AriAnna Carroll, LMHC
Cedar Valley Center for Expressive Arts Therapy, LLC
905 Sycamore St., Waterloo Iowa, 500703
http://cvceat.com
319-888-1022

NEW CLIENT PACKET

Policies, Services and Agreement for Entering into Services

INFORMED CONSENT AND AGREEMENT TO COUNSELING SERVICES:
Please read thoroughly, make a note of any questions you may have. Please consult with AriAnna Carroll, LMHC, directly to discuss any and all questions you have prior to providing signature to this agreement.
After you sign this agreement you will be able to request a printed copy for your records. A copy of this signed agreement will be stored in a highly confidential, HIPPA compliant, encrypted, electronic cloud storage system along with the rest of your clinical file. Please print off this document, fill it out by hand, and bring a hard-copy of this to your first session. If you are unable to print, please let me know and a hard-copy can be provided to you.

CEDAR VALLEY CENTER FOR EXPRESSIVE ARTS THERAPY. LLC, AND ARIANNA CARROLL, LMHC:
Cedar Valley Center for Expressive Arts Therapy is limited liability companies in the state of Iowa located at 905 Sycamore Street, Waterloo Iowa, 50703, providing psychotherapy and professional counseling services as well as educational and support services for children and families. AriAnna (Ari) Carroll, LMHC, is a fully licensed professional counselor in the state of Iowa, #081637, and participates in appropriate peer consultation as well as ongoing continuing education.

BENEFITS OF COUNSELING:
I encourage families to consider the risks and benefits before committing to treatment. Examples of potential benefits would be reduction in symptoms, and improvement in areas such as emotional self-regulation, social and communication skills, distress and/or frustration tolerance, awareness and insight, coping mechanisms, behavior modification, self-confidence, resiliency and competency, problem solving, concentration, and task sequencing skills, conflict resolution, healing or improvement in family relationships, and integration of difficult/traumatic experiences. Participants can develop and maintain a sense of balance in life, a sense of contentment, satisfaction, and skills for coping life's challenges. Clarity of direction in and sense of self develops. Experiences of relaxation and relief from mental and physical tension. Research has consistently supported the value of therapy over time.

RISKS OF COUNSELING:
Occasional uncomfortable levels of sadness, guilt, anxiety, frustration, loneliness, helplessness or other negative feelings as a part of the process of healing and finding balance. Often symptoms will increase in the short term before improving. Unpleasant memories may be recalled through the process. Significant others in one's life may have their own objections or negative reactions to a client's positive changes. Families may feel frustrated when their expectations and urgency for change is not readily met. This is normal and can be supported through verbal and non-verbal processing in therapy.

Overall, the benefits greatly outweigh the risks. When youth, family, and the therapist are all committed to the process of counseling, with understanding therapy is not a "quick fix", transformational results are often observed.

CONFIDENTIALITY POLICIES

In all but a few situations, your confidentiality and privacy are protected by state law and by the ethical rules of our profession. There are some exceptions as follows:

POLICY ON CONFIDENTIALITY FOR CHILD CLIENTS:
In working with child clients, though legally with the parent(s) or legal guardian(s) of child clients, age appropriate privacy is essential to relationship and setting for a child's therapy, Ari will honor what the child does or says in sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations.

POLICY ON CONFIDENTIALITY WITH FAMILIES:
In family therapy the family is an entity, as is the client, although one individual may be deemed the "identified client" for record keeping and insurance reimbursement purposes. The center policy is that Ari is providing individual therapy and family may be a part of individual/family therapy or meet with Ari without individual (child) present. If significant information is revealed during individual session and Ari feels family would benefit from knowing, the individual will be encouraged to bring it up in session with family, alternatively, in the event of risk to safety of self or others, to the extent possible the individual will be informed of what information will be shared with family.

LIMITS ON CONFIDENTIALITY:
Although parents will not be informed of all content from sessions, I make every effort to encourage your child to disclose to you, with my support, thoughts, feelings, or situations that would be helpful for parents to be aware of. The accepting, trusting, private space I create with youth, within our therapeutic relationship, is necessary for progress in therapy. As a mandatory reporter in the state of Iowa, there are exceptions to this rule. Limitations on confidentiality include but are not limited to:

1. When there is suspected child abuse, dependent adult, or elder abuse.
2. If a client discloses that they are a danger to themselves or others and share intent to harm themselves or plan to inflict serious bodily harm to another person. This may include but is not limited to: calling the Department of Human Services, calling local law enforcement, contacting family members, and/or contacting the person(s) who may be in danger due to the threat made against them.
3. Parents or guardians will need to complete a written consent to treat form and communication between therapist and parent/guardian will continue throughout the course of therapy for the minor.
4. When sharing required information with insurance plans to support reimbursement for services, this includes diagnosis and treatment plan information.
5. When sharing information with a third-party support agent for purposes of coordinating care or facilitating service referrals. As appropriate, I provide referrals to medication management providers, such as psychiatrists or ARNPs, pediatric occupational therapists, and/or other mental health professionals.
6. If you are or will be involved in court proceedings and the clinical record is subpoenaed and ordered by a judge.
7. If a guardian ad litem (GAL) is appointed in a custody case involving child clients and she/he is ordered by the court to have access to mental health practitioners and records therein.
8. The Patriot Act of 2001 requires licensed mental health counselors, in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits the counselor from disclosing to the client that the FBI sought or obtained the items under the Act.
9. When seeking professional consultation from colleagues to improve the quality of services provided, details of a diagnosis and treatment plan may be discussed, identifying information about your child or family will not be disclosed.
10. Electronic communications and tele-health include limitations of your confidentiality. Email and cell phone communications cannot be guaranteed confidential. These means of electronic communication are considered "non-secure."
11. In the case of death or incapacitation, all clients will be contacted, and records will be accessed by a designated professional who will ensure confidentiality.
12. In the case we need to collect unpaid payments, a collection agency may be utilized.

IMPORTANT PRACTICE POLICIES AND PROCEDURES

ELECTRONIC DATA STORAGE PROCEDURE:
I utilize a HIPAA compliant portal called KASA Solutions for clinical record keeping and billing purposes. Their platform is encrypted, secure cloud-based storage and is HIPAA compliant. You can read more about KASA Solutions at kasasolutions.com.

YOUR CLINICAL RECORD:
You should be aware that, pursuant to HIPAA, information is kept about all of clients in a collection of professional records. This constitutes your Clinical Record and your clinical record is stored in a HIPAA compliant electronic location. Ari observes legal and ethical rules for maintaining your confidentiality.

COMPLAINTS OR GRIEVANCES:
If you feel that there is basis for a formal complaint or grievance about anything related to the professional services provided, it is requested that you to first communicate your concerns to Ari directly so that she will be informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complaint about me and may do so by contacting the board at the following address and phone number:
Iowa Board of Behavioral Science, Bureau of Professional Licensure
Iowa Department of Public Health
Lucas State Office Bldg., 5th Floor
321 E. 12th St., Des Moines, IA 50319-0075
Phone (515) 281-0254

CLIENT CONTACT POLICY:
I need to be able to communicate regarding appointments, scheduling, and service-related issues. You will need to provide a phone number and email address where you can receive messages related to appointment reminders, scheduling, and billing matters. In an effort to protect your privacy, messages I leave you will not include specific mental health information.

TELE-HEALTH POLICIES AND YOUR CONFIDENTIALITY:
In this age of electronic communication, we are required to be very clear with our clients as to the nature of the risks and benefits of “tele-health.” Any time you and your therapist communicate in a way that cannot be guaranteed as secure in maintaining your confidentiality, there is a risk involved. There are limits to your confidentiality when participating in any form of “telehealth.”

Tele-health is defined by the U.S. Department of Health and Human Services as:
The use of electronic information and telecommunications technologies to support distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications. In order to make every effort to keep secure the confidentiality of your Private Health Information please note the following specific policies:

EMAIL POLICY:
Email cannot be guaranteed a secure means of transmitting/receiving your Private Health Information. You may choose to forego this electronic system and request hard copy of any letters or support materials from Ari. The use of email should be for brief and general communications when possible. Ari will use encryption tools when communicating with you via email, which provides additional protection against breach of confidentiality. If you email me questions related to mental health concerns or protected health information, I will respond via email to the questions you ask, and this could include a discussion of your mental health or protected health information. I cannot guarantee the security of electronic transmission of email through my email server (Gmail) or through yours and caution you to email sensitive information at your own risk. When requesting information via email, you are acknowledging and accepting the risk and limits of your confidentiality. If you prefer to not receive information via email, you must inform Ari, or emailing will continue and it will be assumed you accept the risks and limits of this form of communication.

TEXTING POLICY:
Texting will only be used for brief notification regarding scheduling reminders or in the event that Ari must cancel your appointment due to emergency. If it happens that Ari must cancel your scheduled session, she will text your cell phone via her password protected email. It could happen, that you receive a text and are in a position where others would view this communication, thereby creating potential for breach of confidentiality. By signing this document, you are accepting the risk and limits of your confidentiality by using texting.

PHONE POLICY:
Phone communications cannot be guaranteed as a confidential form of communication. Ari does not utilize a cell phone at the Center, but typically most clients will use personal cell phones for communicating. Ari makes every effort to ensure our phone conversations are held confidential within her ability to do so. When you have a conversation with Ari via cell phone you are acknowledging and accepting the risk and limits of your confidentiality. If you don't wish to take this risk, you may choose to only use phone communication to schedule an appointment and wait to discuss sensitive information as part of your Private Health Information in person.

VOICEMAIL POLICY:
Per the above phone use policy, my voicemail systems is password protected and secure to the best of ability, but it cannot guarantee complete confidentiality, although every measure is taken to protect this. It is advised that you not leave sensitive information on voicemail, rather utilize voicemail to request a return call and/or to schedule an in-person appointment. Voicemail is checked throughout the week unless on vacation or away for any reason. Ari is accessible Monday-Thursday during normal business hours (generally 8 a.m. to 5 p.m.), and on Friday (generally 8 a.m. to 2 p.m.). When not possible to return calls within the same business day, calls will be returned within 3 business days maximum. Ari is not available when in session with other clients. When away from the office for vacation or business travel and unable to access voicemail and/or email, Ari will notify you in advance and discuss with you community resources for support in case of urgent and emergency issues.

VACATION/TRAVEL POLICY:
When away from the office for vacation or business travel and unable to access voicemail and/or email, Ari will notify you in advance and you in advance and discuss with you community resources for support in case of urgent and emergency issues.

DUAL RELATIONSHIP AND SOCIAL MEDIA POLICY:
Professionally, I have specific standards I uphold regarding conduct both inside, and outside of, my practice as a therapist. It is against my professional code of ethics to engage in a dual relationship, such as a friendship, with clients and/or their families.

In line with professional ethics, requests for friendship on personal social media platforms will not be accepted as this is likely to put your confidentiality at risk and blur therapeutic boundaries. You may choose to follow Ari's business social media pages if you like. There is no expectation that you, as a client, will want to follow any of these platforms and your participation in social media posts is at your discretion. Several followers of these platform are not former or current clients and Ari will never identify you or your child as such on social media. If you happen to follow any of the Ari's social media platforms, it is requested that you please not post any comments identifying yourself or your child as a therapy client. If you do, and this is identified, your post will be removed in order to protect confidentiality and privacy.

You may find Ari and/or the Cedar Valley Center or Expressive Arts Therapy on search engines or on sites that list local therapists and/or businesses. Some sites include forums that allow users to rate their providers and/or add reviews. If you find Ari listed on any of these sites, please know that this is not a request from Ari for a rating or review from you as a client. If you choose to complete a rating or review, protecting your privacy and confidentiality prevents Ari from responding to them. As these sites do not inform Ari when reviews or comments are added, she will rarely ever see them. If you do choose to post something, Ari encourages you to protect your identity to prevent being associated with your other social networks, online groups, accounts, or emails.

PUBLIC/SOCIAL INTERACTION POLICY:
If you meet in a public setting, in order to protect the confidentiality of our therapeutic relationship it is Ari's policy not to approach you or initiate contact with you in order to maintain healthy and clear boundaries. If you say "hello" to Ari, she will smile and return this greeting. Often times, children will become excited and want to talk to Ari when

they see her in settings outside of therapy. This is understandable and normal, and Ari is comfortable with following their lead and matching the tone of their greeting.

SUPERVISION AND PEER CONSULTATION:
As professional counselor, occasionally there is the need to consult with a professional peer or supervisor on the services provided in order to ensure you are receiving the best services possible. This may include details of your case and in this age of electronic technology it may mean that this information is shared via phone conversations. All of these professionals are bound by the same legal and ethical rules of confidentiality. Your name or identifying information is not disclosed unless it is a case of imminent emergency and/or involves Department of Human Services.

POLICIES ON DIVORCE AND/OR CUSTODY CASES:
Due to the sensitive nature of divorce and/or custody cases, there are very specific policies in place regarding subpoenas, custodial documents, and consents that are required prior to treatment. There are also policies related to interviews with court-ordered Guardian ad Litem and/or custody evaluators, in addition to specifics regarding the fees you will be responsible for in the event that that interviews are requested or the policy regarding subpoenas is waived.

Ari is NOT a custody evaluator and cannot make any recommendations on custody arrangements. It is suggested that you consult with your legal representation to explore referral to a licensed professional who DOES provide custody evaluation if needed.

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, there are very specific policies to which you must agree before entering into a counseling relationship with the Cedar Valley Center for Expressive Arts Therapy, AriAnna Carroll, LMHC:

1. Ari maintains the right to request a copy of any most current standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session.

2. In most cases, a contact and written/signed consent with/from both legal guardians is needed before the child will be seen for counseling. In the case that there is a final-decision maker on health-related issues who wants the child to be seen for counseling, even in the case the other parent does not agree, it is to the discretion of Ari as to whether the child will be seen.

3. Interviews will be provided with any court-ordered Guardian ad Litem (GAL) and/or custody evaluator (CE) whom the court has ordered, and any time spent speaking with the GAL or CE will be billed to and paid by you, the client, at Ari's court-related-fee hourly rate.

4. Ari will be in contact with both parents who share in the legal custody of the child being seen for counseling and is open to opportunities for both parents to participate in parent consultations along the way. This does not mean that all concerns will be addressed with both parents. Should your child bring a concern related to one of their parental households and the child agree to disclosure, that concern will be brought to the parent within that household for discussion. Ari will also not communicate between households when parents disagree on discipline approaches. Those concerns should be discussed between parents or with the support of their legal counsel. Therapeutic suggestions based on best practice, such as parenting strategies, will be shared with both parents as appropriate.

5. Family sessions may be recommended and depending on the case, Ari may need to see the child with each parent separately along with siblings and/or other significant family members who live in the homes where the child resides.

6. By signing this agreement, you are acknowledging that should you choose to subpoena Ari, you are threatening the preservation of the integrity of the therapeutic progress and relationship Ari has built with you and/or your child(ren). As a HIPPA covered entity, Ari is required to uphold regulations regarding protected health information, which ultimately belongs to the child(ren) and both parents/guardians, unless there is legal documentation stating otherwise.

7. In the case that Ari is subpoenaed to appear in court, you will be billed for the full standard fee for court related work as per Iowa law for all professional time. This rate typically reflects a professional's hourly fee for service charge. Any time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand as well as any travel time will be billed at this to be determined, per hour rate.

SCHEDULING, CANCELLATION, AND TERMINATION POLICIES AND PROCEDURES

SCHEDULING AND CANCELLATIONS POLICY:
Ari requires 24 hours phone call or emailed notice of cancellation of any appointment.
Our scheduled appointments represent time that Ari has specifically booked for you. As such, in the event that you are unable to attend your session, you must give 24-hour notice, or you will be responsible for a cancellation fee. If a client does not arrive for a scheduled appointment or cancels inside of 24 hours, there will be a $45.00 partial session fee charged for the appointment. On rare occasion, if there is what Ari determines to be an unavoidable emergency or unforeseeable event, such as illness, transportation failure, or significant family altering event, you may discuss this with Ari and she may consider waiving the fee while working to reschedule if possible. Ari requests that we do our best to reschedule missed sessions to maintain our momentum in therapy.

SESSION EXPECTATIONS:
Sessions are typically scheduled on a weekly or biweekly basis, in three-month blocks, with frequency adjusting as appropriate. **Sessions will start and end on time. If you arrive late, the session will be shorter as we do end at the scheduled time and you will be billed the full session fee.**

TERMINATION FROM SERVICES:
If Ari determines she is unable to be of professional assistance to clients, she will speak with you and work towards discontinuing counseling relationships. Ari will terminate a counseling relationship when it becomes reasonably apparent that the client no longer needs assistance, is not likely to benefit, the client will no longer be best served within her care, or may potentially be harmed by continued counseling. Ari may also terminate counseling after multiple late cancellations or no-shows for sessions, when in jeopardy of harm by the client, or another person with whom the client has a relationship, or when clients do not pay fees as agreed upon. In the event one of these scenarios occurs, Ari will provide appropriate referral resources and suggest alternatives. If clients decline the suggested referrals, Ari will follow through with discontinuing the relationship.

SICK POLICY:
Fevers: If your child, or anyone who will have to accompany your child to therapy, has a fever of 100 or higher, please keep your child home. Fevers are frequently a signal that something is wrong. Clients must remain free of fever for 24 hours before returning to therapy.

Vomiting and Diarrhea: If your child, or anyone who will have to accompany your child to therapy, has diarrhea and/or vomiting, please keep your child home. These symptoms are often due to highly contagious illness. Clients must remain symptom free for 24 hours after vomiting/diarrhea has stopped before returning to therapy.

Colds and Coughs: Symptoms of colds and/or cough that warrant keeping **your child, or anyone accompanying your child to therapy**, at home include, but are not limited to:

- Green or yellow nasal drainage
- Persistent, hacking cough
- A cough that is producing green or yellow phlegm
- May present with or without fever

If your child has just a cold, please notify Ari. If your child is unable to participate in their daily routines at home, or to go to school, they are probably too sick to be at therapy.

Rashes and Other Contagious Conditions:
If your child, or anyone who will have to accompany your child to therapy, is experiencing a rash that is unusual, uncomfortable, or presents with other symptoms of illness, please take them to their pediatrician to be assessed prior to returning to therapy. In addition, if your child, or anyone who will have to accompany your child to

therapy, presents with symptoms of contagious conditions such as head lice, pink eye, etc., you will be excused from session that day and asked to go to your pediatrician for support.

Ari takes her responsibility for everyone's health and safety seriously and you will be sent home without being seen should your child, or those who have to accompany your child, show up ill, or with symptoms that prove too severe, to allow for reasonable participation in therapy in Ari's assessment. Please do not be offended if your child, or others, are identified as being too ill to be at the therapy center or in session and you are asked to take them home or to their pediatrician. If you are sent home without being seen due to arriving with illness, you will be charged a partial session fee of $45.00. If a client vomits or has uncontained diarrhea while in therapy, session will end, and you will be charged a partial session fee that will be prorated at Ari's hourly rate for that session type.

WEATHER POLICY:
Ari will follow the Waterloo Community School district policy regarding weather related delays, early dismissals, and cancellations. If school is cancelled, released early, or delayed due to weather conditions, the Center is typically closed at those times as well and you will not have your scheduled appointment. In response to these closures, or other emergency reasons, you will be contacted personally, and Ari will do her best to reschedule those appointments with you when possible. When able to reschedule, or with Ari's discretion, the late cancellation fee due to weather related events not associated with school closures will be waived.

AFTER HOURS AND EMERGENCY SUPPORT:
AriAnna Carroll, LMHC, with the Cedar Valley Center for Expressive Arts Therapy, is not an emergency services agency. Ari does not provide emergency services. If you have a life-threatening emergency, you should call 911 or go to the hospital emergency room of your choice. Only contact Ari in an emergency after you have already obtained emergency assistance from 911 or your choice of medical support.

Other After Hour Mental Health Resources: (not to be substituted for calling 911)
UnityPoint Health - Allen Hospital Emergency Department: 1-319-235-3697
Mercy One Medical Center - Emergency Room:

- Waterloo location: 1-319-272-8000
- Cedar Falls - Satori location: 1-319-268-3000

IMALIVE Suicide Prevention Hotline: 1-800-Suicide (1-800-784-2433)
Suicide Prevention Hotline: 1-800-273-8255
Iowa Help Line: Talk: 855-800-1239 Chat: iowacrisischat.org Text: 855-800-1239
National Alliance on Mental Health Helpline: 1-800-950-6264
Cutting/Self-Injury Hotline 800-366-8288 (800-DONTCUT)
SAMHSA (Substance Abuse and Mental Health Services Association): 1-800-662-HELP (4357)
Substance Abuse Hotline: 866-242-4111
Abuse Victim Hotline: 866-662-4535
Domestic Violence Hotline: 800-942-0333
GLBT National Youth Talkline: 800-246-7743
Parents, Families, and Friends of Lesbians and Gays Hotline: 800-284-7821
The Lifeline Teen Hotline: 800-443-8336
Foundation 2 24-hour hotline: text and chat 800-332-4224

Additional Mental Health Resources:
NAMI Iowa
One Iowa
The Trevor Project
Iowa Coalition Against Sexual Assault
National Institute of Mental Health
National Center for PTSD
International OCD Foundation
Postpartum Support International-Iowa: https://psichapers.com/ia
Postpartum Support International
Postpartum Dads
National Center for PTSD
International OCD Foundation
Prevent Child Abuse Iowa https://pcaiowa.org/resources/
Iowa DHS Child Abuse Hotline https://dhs.iowa.gov/child-abuse
Childhelp USA
National Child Abuse Hotline: 1-800-4-A-CHILD (1-800-422-4453)
Call 211 from your phone for United Way Information and Referrals

INSURANCE INFOMRATION AND FINANCIAL AGREEMENT

FEES, PAYMENT, INSURANCE:

Please indicate If you have a Health Savings Account (HSA): ☐Y ☐N
Client Information:
Name:_____ Date of Birth:_____
Responsible party name:_____ Relationship to client: _____
Home Address: _____
City: _____ State _____ ZIP _____
Phone numbers for responsible party:
(cell) _____ (home) _____ (work) _____
Please indicate primary phone number: _____
Home: OK to leave message related to billing and/or insurance? ☐Y ☐N
Work : OK to leave message related to billing and/or insurance? ☐Y ☐N
Cell: OK to leave message related to billing and/or insurance? ☐Y ☐N
E-mail address: _____
OK to email related to billing and/or insurance? ☐Y ☐N

IMPORTANT: It is **essential** that you fill out the rest of the form very carefully and that you provide **all the necessary information regarding ALL of your insurances.** Please note that if you do not provide accurate information you will then be responsible for payment or will be charged for re-submission of claims.

I ONLY HAVE ONE INSURANCE ***and understand that if I have another one at any time and do not communicate the information to*** **AriAnna Carroll, LMHC, at Cedar Valley Center for Expressive Arts Therapy*****, I might be responsible for payment in full.***

☐ **Yes** ☐ **No** (*If no, make sure you fill in all the information in the form below)*

PRIMARY INSURANCE INFORMATION:
Insurance Policy holder's/insured parent's:
Subscriber's Relationship to Client:
☐ Parent ☐ Guardian ☐ Other
INSURANCE COMPANY NAME: _____
Subscriber's Name: _____ Date of Birth:_____
Subscriber ID Number: _____
Policy number: _____ Group Number: _____
Insurance Phone Number: _____
Insurance Claim address: Street, City, State, ZIP:
_____
If Insured Through Employer:
Employer: _____ Employer phone: _____
Employer's address: Street, City, State, ZIP:
_____

Co-Pay Amount: _____ Deductible amount: _____ Pre-authorization required: ☐ YES ☐ NO If yes,
Number to call: _____
Important: In order to bill your insurance, we must have a copy of your insurance card on file.

SECONDARY INSURANCE INFORMATION:
Insurance Policy holder's/insured parent's:
Subscriber's Relationship to Client:
☐ Parent ☐ Guardian ☐ Other
INSURANCE COMPANY NAME: _____
Subscriber's Name: _____ Date of Birth:_____
Subscriber ID Number: _____
Policy number: _____ Group Number: _____
Insurance Phone Number: _____
Insurance Claim address: Street, City, State, ZIP:
_____

If Insured Through Employer:
Employer: _____ Employer phone: _____
Employer's address: Street, City, State, ZIP:
_____

Co-Pay Amount: _____ Deductible amount: _____ Pre-authorization required: ☐ YES ☐ NO If yes, Number to call: _____
Important: In order to bill your insurance, we must have a copy of your insurance card on file.

Billing Policy

You are responsible for 100% of the costs of services not covered by insurance. You may choose to submit your receipt for services to your insurance for out-of-network benefits, but Ari does not deal directly with your insurance if she is not in network with them. You are responsible for keeping track of your session statements and filing with your insurance if Ari is not in network with your insurance provider. If you will be using insurance to pay for services and have a co-pay amount, you are responsible for knowing this amount and paying this at the time of service. You may also elect to private pay for services, if you so choose. Please see Ari to discuss private pay rates for services.

In the event that your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, legal means to secure the payment may be used. This could mean utilizing a collection agency or involving small claims court. If legal action is required, the costs will be included in the claim. In most collection situations, the only information Ari would need to release would be the responsible party's name, the nature of services provided, and the amount due.

Credit Card Authorization

To the extent possible and as a convenience for both parties, a credit card or debit card may be kept on file in and encrypted electronic system. With your signature, your credit card or debit card will be stored at the onset of treatment for future copays, deductibles or no show/late cancel fees. This helps to eliminate the need for repeated billing communications. By entering into this agreement, you are authorizing that these charges may be applied without contacting the responsible party. Your statement of charges can be viewed and printed through the KASA patient portal, or you may discuss alternatives for receiving receipts with Ari. You also may revoke this at any time or agree to provide updated information as necessary.

Forms of Payment

I accept Visa, MasterCard, American Express, and Discover. **Checks should be made out to Cedar Valley Center for Expressive Arts Therapy, LLC. Cash is welcome as well. Check or cash must be for exact amount. A receipt is available to you upon request, or, if you are signed up for the KASA client portal, you will be able to view your payments online through the statements section and print receipts at your discretion. If you are private pay or need to provide a co-pay for services, payment is due at the beginning of each session. If a child client is being seen, please be discreet in submitting payment and we ask that you never have the child involved in the payment process.

FEE STRUCTURE:

Standard Fee Structure Outlined Below

Initial Intake (Diagnostic Assessment) Session (60 to 90 minutes, depending on need): $200.00 - $250.00
Individual Therapy Sessions (45-50 minutes): $150.00
Individual Therapy Session (60 minutes): $170.00
Family Therapy Session without client present (45-50 minutes): $150.00
Family Therapy Sessions (60 minutes): $170.00
Family Therapy Sessions (90 minutes): $200.00
Individual Sessions; individual and/or with family member (30 minutes): $75.00
Crisis Therapy/Assessment (first 60 minutes): $200.00 Each Additional 30 minutes: $100.00
Group Therapy Session (60 minutes): $40.00
Phone Sessions (30 minutes) $75.00
Extended services (30 minutes beyond usual service block): $50.00

Other Fees Charged

- If a client does not arrive for a scheduled appointment or cancels inside of 24 hours, there will be a $45.00 partial session fee charged for the appointment.
- Phone or email contact that exceeds 10 minutes in a 24-hour period will be billed my pro-rated session fee of $150/50 minutes for the time spent reading and/or responding to your concern/situation/issue.
- Preparation of Summaries of Treatment or Letters at request of client: $25.00 per item requested
- Court Related and/or Child Specialist Work for Collaborative Law Cases: Depending on court approval, potentially up to $150.00 to $250/hour for any and all time spent on the case. This includes, case preparation time, travel time, time waiting for court, time participating in court, and time engaged in any other case/court-related requirement and/or activity. Time spent will be pro-rated at this hourly rate.
- Administrative Fee for Record Copy Requests: $25.00
- There is a $25.00 fee for any returned checks. That fee is due at the time of your next session, along with the payment for that session. If a check is returned for insufficient funds, it is required that you pay using cash or credit card only from that point forward.

FEE FOR SERVICE AGREEMENT:

Please note, your entire record including this form is stored on HIPAA compliant electronic server.

Every time I, _____(PARENT/GUARDIAN NAME) schedule an appointment with my therapist, AriAnna Carroll, LMHC, for my child/youth/and/or family, I understand that I am entering into a contract with AriAnna Carroll, LMHC, and for the professional time and services of my therapist.

I recognize that professional services include time and services for preparation for my scheduled session, the actual time in session, time spent outside of session with case review, case notes, confidential consultations with supervisors or professional colleagues as outlined above.

I understand my therapist's professional fees as outlined in this Agreement to Enter into Counseling Services for scheduled sessions.

I understand that AriAnna Carroll, LMHC, has a cancellation policy requiring no less than 24 hours advance notice in order to be released from the contract for my therapist's time and services of preparation for my session.

I understand and agree that if I fail to cancel my appointment inside of the 24-hour minimum time period prior to my session I will be charged a $45.00 fee for the appointment.

I hereby authorize AriAnna Carroll, LMHC, to charge my credit card for any missed sessions or unpaid charges per this contract. I understand my credit card will be stored in a triple encrypted merchant services system for my protection.

I understand if there is an emergency situation that prohibits me from canceling within 24 hours I can discuss this with my therapist directly and request a waiver of this policy but I understand that AriAnna Carroll, LMHC, is not bound to grant that waiver and may, by this contract, proceed with charging my credit card as agreed herein.

I understand if payment is not made before or during my scheduled session, I am hereby authorizing AriAnna Carroll, LMHC, to charge my afore-listed credit card for services rendered.

I understand this agreement authorizes AriAnna Carroll, LMHC, to charge my credit card for services requested and rendered outside of the office such as email counseling, phone sessions, preparation of documents requested by me, or any court related proceedings.

AGREEMENT TO ENTER INTO COUNSELING SERVICES
AND ABIDE BY FEE AGREEMENT AND ALL POLICIES HERIN

I have read or had read to me all the information in New Client Packet.

I have had a chance to review and ask questions about all and any information in this New Client Packet before signing this agreement.

I have had all questions answered to my satisfaction prior.

I agree to abide by all the policies outlined herein including my full agreement not to have Cedar Valley Center for Expressive Arts Therapy, or AriAnna Carroll, LMHC, subpoenaed by myself or any attorney I may employ.

By signing this agreement, I am consenting to treatment and/or treatment of a minor, understand all the benefits and risks of counseling as outlined herein. I understand all policies and agree to the Insurance and Financial Agreement as outlined above. I also hereby acknowledge that I have received and reviewed the HIPAA Privacy Policy notice form mentioned herein.

Client name:_____

Name of parent/guardian of child client: _____

Signature of parent/guardian of child client: _____

Name of parent/guardian of child client: _____

Signature of parent/guardian of child client: _____

If applicable, signature of emancipated youth client: _____

DATE:_____

Thank you! I look forward to supporting you and your child!

HIPAA Privacy Policy
Cedar Valley Center for Expressive Arts Therapy, LLC
AriAnna Carroll, LMHC
PRIVACY PROTECTION NOTICE

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. THIS POLICY IS POSTED ON OUR WEBSITE AT https://cvceat.com AND A PAPER COPY IS AVAILABLE IN THE CENTER FOR YOUR REVIEW AS WELL.

Your Rights to Privacy under HIPAA Preamble:
Communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. PHI consists of three (3) components: treatment, payment, and health care operations. Treatment refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition. Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you. Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary." The use of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks within my office related to your care. Disclosures refer to activities you authorize which occur outside my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

Uses and Disclosures of Protected Health Information Requiring Authorization:
The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might by your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so. There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist -client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate from the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are my notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services

rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of your care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your "designated mental health record." You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

Business Associates Disclosures:
HIPAA requires that I ensure that all those performing ancillary administrative service for my practice and refers to these people as "Business Associates" sign and enter into a HIPAA compliant Business Associate Agreement so that your privacy is ensured at all times.

Uses and Disclosures Not Requiring Consent nor Authorization:

- By law, protected health information may be released without your consent or authorization for the following reasons:
- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Mental Health Counselors in Iowa)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).
- I never release any information of any sort for marketing purposes.

Client's Rights and My Duties:
You have a right to the following:

- You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- The right to request restrictions on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;
- You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- The right to inspect and receive a copy of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- The right to an accounting of non-authorized disclosures of your protected health information;
- The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- The right to revoke your authorization of your protected health information except to the extent that action has already been taken. For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters.

I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). My duties as a Licensed Mental Health Counselor on

these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

Complaints:
AriAnna Carroll, LMHC, is the appointed “Privacy Officer” for Cedar Valley Center for Expressive Arts Therapy, LLC per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to speak to Ari immediately about this matter. You will always find Ari willing to talk to you about preserving the privacy of your protected mental health information. You may also contact the State of Iowa Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
AriAnna Carroll, LMHC Date