Informed Consent for Treatment
Confidentiality and Consent to Use and Disclose Health Information

Client Name (legal): Client DOB:

Parent/Legal Custodial Guardian:

Client Address:

Syntero2 is a group practice of independently contracted clinicians. Syntero provides administrative services such as billing, scheduling, etc. Your clinician is licensed by the State of Ohio Counselor, Social Worker, Marriage and Family Therapist Board or The Ohio Board of Psychology to engage in mental health assessment and psychotherapy, independently. Case consultation is considered a best practice in mental health counseling/therapy and therefore, all clinicians affiliated with Syntero2 will engage in regular case consultation. This consultation will be with other clinicians, including those with more experience and/or licensed as a Supervisor and will not include identifying information on any client. It is possible, however, within the case discussion that a client's identity could be discerned incidentally. All clinicians engaged in our case consultations are required by their professional standards to keep all client information strictly confidential.

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1. The approach to psychotherapy will reflect the various evidenced based therapeutic modalities and is a collaborative effort between the clinician and client. By entering into this therapeutic relationship, you are stating that you are prepared to attend scheduled appointments and partner in the therapeutic process. It is expected that you will make the commitment to attend scheduled appointments. By signing this consent, you are acknowledging that repeated cancellations call into question your commitment and/or availability to the therapeutic process, impede progress, and can result in the loss of scheduled appointment times previously agreed upon and/or termination of services.
2. You have the right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment, or therapy on behalf of a minor client.
3. Your clinician cannot be reached outside of scheduled appointments. If you are experiencing an emergency, please contact 988, the National Mental Health & Suicide Helpline, or dial 911 or go to your local emergency department. If the client is under age 18, you may contact Nationwide Children's Crisis Line at 614-722-1800.
4. Your appointment time has been blocked off for you. You agree to make every effort to keep your scheduled appointment. If you are unable to keep your appointment, it is expected to give 1 business day notice. Failure to do so will result in a cancellation fee.
5. You have the right to be informed in advance of the reason(s) for termination of services and to be involved in planning for transition of care. Should your clinician determine they are not able to provide care, you have the right to receive an explanation of the reasons for denial of service(s).
6. You understand that you have the responsibility to provide accurate and complete information in order for treatment to be appropriate and effective, and for accurate assessment and evaluation to occur.
7. Your clinician may use several therapeutic techniques in counseling. Your clinician will talk with you about clinical approaches so you can come to a collaborative agreement about the best method to help you achieve your treatment goals.

8. The services offered can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you may experience uncomfortable feelings like sadness, guilt, anger, shame, frustration, loneliness, and helplessness. On the other hand, mental health services have also been shown to have benefits for people. Treatment may often lead to changes in relationships, functioning, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience or to the success of treatment. Treatment goals may not be achieved should you decide to discontinue treatment against the advice of you or your child's clinician, and/or continued cancellations occur.

Confidentiality

We are committed to protecting the confidential nature of information regarding your health status. Federal laws as well as the Code of Ethics of the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board and other licensure boards ensure that the conversations you will be having with your clinician will be held in strict confidence. There are, however, certain exceptions to this important rule. The Notice of Privacy Practices explains this information in detail.

1. Ohio law requires your clinician to report to any suspected physical, sexual, or emotional abuse, neglect or abandonment of any child that is currently under the age of 18 years.
2. Ohio law requires licensees of the Counselor, Social Work, Marriage and Family Therapist Board report suspicion of animal abuse.
3. Ohio law requires your clinician to report elder abuse, neglect, exploitation, or the suspicion of abuse.
4. Your clinician is mandated by law to warn and protect any intended victim if there is reason to suspect bodily harm toward yourself or someone else. Your clinician reserves the right to inform possible affected parties and/or make appropriate referrals, if necessary, including contacting the police.
5. If you are involved in a court proceeding and a request is made for information concerning your treatment, your clinician cannot provide such information without your (or your legal representative's) written authorization, or a court order or subpoena. If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your clinician to disclose information.
6. If a government agency is requesting the information, your clinician may be required to provide it.
7. If you file a complaint or lawsuit against your clinician, he/she may disclose relevant information about you in order to defend him/herself.
8. If you file a worker's compensation claim, your clinician may, upon appropriate request, have to provide a copy of your records or a report of your treatment.

Consulting with Other Therapists and Attorneys

By signing below, you agree that your clinician will consult with other clinicians and possibly other health care providers about your care. In addition, from time to time, your clinician may feel the need to discuss legal issues involving your case with their consulting attorney. By signing below, you consent to these consultations, which will be limited to the amount of information necessary for your clinician to properly address issues that may arise in your therapy.

Electronic Communication

Electronic messages (email, text messages, etc.) are vulnerable to breaches of privacy, despite standard safeguards, which are outside our control. Therefore, we are unable to exchange clinical information with you by electronic communication. We can communicate regarding scheduling or billing issues. By signing this consent, you agree to these conditions and understand, and agree to the fact, that if you initiate an email or text message to us, your identification, information that you are communicating with a clinician, and/or other Protected Health Information could inadvertently be disclosed to an outside party, and that you understand that these forms of communication are not encrypted.

Initial where applicable:

☐ I agree to electronic communication knowing it is not secure or encrypted.

☐ I do not agree to electronic communication and prefer only phone calls to the following phone number. I have voicemail activated on this number and give permission for my clinician to leave a message at _____ (number).

Health Information

The Notice of Privacy Practices* (NPP) explains in more detail your rights and how we can use and share your information.

*If you would like a copy of the Syntero2's "Notice of Privacy Practices" which explains this information in detail, one can be provided to you at your initial appointment. This document is also available online at www.syntero.org/syntero2

Prohibition of audio, video or photographic recording

While in psychotherapy sessions and/or in the office of Syntero2, there is to be no audio, video or photographic content recorded. By signing below, you agree to not use any type of documenting device or recording device while attending services, and that doing so could lead to termination of your treatment. If, due to unusual circumstances, you would like to record or videotape your individual psychotherapy session, and if your clinician deems an exception to this prohibition is reasonable and necessary, the exception will be granted to you in writing.

Telehealth Services/ Electronic Service Delivery

Telehealth includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making through the use of internet-based videoconferencing or phone calls.

1. The benefits of telehealth include greater flexibility by geographical location, reduction of travel to a physical office and participation from your own home environment.
2. The risks of telehealth include the potential breakdown in the technology including poor connection, loss of sound or loss of connection. A second factor that may impact the communication is that nonverbal cues are less readily available to both the clinician and the client.
3. All existing laws regarding privacy, confidentiality, access to mental health information, and client rights and grievance procedures apply the same as face-to-face sessions.
4. Nobody will record the session without the permission from the other person(s).
5. It is important to be in a quiet, private space that is free of distractions (including computers, additional phones, or other devices) during the session.
6. Only agreed upon participants will be present in the room of the clinician and the client during the telehealth session.
7. The clinician will verify the physical address of the client's location at the start of each session. This is to ensure we are "meeting" at a place that will protect your confidentiality (e.g. No coffee shops or public places). Sessions will not occur while any of the participants are driving.
8. It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the clinician in advance by phone.
9. We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
10. We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
11. If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions.
12. Your clinician may determine that due to certain circumstances, telehealth is no longer appropriate and that we should consider alternative resources for your treatment.

Insurance and Fees

Please review this agreement before signing. By signing this informed consent, you agree to abide by the fee agreement. You also understand that you are financially responsible for the amount of charges related to the services you are seeking.

By signing this form, you acknowledge that insurance will not be billed and that you are responsible for the full balance of your account for services rendered, regardless of any payments or promise of payment by your insurance company or other third party. Payment is due in full at time of service.

- Initial Session (50-60 minutes): $175
- Follow-up Session (45-55 minutes): $150

Clients who would like to submit for reimbursement from their insurance company may request a "superbill". A superbill is a detailed document that allows clients to bill their insurance company directly. It includes information similar to an insurance claim form, such as the date of the service provided, procedure codes and a total balance due. Clients maintain full responsibility for submitting superbills directly to their insurance company for reimbursement. Syntero2 does not guarantee reimbursement for these services.

CANCELATION POLICY:

By signing this document and initialing below, you understand that **canceling an appointment without 1 business day notice or with no notice will result in a charge $50 for the first missed appointment and a full session fee $150 for any additional missed appointments**. Clients who repeatedly do not give 1 business days' notice for cancellations or who do not keep their scheduled appointments may be terminated. You understand that insurance does not cover missed appointment fees or late cancel fees and you are responsible for payment of these fees at your next appointment. Initialing below, you are stating understanding regarding the collections process noted in the above section.

Legal Proceedings

In the event that your clinician becomes involved in legal proceedings as a result of therapy, such as but not limited to responding to a court order or attending a deposition or a hearing, you agree to pay for fees in connection with such a proceeding. You also agree that your clinician may consult with his/her attorney on how best to proceed and you agree to pay those legal costs. Time for depositions and court may involve preparation, travel time, and waiting to testify. In such situations your clinician may request a retainer which will be charged at the normal rate charge at that time for therapy. If any money in the retainer is not used your clinician will refund the balance. In the event that your clinician does not schedule patients in anticipation of a court proceeding and notice of a cancellation of the court proceeding within one week of its scheduled date is not received, you agree to pay for time your clinician lost with patients that would have otherwise been scheduled.

If requested to testify in a court proceeding or to provide clinical information during a court proceeding, your clinician will require a court order signed by a judge, not a subpoena from your attorney. You agree to notify your attorney of this requirement, which is based on our Board's guidelines and advice of our attorney.

By signing below, you state understanding that your clinician is not a forensic psychologist, a forensic interviewer, or a child custody evaluator. Your clinician cannot provide child custody and/or visitation recommendations for you. Your clinician is limited by the Board's guidelines regarding conflict of interest and scope of practice as to what testimony, if any, may be given.

*By signing below, you are stating that you will provide any and all current and up-to-date child custody paperwork, legal visitation paperwork, and/or legal guardianship paperwork to your child's clinician as you are required by law. You are also stating that you acknowledge responsibility in keeping all of the child's custodial parents and legal guardians up-to-date on all therapy appointments, and keep your child's clinician up-to-date on all legal changes to custody and/or legal proceedings.

Professional Records

The laws and standards of our profession require that your clinician keep Protected Health Information (PHI) about you in your Clinical Record. You have a right to a copy of your medical record and to request we send information from your record to another provider, organization or professional. The Notice of Privacy Practices provides more information about HIPAA and the protection of your PHI. To request medical records, please speak with your clinician. There may be fees associated with processing medical record requests.

Acknowledgement of Notices & Informed Consent

If you have any questions or concerns about the information presented to you in this form, you can speak with your clinician at any time. Signing below indicates that you have read and understand that there are limits on confidentiality, there is a fee and payment procedure and that you hereby give your consent for, and understanding of, all items listed in the above pages.

Your signature certifies that you have either received a copy of the "Notice of Privacy Practices" or waived that right. You understand that you can obtain a copy at any time from your clinician or online via the website www.syntero.org/syntero2

By signing below, you are agreeing to all information outlined above for yourself and/or your child. You consent to receive the services outlined above or you consent for your child, who is under the age of eighteen (18) to receive these services. You have had the opportunity to discuss this consent with your clinician and do hereby give full voluntary consent/ authorization for the treatment for yourself and or your child/family under the conditions set forth.

Client Legal Name (Please print): _____

Client Signature _____ Date: _____

Parent/Legal Custodial Guardian Signature for a minor under 18 years of age

Date Parent/Legal Custodial Guardian Printed Name: