HEIDI BLACKSTUN, MSW. LCSW, MBA
1000 W. Nifong, Bldg. #1
Columbia, MO 65203
573.289.8144

CLIENT'S INFORMED CONSENT

I have chosen to receive assessment and psychotherapy services from Heidi Blackstun, MSW, LCSW, MBA. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between myself and my therapist, I will work with my therapist in a cooperative manner to resolve my concerns.

I understand that during the course of my psychotherapy, material may be discussed which might be upsetting in nature, and that such discussions may be necessary to help me with my concerns.

I understand that confidentiality of records or information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand that records are in compliance with the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) as follows:

1. I understand that state laws require that my therapist report all cases of abuse or neglect of minors or elderly.
2. I understand that state laws require my therapist to report all cases in which there exists a danger to self or others.
3. I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
4. I understand that if I am using my insurance, a diagnosis will be needed.

I understand that at times you may decide that consultation with a colleague will help in my treatment. In this situation my name will not be used.

I have read and have had explained to me these basic rights, including:

1. the right to be informed of the various steps and activities involved in receiving services;
2. the right to confidentiality under federal and state laws relating to the services;
3. the right to humane care and protection from harm, abuse, or neglect;
4. the right to make an informed decision whether to accept or refuse treatment.

I understand that I need to keep you informed of any changes in my medication and/or health.

Additional Information: When you arrive please have a seat in the waiting room. I will come and get you at the beginning of the session. Sessions last for 45 to 60 minutes (depending on insurance benefits). At the end of an appointment we will make arrangements for further sessions. If you cannot keep an appointment time please give me 48 hours notice so I can make the time available to others who need to see me. **If you miss an appointment without notifying me or cancel with less than 48 hours notice, I will need to charge you my full fee for the time.**

I strive to promptly return phone calls but there may be unavoidable delays. If the delay is beyond what you consider a reasonable time frame given the nature of your message, please call again. If you have an emergency and cannot reach me, please contact your primary care physician or other community resources.

You are not obligated to see me any specified number of sessions. I would like for you to give me one session's notice. I would like to avoid a situation where you cancel and then don't reschedule without an explanation. A clean ending can be important.

Insurance companies cover mental health benefits in different ways. With a few, the insurance company will reimburse you or me for a percentage of the charge for services. Some other insurance companies contract with a managed care company for their mental health coverage. Your policy may indicate that you are eligible for up to a certain number of sessions per year. However, this company may be one that will approve only "short term, problem-focused, solution-oriented" therapy. The sessions beyond the few initial sessions need to be approved by a case manager at that company, based on the information I provide to show "medical necessity". If you are covered by such a policy, I may need to provide detailed information either in writing or on the telephone concerning you personal history, drug and alcohol use, problems and progress, to obtain more sessions. Failing to do so will mean denial of benefits. If you choose to use your health care benefits I can submit appropriate claim forms to the company for payment. You are responsible for notifying me of any changes in health coverage.

Payments:
Payments are due at the beginning of the appointment. In the event you do not pay at the time of the session, outstanding balances must be paid prior to beginning the following session. You will be billed at the beginning of each month for all unpaid sessions, cop-pays, no-show appointments, late cancellations and other services.

A $20.00 rebilling charge will be assessed for each additional month a past due (over 30 days) balance is billed. Accounts over 90 days past due will be turned over to a collection.

Your credit rating could be impacted. You will be billed $20.00 for all checks returned for insufficient funds, closed accounts and other bank account issues.

Charges for Court and Litigation Related Work:
In the event I am subpoenaed for court, depositions or other court or litigation related matters, you will be responsible for payment of my time at my regular court hourly rate of $150/hr.

I have read and understand this provision. _____

Finance Charges:
If your account is not paid within 30 days of the date of billing, finance charges of 1.5% per month will accrue and will be compounded monthly. If sent for collection, you are responsible for all costs of collection, including attorneys fees.

I have read and understand this provision._____

Attorneys Fees:
If you default on any payment according to the terms of this agreement and I place this or any other contractual default matter with an attorney, you agree to pay all of Heidi Blackstun's legal fees, costs and expenses incurred.

I have read and understand this provision._____

I understand and agree to the terms specified above.

_____

Client's or parent/guardian signature (Date)

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Witness' signature (Date)