services. I am required to abide by the terms of this Notice of Privacy Practices, and may change the terms of this notice, at any time. A new notice will be effective for all PHI that I maintain at the time of issuance. Upon request, I will provide you with a revised Notice of Privacy Practices in person at any facility where you receive services from me.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Any PHI may be used and disclosed by myself, employees, contractors, agents and attorneys for the purpose of providing mental health services to you. Protected health information is routinely needed in order to ensure proper mental health treatment.

Treatment: Any PHI may be used to provide, coordinate, or manage your or your child's mental health services, including coordination with a third party that has your permission to have access to any PHI, such as other health care professional who may be treating you or your child(ren), a health care specialist or laboratory.

Payment: Your PHI or that of the child(ren) may be used to obtain payment for you or your child(ren)'s health care services.

Health Care Operations: I may use or disclose any PHI to support the business activities including, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities.

You may be asked to provide your name and other necessary information, and you may be called by name in the waiting room when a staff member is ready to see you, and any PHI may be used to contact you about appointments and/or for other operational reasons. Any PHI may be shared with third party "business associates" who perform various activities that assist us in the provision of your or your child(ren)'s mental health services. Other uses and disclosures of any PHI will be made only with your written authorization, which you may revoke in writing at any time, except as permitted or required by law as described below.

OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES WITH YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

The Department may use and/or disclose any PHI to a court of law, to a family member, relative or any other persons you identify on an Authorization Form. You have the opportunity to agree or object to the use and/or disclosure of all or part of any PHI.

PERMITTED OR REQUIRED USES AND DISCLOSURES W/O YOUR AUTORIZATIONS OR OPPORTUNITY TO OBJECT

I may use or disclose any PHI without your authorization when required to do so by law; for public health purposes, to a person who may be at risk of contracting a communicable disease, to a health oversight agency, to an authority authorized to receive reports of abuse or neglect, in certain legal proceedings, and for certain law enforcement purposes. Protected health information may also be disclosed without your authorization to a coroner, medical examiner or funeral director, for certain approved research purposes, to prevent or lessen a threat to health or safety, and to law enforcement authorities for identification or apprehension of an individual.

REQUIRED USES AND DISCLOSURES

I must make disclosures to you, when required by the Secretary of the Department of Health and Human Services and to investigate or determine the Department's compliance with the requirements of the Privacy Rule at 45 CFR Sections 164.500 et.seq.

YOUR RIGHTS UNDER THE FEDERAL PRIVACY RULE

You have the right to inspect and copy your protected health information.
Upon written request, you may inspect and obtain a copy of any PHI for as long as the Department maintains the PHI. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy information

compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or PHI that is subject to a federal or state law prohibiting access to such information.
You have the right to request restriction of your protected health information.
You may ask in writing not use or disclose any part of any PHI for the purposes of treatment, payment or healthcare operations, and not to disclose PHI to family members or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restriction to apply. I am not required to

agree to a restriction you request, and if it is believed that it is in your best interest to permit use and disclosure of any PHI, the PHI will not be restricted, except as required by law. If I do not agree to the requested restriction, they may not use or disclose any PHI in violation of that restriction unless it is needed to provide emergency treatment.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
Upon written request, I will accommodate reasonable requests for alternative means for the communication of confidential information, but may condition this accommodation upon your provision of an alternative address or other method of contact. I will not request an explanation from you as to the basis for the request.
You may have the right to request amendment of any protected health information.
If I created any PHI, you may request in writing an amendment of that information for as long as it is maintained. I may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial.
You have the right to receive an accounting of certain disclosures I have made of any protected health information.

This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, excluding any disclosures I made to you, to family members or friends involved in your care, or for national security, intelligence or notification purposes. Upon written request, you have the right to receive legally specified information regarding disclosures occurring after April 14, 2003, subject to certain exceptions, restrictions, and limitations.

COMPLAINTS RELATED TO USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION OR RIGHTS

You may complain to myself and/or to the Secretary of Health and Human Services if you believe your health information privacy rights have been violated. You may file a complaint, in writing, with company which maintains any PHI. You must state the basis for your complaint. I will not retaliate against you for filing a complaint. You may contact me by email to Attn: Michele McColligan at michelemccolligan@gmail.com for further information about the complaint process, this notice, or your rights set forth above.

I have received a copy of this Notice on the date indicated below.

_____

Print: Client or Parent/Guardian Date

_____

Signature: Client or Parent/ Guardian Date

_____

Michele McColligan LLC, LPC, CAMS, CCATP Date

Michele McColligan, LLC, LPC, CAMS, CCATP

Authorization for Credit Card Payments

Visa, MasterCard, American Express and HSA cards are all accepted. By completing the information below and signing, you agree to have your credit card information stored securely until your file has been closed. You also authorize me to charge your credit card for fees associated with services provided. Charges are made for sessions, no show/late cancelation fees, co-pay and deductible payments. Please note the charge will say THE BARDEN GROUP, LLC.

Name as it appears on your credit card

_____

Card Type: Visa___ MasterCard___ American Express___ HSA___

Card Number: _____

Expiration Date: _____/_____ CVC: _____ (3-digit code on back of card)

Zip Code: _____

_____
Client/Parent Guardian Signature

_____
Michele McColligan, LLC, LPC, CAMS, CCATP

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. **COVID-19 is extremely contagious** and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Barden Behavioral Health has put in place preventative measures to reduce the spread of COVID-19; however, Barden Behavioral Health **cannot guarantee** that you or your child(ren) will not become infected with COVID-19. Further, attending in-person appointments with Barden Behavioral Health **could increase** your risk and your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself and/or my child(ren) may be exposed to or infected by COVID-19 by attending in-person appointments with Barden Behavioral Health and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Barden Behavioral Health may result from the actions, omissions, or negligence of myself and others, including, but not limited to Barden Behavioral Health, their employees, volunteers, and other participants and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself and/or my child(ren) (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my attendance or my child(ren)'s attendance at in-person appointments with Barden Behavioral Health. On my behalf and/or on behalf of my child(ren), I hereby release, covenant not to sue, discharge, and hold harmless the Barden Behavioral Health, its employees, agents, and representatives of and from the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Barden Behavioral Health, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any in-person appointments with Barden Behavioral Health.

_____

Client/Parent/Legal Guardian - Printed Name:

_____

Client/Parent/Legal Guardian - Signature and date:

CLIENT INFORMATION FORM

Today's date: ____/____/____

Your name:

_____

Last First Middle Initial

Childs Name:
(If Applicable)

_____

Last First Middle Initial

Client or Child's Date of birth: _____/_____/_____

Home street address: _____

City: _____State: _____Zip:_____

Home Phone: _____Work Phone: _____

Cell Phone: _____ Email: _____

Calls will be discreet, but please indicate any restrictions or preferences below: For example, would you prefer to be contacted by text, phone call or e-mail? Please note I cannot guarantee 100% security and privacy with the use of smartphones.

_____
_____

Please briefly describe your presenting concern(s):

_____
_____
_____

What are your goals for therapy?

_____
_____

How long do you expect to be in therapy in order to accomplish these goals?

_____