

The Barden Group, LLC

INFORMATION, AUTHORIZATION, & CONSENT TO BEING A COLLATERAL PARTICIPANT

*****(Please print single-sided only and retain this page for your records.)*****

Thank you very much for taking the time to read this authorization form carefully. I have given you this form because you have elected to become part of your friend's, family member's, spouse's, or partner's treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your experience here at Barden Behavioral Health. Specifically, this document is to inform you about your rights, responsibilities, and risks regarding collateral participation. A "collateral participant," means that you are here to assist another person (the designated client), but you are not the primary focus of treatment. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your collateral participation.

DESCRIPTION OF COLLATERAL PARTICIPATION

The role of a collateral participant can vary greatly. For example, a parent or guardian may continuously be involved in the treatment of a minor. Whereas, a partner or friend may only come in once or twice to help the designated client. We will discuss what role you shall take in the client's treatment during our first session. As mentioned above, I am committed to providing treatment to the designated client, and your participation is adjunct to this treatment. Therefore, my legal and ethical responsibility resides strictly with the designated client. This means the following: (1) What the client tells me is confidential, but what you tell me is not. This isn't to say that I plan to divulge any information that you tell me to the public. However, I will not keep secrets from the client, and your information isn't protected by the same laws as the information given to me by the client. (2) Although your participation as a collateral may help you psychologically; it also may not. My primary concern is for the client, and treatment will focus on the client's needs. However, I will be glad to give you other resources for your own treatment if necessary. (3) I will keep a clinical record for the designated client only. Any notes I take regarding your participation will go into the client's chart. The client has the right to access their chart; however, you do not have the right to access this chart without the client's written permission. Parents have a legal right to a minor's chart, but not an ethical right. (4) I will give the client a diagnosis for treatment purposes and, if applicable, for insurance filing. However, I will not give a collateral participant any kind of diagnosis.

PARENTS AS COLLATERAL PARTICIPANTS

Due to the sensitive nature of counseling and the fragile stage of development that your child is currently experiencing, forming a therapeutic bond with me, as their therapist, is very critical at this point. It is important they feel safe and comfortable discussing personal and private topics with me. In effort to respect the privacy and sensitive needs of your child, I will not be discussing the content of therapy sessions with you in detail. It is my hope that through the therapeutic process new skills and insights will be gained by your child so they can discuss these sensitive topics with you in their own time. If your child is too young to do this, we will have family meetings to assist in this process. However, if at any time I make the assessment that your child is in danger or might be dangerous to others, if abuse/neglect is suspected or reported, or if there are any other concerns related to the health and welfare of you or your child, you will be notified immediately so that the necessary actions and precautions can be taken.

I have read the above statement defining "collateral participant." The differences between a *collateral participant* and *client* have been adequately communicated to me and I understand my role and limits to confidentiality.

Collateral Participant - Printed Name: _____

Collateral Participant - Signature and Date: _____

ABOUT THE THERAPIST

GLEN BARDEN, MA, LPC is a Licensed Professional Counselor in the state of Georgia (license # LPC009794) with a Master's degree in Professional Counseling from Liberty University. Glen has vast experience providing therapeutic services for adolescents, adults, couples and families. Glen has received training in Dialectical Behavior Therapy (DBT) and is a member of The American Counseling Association, and received invitation into The International Honor Society of Psychology.

ABOUT THE BARDEN GROUP, LLC

The Barden Group, LLC a limited liability company in the state of Georgia providing a comprehensive therapeutic environment in which our therapists can provide counseling services for adolescents and adults. The Barden Group maintains professional offices for client therapy, as well as group services and peer consultation contracting with both fully licensed therapists and associate licensed therapists who all provide a full range of therapeutic services for adolescents, parents, families and individuals.

POTENTIAL RISKS OF COUNSELING

Your participation in counseling is of your own voluntary decision and may pose some risk to you. Therapy can produce a wide-range of positive and negative emotions which may make you uncomfortable or may impact your relationship with others. If you experience any difficulties during the course of your sessions, you should immediately discuss your concerns with the counselor.

IN CASE OF EMERGENCIES

The Barden Group, LLC is NOT an emergency services provider. Therefore, we do NOT provide emergency services to potential or current clients or collateral participants.

If you are experiencing a life-threatening emergency, please call 911 immediately.

The following is a list of non-emergency mental health resources that may be contacted for afterhours services:

NATIONAL SUICIDE PREVENTION LIFELINE	800-273-8255
COBB MENTAL HEALTH CRISIS LINE...	770-422-0202
RIDGEVIEW INSTITUTE...	770-434-4567
PEACHFORD HOSPITAL...	770-455-3200
LAKEVIEW BEHAVIORAL HEALTH...	678-713-2600

Collateral Participant's Information *(please add additional pages as needed)*

Client Name: _____ Date of Birth: _____

Collateral Participant's Name: _____ Date of Birth: _____

Relationship to Client: _____

Address: _____ City/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer/Occupation/School Info/Grade: _____

Emergency Contact (Name, Relationship, Phone): _____

(Please complete an Authorization for Release of Information form for your Emergency Contact)

What is the primary reason you are participating in the client's treatment?

Have you ever participated as a collateral participant in the client's treatment before? What helped or did not help?

Please list all allergies (including animals, drugs, foods, etc.):

Have you ever expressed or experienced thoughts or feelings of suicide, self-harm, or harm to others? If yes, please provide approximate time frame(s) and details.

What goals or changes would you like to see accomplished by the client through counseling?

CLIENT CONFIDENTIALITY

Due to the sensitive nature of counseling, privacy and confidentiality will be of the utmost concern. Therefore, it is required that any and all information presented within the session(s), whether by the facilitator, therapist, counselor, or group leader (hereafter referred to as "counselor"); or client is not to be discussed outside of the therapeutic setting with anyone except for the following exceptions required by law: 1) The client signs a written release of information indicating informed consent of such release, 2) The client expresses intent to harm him/herself or someone else, including suicidal and homicidal ideation 3) There is a reasonable suspicion of abuse/neglect against a minor, elderly person (60 years or older), or a dependent adult, 4) A court order is received directing the disclosure of information. Before mandated disclosure, privileged communication will be asserted on behalf of the client. Further, clients will be apprised of all mandated disclosures as soon as notification has been received. The Patriot Act of 2001 requires that in certain circumstances, I am required to provide federal law enforcement agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.

Confidentiality includes not acknowledging your receipt of services without your permission. Therefore, if you happen to see your counselor outside the office setting, please do not be insulted if your counselor does not initiate contact. This is for your protection; however, you may initiate an interaction based on your level of comfort and disclosure.

Additionally, some Counselors may be able to provide paperwork for you to file with your insurance company; however, insurance companies require a diagnosis for reimbursement. Confidentiality cannot be guaranteed by your therapist once information is given to insurance companies. Please check with your counselor for clarification.

My professional supervision and/or consultation with other licensed therapists are times where I share information about my cases for purpose of gaining further perspective and ideas for how to best serve my clients without revealing names or identity. Peers, fellow therapists and any supervisor are bound by confidentiality.

In **working with children**, though legally the parent(s) or legal guardian(s) of child clients are the client and confidentiality lies with the client, in order to establish and preserve the essential relationship and setting for a child's therapy, I honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations.

In **working with couples and families**, the couple as an entity and the family as an entity is the client and the Counselor is not providing individual therapy for either half of the couple or for any one member of the family although session with individuals in the couple/family may be a part of the couples/family therapy. The Counselor ***will not be a "secret keeper" nor will the Counselor facilitate secret keeping.*** If anything significant is revealed in an individual session that the Counselor feels another party needs to be told, the Counselor will require it be brought up in the next session together, so it may be therapeutically addressed. If the individual refuses to reveal the Counselor recommended subject, the Counselor has the right to terminate the counseling relationship and refer the couple or family to another Counselor for treatment.

In the case of my death or major medical incapacitation, my records will be accessed by Melanie Peters, LPC.

I have read and received the Notice of Client Confidentiality and its limits as it applies to the client. I understand a collateral participant is not the designated client and I am not afforded the same privilege and confidentiality afforded the client; however, I agree to adhere to the above outlined confidentiality as it relates to the client.

Collateral Participant - Printed Name: _____

Collateral Participant - Signature and Date: _____

ELECTRONIC COMMUNICATION

Secure and private communication cannot be fully assured utilizing cell/smart phone; email or other electronic technologies. It is the collateral participant’s right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Use of non-secure technologies to contact your Counselor will be considered to imply consent to return messages to collateral participant via the same non-secure technology, pending further clarification from collateral participant. **Please check below which modes of communication are permitted and which are not permitted.** This consent may be altered at any time should circumstances of preferences change. If collateral participant chooses not to allow non-secure modes of communication, contact will only be made via wire-to-wire phone; wire-to-wire fax; or regular mail utilizing the address provided on page one of this document.

Voice Communication to collateral participant’s cell/smart phone for:

- Scheduling Appointments ___Allowed ___Not allowed
- Appointment Reminders ___Allowed ___Not allowed
- Between Session Contact ___Allowed ___Not allowed

If permitted, list permitted number(s): _____

Voice Communication from Glen Barden’s cell/smart phone for:

- Scheduling Appointments ___Allowed ___Not allowed
- Appointment Reminders ___Allowed ___Not allowed
- Between Session Contact ___Allowed ___Not allowed
- Authorized 3rd-Party Contact ___Allowed ___Not allowed

Text Communication to collateral participant’s cell/smart phone for:

- Scheduling Appointments ___Allowed ___Not allowed
- Appointment Reminders ___Allowed ___Not allowed
- Between Session Contact ___Allowed ___Not allowed

Text Communication from Glen Barden’s cell/smart phone for:

- Scheduling Appointments ___Allowed ___Not allowed
- Appointment Reminders ___Allowed ___Not allowed
- Between Session Contact ___Allowed ___Not allowed
- Authorized 3rd-Party Contact ___Allowed ___Not allowed

Fax Communication to collateral participant’s non-secured/e-fax for:

- Scheduling Appointments ___Allowed ___Not allowed
- Appointment Reminders ___Allowed ___Not allowed
- Between Session Contact ___Allowed ___Not allowed

If permitted, list permitted fax number(s): _____

Fax Communication from Glen Barden’s non-secured/e-fax for:

- Scheduling Appointments ___Allowed ___Not allowed
- Appointment Reminders ___Allowed ___Not allowed
- Between Session Contact ___Allowed ___Not allowed
- Authorized 3rd-Party Contact ___Allowed ___Not allowed

Contact via the collateral participant's email for:

Scheduling Appointments	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed
Appointment Reminders	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed
Between Session Contact	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed

If permitted, list permitted email address(es): _____

Email Communication from Glen Barden's non-secured/email for:

Scheduling Appointments	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed
Appointment Reminders	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed
Between Session Contact	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed
Authorized 3rd-Party Contact	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed

Teleconferencing based communication to collateral participant's portal/cell/smart phone for:

Scheduling Appointments	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed
Appointment Reminders	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed
Between Session Contact	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed

If permitted, list permitted site(s) or methods: _____

Teleconferencing based communication from Glen Barden's portal/cell/smart phone for:

Scheduling Appointments	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed
Appointment Reminders	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed
Between Session Contact	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed
Authorized 3rd-Party Contact	<input type="checkbox"/> Allowed	<input type="checkbox"/> Not allowed

If permitted, list permitted site(s) or methods: _____

Statement of Validation

I have read the statement of services regarding non-secure electronic communication, it has been adequately communicated to me, and I understand the contents and limits to confidentiality.

Collateral Participant - Printed Name: _____

Collateral Participant - Signature and Date: _____

LEGAL PROCEEDINGS

*****I am not a custody evaluator and cannot make any recommendations on custody. I can refer you to a list of licensed psychologists who provide custody evaluation if needed.*****

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you MUST agree before we enter a counseling relationship:

1. THE BARDEN GROUP, LLC requires a copy of the current, standing court order demonstrating custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session BEFORE I am able to meet your child. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for counseling and will need to obtain written consent for the child to participate in counseling from the legal custodian(s) and prefer to have contact with both parents prior to seeing the child.

2. THE BARDEN GROUP, LLC Counselor(s) will provide an identical summary of a child’s therapy progress, treatment plan information and parent recommendations to both parents who share in the legal custody of the child I am seeing for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.

3. THE BARDEN GROUP, LLC requests all collateral participants waive the right to subpoena THE BARDEN GROUP Counselors to court. This policy is set in order to preserve the efficacy and integrity of the therapeutic progress and relationship with you and/or your child(ren). A Counselors appearance in court often damages the therapeutic relationship between the collateral participant and Counselor, and it is the Counselors ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of their collateral participants. By signing this agreement, you are waiving right to subpoena your Counselor and agreeing in fact to not have any clinical or personal records of the Counselor subpoenaed. THE BARDEN GROUP, LLC Counselors will be happy to provide a referral to another therapist who will be willing to appear in court as an alternative if you would prefer.

4. In cases whereby a THE BARDEN GROUP, LLC Counselor is subpoenaed to appear in court regardless of this waiver – whether to testify or not – an upfront, non-refundable, non-prorated charge of \$1500.00 for one-half (1/2) day will be paid five days in advance. An additional charge of \$375/hr. (rounded up to 15-minute intervals) will be charged for Court Related work, including: any court-mandated appearances, personal preparation, document preparing, consultations with attorneys and/or the guardian ad litem, et al and travel time. All travel costs including airfare, \$0.58 per mile driving allowance, hotel expense (location acceptable to counselor), and \$50 per diem meal allowance will be incurred by the collateral participant.

I understand these policies and hereby waive all rights to subpoena Glen N. Barden, MA, LPC, session notes and the clinical record for any current or future legal proceedings.

Collateral Participant - Printed Name: _____

Collateral Participant - Signature and Date: _____

SCHEDULING AND CANCELLATIONS

Scheduling appointments is handled directly with your counselor. Methods of communication are outlined in the Electronic Communications Policy page within this Informed Consent document. A minimum of 24 hours is required to cancel an appointment. If a collateral participant does not arrive for a scheduled appointment or cancels within 24 hours, a fee of the greater of the full session rate or \$75 will be billed. If there is a true, unavoidable emergency or serious or contagious illness, please call as soon as possible and I will work with you to reschedule and you may request waiver of the 24 hour policy.

Session parameters

Parenting sessions, individual counseling sessions and family sessions are 50 minutes. Sessions will start and end on time. To respect other appointments, if you arrive late, the session will still end at the scheduled time.

Fees, Payment, Insurance

Counselor is not currently on insurance panels; however, most HSA and MRA cards are directly accepted or sessions may be eligible for reimbursement; application towards deductibles; or application towards out-of-network coverage. Please speak directly to your counselor for more information.

All fees are paid directly to The Barden Group, LLC. THE BARDEN GROUP, LLC accepts cash, checks, Master Card, Visa, American Express and most debit cards associated with Healthcare Savings Account (HSA) and Medical Reimbursement Account (MRA). Please note debit or credit card payments are subject to a 3% processing fee.

There is a \$25 fee for any returned checks or declined credit card transaction due to insufficient funds. That \$25 fee is due at the time of your next session, along with the payment for that session. In the event of two (2) declined transactions, prepayment will be required going forward.

Individual Initial Intake Session - \$160.00 (60 minutes)

Individual Sessions - \$140.00 (50 minutes)

Family / Couples Initial Session - \$170.00 (60 minutes)

Family / Couples Sessions - \$160.00 (50 minutes)

DBT Group Sessions - \$40.00

Non-court related preparation of Treatment Summaries or Letter(s) requested by clients: \$75 per item.

Court related fees: Please refer to the Legal Proceedings page within this Informed Consent.

Out of office attendance for IEP's, In-home sessions, etc. will be billed at the normal hourly rate (door-to-door), plus \$0.58 per mile travel costs.

A limited number of reduced fee slots are available with application and are extended based on financial need. Please ask about reduced fee options. I will be more than happy to discuss alternative payment agreements at our initial intake session. A reduced fee agreement will be signed once approved.

Signature indicating I have read and understand the Notice of Scheduling and Cancellations Policy:

Collateral Participant - Printed Name: _____

Collateral Participant - Signature and Date: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Our practice is dedicated to maintaining the privacy of your protected health information. I am required by law and must provide you with this important information. The information presented here is a shorter version of the full, legally required Notice of Privacy Practices (NPP), which is located in the binder on the wall bin in the waiting area. Please refer to the NPP for more information. Also, feel free to take a personal copy from the binder. Since we cannot cover all possible situations, please talk with me about any questions or problems. I will use the information about your health that I get from you or from others, mainly to provide the client with treatment, to arrange payment for services, or for other business activities, which are called in the law "healthcare operations". After you have read this NPP, I will ask you to sign a consent form to let me use and share this information. If you do not consent and sign, I cannot treat the client. Of course, I will keep your health information private, but there are times when the laws require me to use or share it, such as the following:

- 1) When there is a serious threat to you, your child's or the client's health and/or safety, or the health and/or safety of another individual and/or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.
- 2) Some lawsuits and legal or court proceedings.
- 3) If a law enforcement official legally requires me to do so.
- 4) For workers compensation and similar benefit programs.

There are situations like these that do not happen very often. They are described in the long version of NPP.

COLLATERAL PARTICIPANT RECORDS

You should be aware that, pursuant to Health Information Portability and Accountability Act (HIPAA), I keep information about all my clients and collateral participants in a collection of professional records. This constitutes the client's Clinical Record. I keep brief notes indicating the date and time of your session, issues/themes observed in session, interventions utilized, treatment plan, fees charged and paid. You may schedule an appointment to examine notes from your session, but the client's Clinical Record can only be viewed with the client's written permission. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, I recommend that you initially review them in my presence within a scheduled session, or have them forwarded to another mental health professional so you can discuss the contents. There will be an administrative fee of \$35 charged for copying and mailing the record for release.

CLIENT - COLLATERAL PARTICIPANT RIGHTS

HIPAA provides clients with several new or expanded rights regarding the Clinical Records and disclosures of protected health information. These rights include requesting that I amend the record; requesting restrictions on what information from the Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints made about my policies and procedures recorded in the records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. A copy of HIPAA rights is located in a blue binder in our lobby for review or we can provide a copy to you at any time. These rights do not extend to collateral participants.

COMPLAINTS OR GRIEVANCES

If you feel that there is basis for a formal complaint or grievance about anything related to the professional services I am providing, I invite you to first communicate your concerns to me directly so that I will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about me with my licensing board and may do so by contacting the board at the following address and phone number: Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists 237 Coliseum Drive Macon, GA 31217-3858 (478) 207-2440

I have read the Notice of Privacy Policies, it has been adequately communicated to me, and I understand the contents and limits to confidentiality.

Collateral Participant - Printed Name: _____

Collateral Participant - Signature and Date: _____

NON-RECORDING AGREEMENT

Successful therapy depends on building a relationship of trust, good faith, and openness between collateral participant(s) and therapist(s). Often, audio or video recording can inhibit candor and introspection in therapy. Covert recording is a direct violation of trust and good faith to all the other persons in the room.

In addition, recordings made and taken home by collateral participants sometimes fall into unintended hands through loss, random or targeted theft, or action by police, court or governmental agency. Such loss could compromise or nullify your legal expectation of confidentiality in the extremely sensitive personal or interpersonal matters that may have been discussed. Courts may not give your own recordings all the legal confidentiality they give to a therapist's office notes and may find them self-serving. Collateral participant recordings can more easily end up becoming an issue in conflicts such as divorce, child custody, or other legal cases or be used by agencies of government. A collateral participant who makes a recording solely for personal use or to use against a partner may later be surprised to find the recording being used against him- or herself instead. And once an unfavorable recording exists, its deletion can become legally punishable if a subpoena is issued for it. Additionally, most users of recording technology lack the technological tools and knowledge required to delete a recording in a way that makes it unrecoverable and unhackable.

Factors like these undermine the therapeutic process and the building or rebuilding of trust that takes place between partners in session and between the collateral participant(s) and therapist(s).

For these reasons and others like them, The Barden Group maintains a strict policy on recording.

Therefore, the Collateral Participant agrees that:

1. Recording may only take place with the knowledge and explicit consent of ALL (not just one) collateral participants, therapists, and other persons present during a session or other interaction, whether face-to-face or taking place by live textual, audio, or video link.
2. Consent for each recording must take the form of dated written signatures from all persons on a paper form available for that purpose, with a copy to each person recorded. Additionally the recording itself must include the live consent of all persons present, with such consent stated at the start of the recording or when they join a session or interaction already in progress.

Therapists at Barden Behavioral Health will only consent to recording of a session for exceptional reasons and only after the drawbacks and risks have been discussed and the benefit clearly outweighs them.

Violation of this policy by covert recording or non-conformance with this agreement will lead to termination of therapy.

I acknowledge that I have read and understood this policy, accept it, and pledge to uphold it.

Collateral Participant - Printed Name: _____

Collateral Participant - Signature and Date: _____

Therapist Signature and Date: _____

AGREEMENT TO ENTER INTO COUNSELING SERVICES AND FEE FOR SERVICES AGREEMENT

I have read or had read to me and understand all the information in the above paperwork. I have had a chance to review and ask questions and have all questions answered to my satisfaction. I agree to abide by all the policies outlined herein. By signing this agreement, I am consenting to treatment and understand all the benefits and risks of counseling. I also hereby acknowledge that I have received the Notice of Privacy Policies.

Every time I schedule an appointment with Glen Barden, MA, LPC (collateral participant’s therapist) I understand that I am entering into a contract with The Barden Group, LLC for the professional time and services provided for within that appointment time. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and confidential consultations with other professionals as agreed in writing by me to assist with my treatment. I understand my therapist’s professional fees as outlined in our Agreement to enter into counseling services as a **collateral participant** for scheduled sessions. I understand I have a right to request information about reduced fee options at any time. At this time Glen Barden, MA, LPC (collateral participant’s therapist) and I have agreed that my fee for sessions will be \$_____ and I agree to pay this fee at the time of each session. I understand that THE BARDEN GROUP, LLC does not reimburse for cancelled appointments that were paid for in advance but that any such fees will be credited to my account and applied to future services provided.

I understand that The Barden Group, LLC’s cancellation policy requires 24 hours advanced notice to be released from the contract for Glen Barden, MA, LPC (collateral participant’s therapist)’s time and services of preparation for my session. **I agree that if I fail to cancel my appointment within the 24-hour minimum time-period prior to my session I will be charged the greater of the full session rate or \$75 for the appointment.** I also understand if there is an emergency that prohibits me from canceling within 24 hours I can discuss this with Glen Barden, MA, LPC (collateral participant’s therapist) directly and request a waiver of this policy.

I understand there is a \$25 fee if my credit card or check is declined due to insufficient funds. That \$25 fee is due at the time of my next session, along with the payment for that session. In the event of two (2) declined transactions, I understand cash payment will be required going forward.

I authorize _____ to schedule appointments on mine and their behalf.

(For example, spouse or minor who drives self to appointment but is not responsible for payment).

THE BARDEN GROUP, LLC uses HIPAA compliant IVY PAY as its payment and billing system. Your receipt will include CPT codes and diagnostic codes for insurance submission as well as a good faith estimate in compliance with the No Surprises Act.

I understand I will receive a text message directly from IVY PAY with a link to set-up my account for payment and agree to do so within 24 hours of my session. I agree to continue utilizing IVY PAY for payment unless other arrangements are made with my therapist.

Collateral Participant - Printed Name: _____

Collateral Participant - Signature and Date: _____

Therapist Signature and Date: _____