Policies and Procedures

The Therapeutic Relationship and Scope of Treatment
As a patient of Summit Mental Health Services, you have the right to participate in the creation of your treatment plan and understand the therapist's clinical approach. Your therapist will be more than happy to explain their preferred treatment modalities for your particular situation upon request. You have a right to ask questions and seek information. The duration of your treatment and the frequency of your visits are issues that will be discussed with you and influenced by your preferences. If the therapist believes that you would be best served by another behavioral health professional, a referral will be provided along with an explanation of why that referral is being offered to you.
Initials ____

Appointments
Appointments typically run for 45-50 minutes to allow for record keeping and preparation. Please note that appointments for patients under the age of 15 usually begin with a "parent component" in which the patient waits in the waiting room while the therapist meets briefly with the caregiver to review any strategies being attempted in the home or community and to review observed progress or concerns.

There is a **$65 fee applied for any missed visits** or visits cancelled within the 24 hours prior to the appointment time. That fee must be processed before another visit may be scheduled. Please speak to your therapist with any questions about this policy. More than three no-shows or cancellations within the 24 hour timeframe will result in the transfer of treatment to an appropriate community resource or termination of the therapy.
Note: In case of an unavoidable emergency or a patient attempting to contact the office while the therapist is in session, the fee will not apply.
Initials ____

Confidentiality and Consent for Evaluation and Treatment

1. I understand that I will be informed of the goals and benefits of the services provided by Summit Mental Health Services.
2. I understand that the services provided by this office are designed to promote personal growth for the patient. Such growth is not always easy and may require the patient to challenge their usual ways of thinking, and cause temporary emotional distress. There is no guarantee of a positive outcome simply based upon the patient's attendance at counseling sessions.
3. I understand that I have a right to ask questions about my treatment plan and the treatment modalities used by the therapist.
4. I understand that communication shared within each clinical session and recorded in the medical record is confidential as governed by law and will not be released without the patient or legal guardian's written consent.
5. I understand that there are special conditions that may mandate the release of confidential information to provide for the protection of the patient, a named person under the age of 18, or a disabled or aged adult. Such information may be shared if there exists a danger or potential harm to the patient or a specifically named child, the patient requires hospitalization because they are a threat to themselves or others, if the patient requires a court ordered examination, if the patient discloses information about the abuse or neglect of a child, aged, or disabled adult, or if the patient's mental condition is being used as a legal defense in any type of legal scenario. Insurance companies may request a clinical summary or other information from the medical record to justify provision of benefits.
   Initials ____
6. I am informed as to the HIPPA Notice of Privacy Practices
   Initials ____

Fees
Payment for services is expected prior to the start of each session. Summit Mental Health Services charges $85 for each session for private pay. The office accepts cash, MasterCard, Visa, Discover, and check payment. Receipt for payment is available upon request. The office will file with your insurance company and accept the agreed upon deductible, coinsurance or copayment as long as the office is a participating provider with your insurance company. You are welcome to file independently if the office is not a participating provider with your insurance company. If your insurance company denies payment of any claim, your account will be billed and payment will be required prior to the scheduling of further sessions. ***A $65.00 late cancellation fee will be applied when appointments are missed or not cancelled prior to the 24 hours before the appointment***. The cancellation fee must be paid prior to the scheduling or attending of future sessions.
Initials____

Record Keeping
The patient has a right to review their medical records. Summit Mental Health Services will maintain medical records for seven years from the time of termination of services. Anytime a patient desires records to be released, a written release of information must be completed and added to the medical record. That release of information will clearly state the information to be released and a date range for when the information is allowed to be shared with the stated party.

Clinical summaries are occasionally requested by patients and their families. Such summaries are available at a fee of $110 to be paid prior to the completion of the report. Completion of reports or forms that are able to be done during the clinical session will not require an additional fee but will require a release of information form to be completed. Summit Mental Health Services does not complete any type of legal reporting.
Initials____

Emergency Policy
Summit Mental Health Services does not provide after hours or weekend care. In the event of an emergency, dial 911 or proceed to the nearest emergency room for evaluation.
Initials ____

Consent for Treatment
I hereby consent for Summit Mental Health Services to provide evaluation and psychotherapy services to myself, my minor child, or dependent.
Initials____

I am accepting this notice **(Circle one)** on behalf of myself/ on behalf of a minor.
I understand and accept all of the above listed policies and procedures.

_________________________________ __________

Signature Date

PLEASE READ FULLY AND SIGN

LEGAL INVOLVEMENT AND YOUR THERAPIST

If your visit to our office will require our involvement in a legal process such as a deposition, court ordered evaluation, court appearance, or involvement in custody disputes, or other legal proceedings, we cannot guarantee confidentiality. Although we will follow our statutory obligations to honor your privacy and your confidentiality, the court can order our disclosure under specific circumstances beyond our control. Please consult with your attorney prior to your first session if you believe our services will involve the legal system.

Please be aware that our fees for involvement in the legal process are $220.00 per hour with a three hour minimum, plus any related travel time involved. Any clinical summaries, court updates, and 504 recommendation letters are billed at $35.00 per report. More in depth reporting is billed at a rate of $220.00 per hour. The legal process is time sensitive and often requires us to cancel or reschedule appointments with other patients. In order to recoup our expenses for legal processes, we must collect these fees in advance. The minimum of three hours of time (a total of $660) is due one week prior to any scheduled court appearance or deposition date. If the client is a minor, the individual signed below will be responsible for the fees incurred as a result of legal proceedings. If the individual signed below is not the minor's parent or legal guardian, Summit Mental Health Services must have legal documentation of responsibility on file prior to the first session with the child.

The fees for involvement in the legal process are not billable nor reimbursed by your insurance carrier. All fees are your responsibility and are payable in advance. Summit Mental Health Services will not balance bill third parties or attorneys. We will accept cash, check or credit card payment for our fees.

We are not attorneys. For information of a legal nature please consult and follow the advice of a competent attorney. If your attorney requests information regarding your sessions with us, you will need to execute a signed written waiver of confidentiality.

As in all legal proceedings, final disposition is the responsibility of the court.

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Patient or Responsible Party Signature

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Printed name of Patient or Responsible Party

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Patient Name

Communication with Summit Mental Health Services

At Summit Mental Health Services, we strive to maintain excellent communication with our clients. We like to confirm appointments the day before each scheduled visit and occasionally have occasion to contact the client and/or family between visits.

Below, please list a method of communication that you prefer for confirmation calls and other types of communication. If more than one type of communication is acceptable, please check both boxes and include the contact information.

__ Text me at ____________________________
Phone number

__ Email me at ____
Email address

__ Telephone me at ______________________
Phone number

I understand that by listing the information above, I am agreeing to allow Summit Mental Health Services, LLC to utilize such communication methods to reach me. I understand that Summit Mental Health Services uses a confidential email account to reach clients. I agree that I am solely responsible for the security of emails that I send/receive and that Summit Mental Health Services is not responsible for a breech of privacy, confidentiality, or security for emails that I send/receive.

______________________________________ ____________
Signature Date

Initial Release of Information

Many insurance companies are recommending communication between the client's primary care physician and mental health provider to best coordinate care. Please indicate below whether you would like this office to communicate with you or your child's primary care provider.

__ Yes, please inform the primary care provider that I am working with your office.

__ No, please do not have any communication with my primary care provider unless I request such communication in the future.

Doctor and Group Name: ____
Doctor/Group Address: ____
____
Doctor/Group Phone: ____________________________

Additionally, Summit Mental Health Services strives to promote client growth through collaboration with community members whenever appropriate. If you have a teacher, attorney, community group or other affiliation that you wish to allow to speak with the therapist, please list the person's information below.

Name: ____
Address: ____
____
Phone: ____
Email: ____

I understand that by listing the contact information above, I authorize _________________________________ at Summit Mental Health Services, to have direct communication with the above named individual(s). I understand that I may revoke this release of information at any time by submitting a change in writing to this office.

___________________________________ ____________
Signature Date