

MENTAL HEALTH BILL OF RIGHTS

"This Mental Health Bill of Rights is provided by law to persons receiving mental health services in the State of New Hampshire. Its purpose is to protect the rights and enhance the well being of clients, by informing them of key aspects of the clinical relationship. As a client of a New Hampshire Mental Health Practitioner, you have, without asking, the right:

(1) To be treated in a professional, respectful, competent and ethical manner consistent with all applicable state laws and the following professional ethical standards:

- a. for psychologists, the American Psychological Association;
- b. for independent clinical social workers; the National Association of Social Workers;
- c. for pastoral psychotherapists; the American Association of Pastoral Counselors
- d. for clinical mental health counselors; the American Mental Health Counselor Association; and
- e. for marriage and family therapists; the American Association for Marriage and Family Therapists.

(2) To receive full information about your treatment provider's knowledge, skills, experience and credentials.

(3) To have the information you disclose to your mental health provider kept confidential within the limits of state and federal law. Communications between mental health providers and clients are typically confidential, unless the law requires their disclosure. Mental health providers will inform you of the legal exceptions to confidentiality, and should such an exception arise, will share only such information as required by law. Examples of such exceptions include but are not limited to:

- a. abuse of a child;
- b. abuse of an incapacitated adult;
- c. Health Information Portability and Accountability Act (HIPAA) regulation compliance;
- d. certain rights you may have waived when contracting for third party financial coverage;
- e. orders of the court; and
- f. significant threats to self, others or property.

(4) To a safe setting and to know that the services provided are effective and of a quality consistent with the standard of care within each profession and to know that sexual relations between a mental health provider and a client or former client are a violation of the law (RSA 330-A:36).

(5) To obtain information, as allowed by law, pertaining to the mental health provider's assessment, assessment procedures and mental health diagnoses (RSA 330-A:2 VI).

(6) To participate meaningfully in the planning, implementation and termination or referral of your treatment.

(7) To documented informed consent: to be informed of the risks and benefits of the proposed treatment, the risks and benefits of alternative treatments and the risks and benefits of no treatment. When obtaining informed consent for treatment for which safety and effectiveness have not been established, therapists will inform their clients of this and of the voluntary nature of their participation. In addition, clients have the right to be informed of their rights and responsibilities, and of the mental health provider's practice policies regarding confidentiality, office hours, fees, missed appointments, billing policies, electronic communications, managed care issues, record management, and other relevant matters except as otherwise provided by law.

(8) To obtain information regarding the provision(s) for emergency coverage.

(9) To receive a copy of your mental health record within 30 days upon written request (except as otherwise provided by law), by paying a nominal fee designed to defray the administrative costs of reproducing the record.

(10) To know that your mental health provider is licensed by the State of New Hampshire to provide mental health services.

a. You have the right to obtain information about mental health practice in New Hampshire. You may contact the Board of Mental Health Practice for a list names, addresses, phone numbers and websites of state and national professional associations listed in Mhp 502.02 (a)(1)(a-e).

b. You have the right to discuss questions or concerns about the mental health services you receive with your provider.

c. You have the right to file a complaint with the Board of Mental Health Practice."

(b) A licensee shall post a copy of the above mental health bill of rights in a prominent location in the office of the mental health practitioner and provide a copy upon request.

(c) A licensee shall provide a copy of the mental health bill of rights to the client and/or agency if the assessment, consultation or intervention is provided outside the office.

C.R.E.A.T.E!
Center for Expressive Arts, Therapy and Education, P.L.L.C.
141 Union St
Manchester, NH 03103
603-625-0010

NOTICE TO CLIENTS

Established in 2006, C.R.E.A.T.E! The Center for Expressive Arts, Therapy and Education, P.L.L.C. is a private, professional mental health practice providing psychotherapy, expressive arts therapy, evaluations and workshops to children, adolescents, and adults. Forms of therapy offered include individual, couple, family and group therapy. Traditional, EMDR and arts-based therapy approaches are utilized for the benefit of the client. C.R.E.A.T.E! The Center for Expressive Arts, Therapy and Education, P.L.L.C. is an independent agency is solely responsible for its actions and the actions of its staff, interns, master's level counselors and volunteers.

As a multi-purpose facility, a variety of activities are offered and held through C.R.E.A.T.E! The Center for Expressive Arts, Therapy and Education, P.L.L.C. at its office in the Castle at 141 Union St, Manchester, NH. Besides traditional mental health counseling and arts-based therapies, services such as Reiki, massage, yoga, hypnotherapy, arts-based workshops, and seminars as well as non-therapy events such as gallery openings, elder programs, children's programs and fund-raiser are held at the Castle. All care is given to protect client confidentiality and to create a safe space. The variety of activities help in this in that no one can automatically assume why another is present. If you find at any time you are uncomfortable, please let us know and we will do all we can to make the appropriate adjustments. If we can not, then we will help transfer you to another agency that will be more suitable.

THE HEALING AND GROWING PROCESS

Psychotherapy is a relationship-based process that involves working together in an atmosphere of mutual respect and interest. Through working on previous and current life issues, future dilemmas become more manageable. Success in counseling is based on the participant's willingness to engage in the process. A participant only gets out of counseling what they are willing to put into counseling. As a healing and growing process, things can get worse before they get better. If that happens, please let your counselor know so a plan can be worked on to help keep you heading towards your therapy goals.

C.R.E.A.T.E! offers professional, yet personal services and is committed to a strong belief in ethics and confidentiality. The decision to obtain help is very courageous and difficult. We recognize that it is people's strength that brings them to work with us.

CLIENTS RIGHTS

C.R.E.A.T.E! acknowledges and supports the clients rights and responsibilities as they are described in the "Mental Health Bill of Rights".

INTAKES, SCREENINGS, ASSESSMENTS, AND EVALUATIONS

Intakes, screenings, assessments, and evaluations each have a specific goal, process, scope, and implication. These will be reviewed with you as well as any potential consequences for participation in or referral to participate in any of these.

CONFIDENTIALITY

Under New Hampshire law, communication between a client and a license psychotherapist are privileged (confidential) and may not be disclosed without the specific authorization of the client. Exceptions to this are the following:

- Your therapist may legally speak to a member of your family or another clinician without your prior consent in case of an emergency.
- If you disclose that you intend/will harm another person, your therapist will attempt to inform that person, as well as the police.
- If you disclose the physical, sexual, emotional abuse or neglect of a child, elderly, or vulnerable adult by you or someone else; your therapist is legally required to notify the appropriate protective services and the police within 72 hours of your disclosure.
- If your therapist has good reason to believe that you are in imminent risk of harming yourself, your therapist will legally break confidentiality and inform an appropriate crisis center, hot line, emergency room, the police, etc. When appropriate, your therapist will explore other options with you.
- Although communications between a client and a licensed psychotherapist are confidential, parents of a minor child (even non-custodial parents) have a right to access and authorize release of information. If this is a concern, please discuss it with your therapist BEFORE beginning treatment.
- If the client is an adolescent, the content of the therapy session will be considered confidential unless there is reason to believe that the adolescent is a danger to himself/herself or other people. These risky behaviors may or may not include drug use, risky sexual behaviors, illegal activities, etc
- If you and your spouse are in couple's therapy and participate in individual sessions with your therapist, what you disclose in the individual sessions may be considered part of the couple's therapy. Treatment records of couple's sessions contain information about each person. Therefore, both clients agree that treatment records will only be released by joint consent. In the event of a disagreement, the records will not be released without a court order.
- Unmarried individuals in a couple's therapy do not have the privilege to the same extent that married individuals have due to the legal status of their relationship. However, each person is asked to maintain the confidence of the other.

- If you are in group therapy, what you share in your group therapy is not considered by law to be privileged. Therefore, it is highly recommended that group members not disclosed information shared by other group members. Of course, group facilitators maintain confidentiality.
- Court mandated clients are required to sign a release of confidential information in order for C.R.E.A.T.E! to remain in ongoing communication with the appropriate court and legal agencies. Therapists report on payment, participation, and attendance, as well as specific concerns.
- If a court order is issued for the release of your records, your therapist will request, but does not need your signed authorization.
- As part of a professional organization, your therapist at times consults with other colleagues and professionals under the umbrella of C.R.E.A.T.E! in order to coordinate treatment and maintain high quality of treatment. When deemed necessary by the Executive Director, outside supervision will be sought for additional input and direction on client cases. The prerogative and responsibility of privilege exists between C.R.E.A.T.E! and outside persons and organizations. If you object to your case being reviewed in these manners, please notify your therapist at this time.
- Any information related to substance abuse or HIV or any other STD will only be released after that category is acknowledged on the release form by the signer initializing that particular action.
- Once information is sent outside this office, C.R.E.A.T.E! cannot control and is no longer responsible for its use and dissemination.
- A recorded message left on the answering service may be heard by any clinical, clerical, or administrative staff member who is checking messages. Any operator-assisted call is automatically recorded and saved by the answering service when one is used. While rules of privacy and confidentiality do apply in both circumstances, the recorded message may also be used as evidence in a civil or criminal proceeding, if this use is compelled by an overriding statute, ordered by a court with the appropriate jurisdiction, or permission is granted to do so by the client, the client's guardian, designee, surviving trustee or parent.
- If a translator is provided to you for either a court ordered program or psychotherapy, that translator's services are necessary and required in all of your contacts with and about the office. *For Example:* If you place an emergency call through the answering service, they will make every effort to elicit the services of one of your translators to enable you to speak to your worker. If you are, at any time, unable to wait or you feel an imminent risk, then you are to call 911.
- C.R.E.A.T.E! takes reasonable steps to ensure the confidentiality of all its clients. However, C.R.E.A.T.E! can not protect information once it leaves the building by phone, fax, email, regular mail or is picked up by a client or a person the client authorized.
- All Psychotherapy cases in New Hampshire are subject to activity by the New Hampshire Board of Mental Health Practice at any time.

CONFIDENTIALITY AND THE WAITING ROOM

This waiting room is a common area in which the clinician is committed to partnering with you to maintain your confidentiality. To do so we ask, the clinician and the client:

- wait until the clinician and client are in their room to talk about concerns or updates
- ask to update the clinician about their child at the beginning of the session and then proceed to a room for the discussion
- agree that the session ends at the door of the counseling room
- hold phone conversations outside the waiting room
- be aware of the information being shared with other people in the waiting room if you talk to others
- parents are to stay in the waiting room unless a specific arrangement has been made with the clinician

CUSTODY AND RELEASES

This Informed Consent Form is a consent for treatment. In the case of a minor, any and all people who have legal decision making authority for the child (meaning "legal custody" not just "physical custody") must consent to the counseling before a therapist can see the child. In cases of divorce, separation and/or guardianship, appropriate paperwork must be on file with C.R.E.A.T.E! detailing the parental and/or guardianship arrangement before the child can be seen. In all cases, if a parent or guardian (whether actively involved in a child's life or otherwise) states they do not wish the child to be seen or to continue in counseling, then counseling service have to be stopped until consent is again established. An exception to this is if there is a court order stating the child is to receive counseling, then a copy of the most current order must be on file for the child to begin. In this situation, the court order supersedes parental rights. Any other situations are handled on a case by case basis.

RECORDS

According to the Health Care Act of 1992, and New Hampshire law, you have a right to review a copy of your file for an appropriate fee. You also have the right to request that your therapist provides a copy of your file to other health care providers with your written authorization. The only portion of your record that this organization can provide or share is that information which has been generated here. Your clinical records are kept in a safe place for a minimum of seven years for adults and the age of majority (18 years), plus seven years for children. Records will be maintained confidentially in this office in accordance with New Hampshire State Law.

MANAGED CARE

If your therapy is being paid for by a managed care company, there are further limitations to your rights imposed by your insurance policy. These may include their decision to limit the number of sessions available to you, and/or limit the time within which you must complete your therapy. If we are not "in-network" providers, they may also decide that they will not pay for you to see one of our providers. They may also decide to reimburse at a lower rate if your provider is not "in-network". We take the steps necessary for the providers at C.R.E.A.T.E! to become a part of as many networks as possible, however, some of the networks are not accepting applications for additional providers. If your insurance provider or insurance policy changes, C.R.E.A.T.E! will do what we can to continue services. However, it is possible with such a change that you may need to be changed to another therapist or possibly need to be referred to another agency. If this happens, C.R.E.A.T.E! will help make these alterations as smooth as possible.

DIAGNOSIS

If a third party such as an insurance company is paying for part of your bill, your provider is normally required to give a diagnosis to that third party in order to be paid. Diagnoses are professional terms that describe the nature of your problem, as well as relating whether the problems are short-term or long-term.

In addition, managed care companies usually require detailed reports of your progress in treatment in order to authorize further visits. Your insurance may not authorize further visits. These treatment summaries require more than a diagnosis, and often request information on presenting problem, treatment goals, and progress. Your provider will act to protect your privacy by submitting only the necessary information, but there is no guarantee that your privacy will be completely protected.

CODES OF ETHICS / PROFESSIONAL BOUNDARIES

Therapists working in the helping professions are required by this professional organization to operate within the professions' code of ethics. They include but are not limited to the establishing and maintaining of appropriate professional boundaries. A therapist may not become involved in any type of personal relationship with a client i.e. sexually, business, etc. The therapist can serve only one role in the client's life i.e. cannot be the client's employer and therapist. Also, the therapist's role in therapy should be clearly defined. For additional and specific ethical standards, please consult your Therapist Code of Ethical Standards displayed in the waiting area.

DISAGREEMENTS / GRIEVANCES

If you feel that you and your therapist are at an impasse with your case, then you are expected to discuss this with your therapist. If the issue is not resolvable, you can meet together with your therapist's supervisor. Finally, you may meet with your therapist and the director of the agency if your conflict still has not been resolved. Therapy services can and will be suspended during any such discussions until resolution is obtained. The determination to continue services after a conflict will be determined on a case by case basis. If a healthy relationship can not be re-established, then referrals will be made and services at C.R.E.A.T.E! will be discontinued.

In addition to the above, if you feel that your rights have been violated and you wish to make a formal complaint, you are entitled to contact the professional organization and/or licensing board to which your therapist belongs.

- The National Association of Social Workers (NASW) can be reached by calling (603) 226-7135.
- The New Hampshire Board of Mental Health can be reached by calling (603) 271-6762.

INTERNSHIP PROGRAM

C.R.E.A.T.E! offers an internship for undergraduate and graduate school students. This program enables qualified, highly supervised advanced clinical students the opportunity of gaining valuable experience while providing an important community service. Through the internship program, C.R.E.A.T.E! can provide low cost and/or timely counseling providing more options for those seeking services. Because internships are time limited, people meeting with an intern will have to change counselors when the internship is over. C.R.E.A.T.E! commits to providing ongoing internships so that clients will be able to transfer to new interns without gaps in services. However, if there are no interns to transfer to, all reasonable attempts will be made to help clients transfer to other agencies and/or supports.

CELL PHONES AND TEXTING DURING SESSIONS

In order to maximize the therapy experience, unless you have talked to your counselor to make arrangements for an emergent call, please refrain from answering cell phones and/or texting during sessions.

AGRESSION AND/OR THREATS

The clinician has the right to end a session, phone call or conversation if he/she at any time feels threatened or endangered. Consequences of a terminated session will be discussed later if and when safe boundaries have been re-established. In cases such as this, determination of the continuation of therapy will be made by the executive director with input from the clinician.

COUNSELOR'S ENDING OF COUNSELING

Counseling can be terminated if the clinician believes the primary role of the counseling is not for personal growth, development or change. For example (though not limited to this example), counseling can be terminated if the counselor believes a parent has brought a child to counseling in order to build a court case against the other parent. Final determination of such action will be made between the clinician and the executive director.

TERMINATION, CLOSING CASE FILES AND ART WORK

Psychotherapy is a process involving clear communication between client and therapist, who work as a team. Once a treatment plan is established agreed upon, treatment proceeds until the plan is fulfilled. If you wish to terminate before completion of the treatment plan, a final session will be scheduled in order to summarize progress, to discuss any major unresolved issues, or to assist you with transfer to another therapist/provider. Please give seven days notice if you plan to terminate before completing your treatment plan. This is particularly important in group psychotherapy, as the treatment process includes the other members in your group.

If your therapist and/or C.R.E.A.T.E! determine your treatment to be no longer in your best interest (or in the case of a child, in your child's best interest), he/she/we reserves the right to initiate the termination of your treatment. Additionally, if your therapist and/or C.R.E.A.T.E!

determine your case needs more or different expertise than we are able to provide, he/she/we reserve the right to initiate a transfer of your case (to another therapist or another agency) and/or termination of your case.

Case files will be closed if there is no communication from the client for two months after the last attended session unless a special arrangement has been made. Cases can be closed without written notification, if they meet any of the above conditions. Cases can be reopened upon the request of the client if there is a zero balance and with the approval of the executive director.

Art work made as part of the sessions belong to the client and are usually taken home at the end of sessions. Art work that is not taken by the client will be destroyed when the case is close unless other arrangements are made.

Lastly, if at any time you have questions regarding confidentiality, the release of information related to your case, financial responsibility, managed care, or the therapeutic process, please feel free to speak directly with your therapist on these matters.

FINANCIAL POLICIES

The client's charge, per 45 or 50 minute therapy session, will be established at the onset of treatment and will be understood as the Financial Agreement. The payment is due at time of service. Excessive balances can and may result in termination of services until the balances are completely paid. This agreement can be modified at any time with the mutual consent of the client and C.R.E.A.T.E!.

BILLING

Depending upon the client's particular situation, the charge may be paid for by the client only or by the client and second or third party, i.e. Insurance Company, Vocational Rehab, parents, etc. When this occurs, the amount paid by the client directly is referred to as the Fee. Third party billing is done through the office of C.R.E.A.T.E! as a courtesy to and convenience for the client.

RESPONSIBILITY

Ultimately the client (or family) is responsible for the entire payment of the charge. If insurance or other moneys are billed and received, they are done so as a courtesy to the client. A contract exists between the client and their insurance company for the benefit of the client. The insurance company pays on the client's behalf.

ATTENDANCE

The scheduling of an appointment construes the making of a contract with the therapist of time for money. This contract assumes either attendance or timely notice of cancellation of the appointment. Timely notification is considered 24 hours in advance of the appointment but please notify C.R.E.A.T.E! as soon as you are aware you can not make an appointment. Your therapist is paid per client seen and thus does not get paid if you do not show. Calling well in advance at least allows the possibility of C.R.E.A.T.E! using that time slot for someone else and for your therapist to be paid.

CANCELLATION

A client who cancels on the day of their appointment will be charged a reduced fee rate of \$50 regardless of co-pay or other fee arrangements. Insurance companies can not be charged for missed sessions, thus it is the client's responsibility to pay this amount at the beginning of the next session. It is our understanding that unexpected situations occur. Thus, the cancellation fee for the first time there is a cancellation on the day of an appointment will be waived. All subsequent cancellations on the day of an appointment will be charged as stated above. The cancellation fee can be avoided if the client reschedules their appointment later in the same week. Rescheduling of the appointment is based on therapist's availability and if a mutual time is not workable the client continues to be responsible for the cancellation fee.

NO CALL/NO SHOW AND SAME DAY CANCELLATIONS

Clients who do not call the office to cancel their appointment and do not show for their appointment will be automatically charged a reduced fee rate of \$50 regardless of co-pay or other fee arrangements.

Clients who cancel the same day of their appointment will be automatically charged a reduced fee rate of \$50 regardless of co-pay or other fee arrangements.

Clients seeing interns will be automatically charged a \$20 fee regardless of the fee arrangement for no call/no show or same day cancellations.

Waivers for specific dates or situations can be attended to by your clinician. Payment for missed sessions must be mailed to C.R.E.A.T.E! or paid at the next session.

SNOW

For client cancellations due to snows of two inches or more, no cancellation fee will be charged and the therapist will work with the client to reschedule the appointment in the same week. Cancellations due to snow need to be called into the office and left in voice mail as early as the client makes their decision not to attend.

A client who does not call and does not show for their appointment during a snow will be charged the reduced fee rate of \$50 regardless of co-pay or other fees. Clients or interns will be charged \$20 for the same occurrence regardless of fee arrangement.

MEDICAID EXCEPTION

Medicaid recipients are not charged these fees due to an agreement between C.R.E.A.T.E! and the stated Medicaid office. However, Medicaid recipients are still required to attend their sessions and if they can not attend a session they are required to cancel in a timely manner. Missed sessions accumulate and are dealt with in the same manner as all other clients and as stated below.

CONSEQUENCES OF MISSED SESSIONS

When cancellations made the day of an appointment and/or no shows together add up to three or more, it is seen as a sign that the client is not interested or invested in the counseling process. At this point, the clinician under the direction of the Executive Director reserves the right to transfer the client to another clinician, place the client on a same day call list or terminate counseling with a referral to another agency. A client placed on the same day call list will need to call each day they are available to see if their clinician has an opening that day. If there is an opening, the client will be able to schedule. If no appointment is available that day, then the client will need to call the next time they are able to see if there is an opening. Once a client has called, made an appointment and followed through on the appointment three consecutive times, they will be able to schedule appointments in advanced as normal.

SICKNESSES AND CONTAGIONS

If you or a member of your family has a sickness, contagion, infestation or such (i.e. strep throat, flu, contagious cold, MRSA, fever, lice, bed bugs, etc.), please call to reschedule your appointment. Please cancel as soon as you know you are not able to make the session. Cancellations made the day of an appointment may still be charged the same day cancellation fee or counted towards the three missed session for Medicaid clients. Determination to waive the consequence will be determined by the counselor with the agreement of the executive director. In most cases, clients are aware of their symptoms the day before a session and should call then to avoid any consequences of same day cancellations.

PAYMENTS & COLLECTIONS

Clients or families are expected to pay the fee portion of their bill at each session they attend. We accept personal checks, cash, money orders, and both Visa and MasterCard. Counseling can be suspended if the client's account is not current.

Session fees are billed at \$150.00 for intakes and/or initial assessments and \$95.00 per hour for treatment. Sliding scale private pay can be \$60 - \$95/session. Clients are responsible for any fee their insurance company does not cover. These fees are generally the co-pay and/or deductibles. Clients should attend to their policy renewal dates because clients (including those on Medicaid and Medicare) will be held responsible for the full amount for sessions the insurance company does not cover.

Letter writing (including updates, reports, evaluations, etc) for court, DCYF, probation officers and other people (outside of normal billing) is charged at \$15 per quarter hour increments. Accounts must be current before letters are received. Insurance companies do not reimburse for this service, thus payment is the responsibility of the requestor.

Phone conversations longer than 10 minutes are charged at \$15 per quarter hour increments and will be added to the client's bill and expected to be paid for by the next session. The payment is the responsibility of the phone caller as insurance companies do not reimburse for this service.

Court fees are \$175.00 per hour with a 3 hour minimum and \$95.00 per hour is charged for court preparation time. Preparation time can include but is not limited to consultation time with a lawyer even if the therapist is not required to go to court. Payment is required prior to court.

Groups, programs, other therapies, trainings and offerings have various prices.

Collection Agencies can be used to collect outstanding bills. Information needed to collect past due amounts can be shared with the collection agency.

PATIENT CONSENT FOR US AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

1. The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of any protected health information (PHI) necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out its health care operations. The Provider explained to me that the Privacy Notice or copies thereof will be available to me in the future upon my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice prior to my signing this Consent.
2. The Provider reserves the right to change its privacy policies that are described in its Privacy Notice, in accordance with applicable law.

3. I understand, agree, and consent to appointment reminders by phone, fax, email or regular mail may be used, sent, or mailed to me by the Provider. *For Example:* telephoning my home and leaving a message on my answering machine, or with the individual answering the telephone.
4. The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for the treatment, as necessary for the Provider to conduct its specific health care operation.
5. I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, I understand that the Provider is not required to agree to any restrictions that I have requested. If the Provider agrees to a requested restriction, then the restriction is binding on the Provider.
6. I understand that this Consent is valid for **seven** years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this Consent.
7. I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.
9. I understand that the policies and procedures spelled out in the Informed Consent, Notice to Clients, HIPAA information form, PHI information form and the other C.R.E.A.T.E! Center for Expressive Arts, Therapy and Education forms can be changed without notice and are periodically updated. The most current version is always available through one's counselor or the main desk.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

RIGHT TO TREATMENT WAIVER & INFORMED CONSENT

- I understand that psychotherapy is a form of medical treatment. I further understand that the purpose of this treatment is to improve my (or my child's) health and/or relationships. However, I realize that it is possible that disruptions in my (or my child's) health or relationships may occur during the treatment process, and I agree that I will discuss the nature and frequency of these disruptions if they occur.
- I have read the outline and this statement in full, and have had sufficient time to be sure that I considered it carefully. I have asked questions about any sections that I did not understand fully, or that I had concerns about.
- I consent to charges for my treatment being submitted to my insurance company.
- I consent to the use of a diagnosis for billing and authorization purposes, and to release information necessary to complete the billing and treatment plan.
- I agree to be responsible in a timely manner for payment of charges related to my/my child's therapy, group sessions and/or other services provided by C.R.E.A.T.E! Center for Expressive Arts, Therapy and Education, P.L.L.C. that are not covered by insurance, and are due from me.
- I agree to undertake therapy with C.R.E.A.T.E! Center for Expressive Arts, Therapy and Education, P.L.L.C. or if I am the parent or legal guardian of a minor child beginning treatment, the child may undergo therapy with C.R.E.A.T.E! Center for Expressive Arts, Therapy and Education, P.L.L.C.
- I understand that medications are not prescribed by this practice. For people needing/wanting medications, the therapist is willing to work in conjunction with the client and the client's physician for the best of the client. A signed release form will be needed for communication with client's physician, staff and office. For people who do not have a primary care physician, recommendations can be made but I understand that I am responsible for my own well-being and maintenance thereof.
- I understand C.R.E.A.T.E! reserves the right to service cases which fit its organization, structure, expertise and mission.
- By signing below, I indicate my agreement to the terms of the Statement of Understanding and this informed Consent.
- I have read the attached Notice to Clients, and I agree to enter treatment. I have been informed about my rights as a client, I have had the opportunity to discuss these rights, and I understand them at this time. I understand the privacy procedures and limitations and have had an opportunity to discuss them. I understand that if, at any time, I have questions regarding these rights, I can and should speak to my therapist about my concerns.
- This agreement is continuing and binding until disallowed by one or both parties.

Signature of Client/Parent/Guardian or Authorized Representative

Date

Printed Name of Client/Parent/Guardian or Authorized Representative

Signature of Witness

Date

Printed Name of Witness

Printed Name of Child in Case of a Minor

C.R.E.A.T.E!
Center for Expressive Arts, Therapy and Education, P.L.L.C.
141 Union St
Manchester, NH 03103
603-625-0010

FEE AGREEMENT

I have read and understand the financial policies and agree that I am ultimately responsible for ensuring that C.R.E.A.T.E! receives payment for the services provided.

I understand if using a third party payer such as an insurance company, I am responsible for any co-pays, deductible, co-insurances or any amounts my insurance does not reimburse.

I understand if I fall out of the insurance policy that I am responsible for the full cost of the unreimbursed session(s).

I understand that C.R.E.A.T.E! as a curtesy will find out what my insurance policy requires me to pay. I understand I may also call my insurance company to review any information. I understand ultimately, payment information is determined by the EOB statement the insurance company sends and payment will be made in accordance with the EOB.

I understand if I have a disagreement with the insurance company, I am required to pay C.R.E.A.T.E! the amount on the EOB. If the amount is reimbursed by the third party, C.R.E.A.T.E! will refund the payment.

I understand payment for session is due at time of service.

X _____
Signature of Client/Parent/Guardian or Authorized Representative

Date

Signature of Witness

Date

**AUTHORIZATION FOR RELEASE OF INFORMATION &
ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize the release of medical information by C.R.E.A.T.E! Center for Expressive Arts, Therapy and Education, P.L.L.C., relating to services provided solely by C.R.E.A.T.E! Center for Expressive Arts, Therapy and Education, P.L.L.C., to any company having coverage on me (or my employer if coverage is under a group insurance plan) as necessary for processing my insurance claim(s). In consideration of services rendered, or to be rendered, I hereby irrevocably assign and transfer to C.R.E.A.T.E! Center for Expressive Arts, Therapy and Education, P.L.L.C., all benefits payable under my insurance policy. I hereby authorize C.R.E.A.T.E! Center for Expressive Arts, Therapy and Education, P.L.L.C. to bill my insurance carrier directly for services rendered. I further authorize the insurance company to pay directly to C.R.E.A.T.E! Center for Expressive Arts, Therapy and Education, P.L.L.C., when indicated and appropriate, all benefits due under said policy for services rendered.

X _____
Signature of Client/Parent/Guardian or Authorized Representative

Date

Signature of Witness

Date