Insurance Information

Patient's name Date of birth address:

Subscriber's name and date of birth (if different) :

Insurance ID:

Ron Gluff LPC

The initial consultation fee is 125 dollars for counseling services. I will usually schedule one appointment hour of 50 minutes duration or longer when needed or necessary. The appointments may vary in frequency. In addition to appointments, I charge 150 dollars per hour for other professional services including: report/letter writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals that you have authorized, preparation or records or treatment summaries, and the time spent performing any other service that you may request of me. If you become involved in legal matters that require my participation, you will be expected pay for my professional time, including preparation and transportation costs. I charge 700 dollars per hour with a four-hour minimal requirement preparation, time travel, and attendance a-I any legal proceedings. In addition, this fee will need to be paid in advance.

Client/ Parent/ Legal Guardian initial _____

Spouse/ Parent or Guardian initial _____

Billing

You are expected to pay at the time of OP services, unless we agree otherwise or unless I have contact with your managed care company. If I have a contract with your managed care company the billing procedures of that company will be followed, and you be expected to pay the co-pay or payment towards the deductible, which is the amount not covered by your insurance at the time service is provided to yon. By having my office process insurance forms, it is important for you understand that this does not eliminate your financial obligations to treatment. Our office will enter a dispute with your insurance company over any claim, and we will provide necessary documentation that your insurance company requests to. It is ultimately your responsibility to resolve any dispute over payments made or not made by your insurance company. Therefore. it is very important that you find out exactly what mental health services your insurance policy covers. You should read carefully the section in your insurance coverage booklet that describes mental health services. If you have any questions about the coverage, call your plan administrator. Of course, I will provide you whatever information that I may have from professional experience and I will be happy to help in understanding the information you receive from your insurance company, if it is necessary to clear confusion, my staff or I will be willing to call the company on your behalf. You should also be aware that your contract wi.th your insurance company requires that I provide it with information relevant to the services that I provide to you and I am required to provide a clinical diagnosis; Sometimes I am required to provide additional clinical information such as treatment plans or summaries or copies of your entire clinical record. In each situation, I will make every effort to release the minimum amount of information that is necessary for the purpose requested. The information will become part of the insurance company files and will be probably stored in a computer. Though all insurance companies claim to keep that information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with

a national medical information databank. I will provide you a copy you with a copy of any report that I submit, if you request it. By signing this agreement, you agree that I can provide requested information to your carrier. Once we have all the information about your insurance coverage, we will discuss what we expect to accomplish with the benefits that are available and what will happen if they run out before you ready to end our sessions, it is important to remember that you0 always have the right to pay for my services yourself. You may qualify for sliding scale payments. If I am covered by your insurance plan, or if I am not covered your insurance, you will be responsible for paying the full fee of my services at the time they are provided and my billing department will fill out a super bill for you to submit to your insurance company and provide with any assistance that I can in helping you receive the benefits to which you are entitled to; however you (not your insurance company) are responsible for full payment of my fees. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

Client/Parent/ Legal Guardian initial

_____

Spouse/Other Parent/ Guardian initial

_____

I require a 24hour in notice for any cancelation of any appointment. It is possible to call and leave a message 24 hour a day. You will be charged the full cancelation fee for any late cancelations not made in 24 hours and for any no shows to the appointment. Late cancellations with be billed directly to you and not your insurance company.

Client/ParentlLegal Guardian initial

_____

Spouse/Other Parent/ Guardian _____

If your account has not been paid for more than 45 days and arrangements for payment have not been agreed upon. Ron Gluff LPC LLC, reserves the right to charge your credit card or send. the account to attorney or a collections agency, which may also negatively affect your credit score. You will be become responsible for any additional fees from the collection agency.

Client/Parent/Legal Guardian initial

_____

Spouse/ Other Parent/ or Guardian initial

_____

There will be a $75 dollar for any check that is returned due to non-sufficient funds.

Client Parent/Legal Guardian initial _____

Spouse/Other Parent/ Guardian initial _____

Professional Records and Procedures

The law and standards of my profession require that I keep protection health information about you, your child in your clinical record, Expect in unusual circumstances that involve danger to yourself, others, and neglect/abuse of a child or elderly person or where information has been supplied to me confidentially by others, you may examine and receive a copy of you/your child 's records if you request it in writing. Because these are professional records, they can be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional, so you can discuss the contents, (I am willing sometimes to provide the service without a charge). In most situations, I can charge a copying fee of 35 cents per page (add for certain other expenses). If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request. You will be charged an appropriate fee for any professional time spent in responding to information requests, although I am sometimes conduct a review without charge,

Other important information About professional treatment records includes the following:

Treatment records are securely stored in a locked filing cabinets and/or password protected computerized files.

Treatment records will be maintained by me for 7 years from the date of your last clinical contact, or in the case of treatment record for children, 7 years past the date of the last clinical contact/ 3 years past the child's 18t birthday, whichever is greater,

After this time has elapsed, records may be destroyed by me by way of paper shredding and/or deletion of computerized files.

In the event that my office location changes or that I terminate or sell my practice at some point in the future, clients whose records I am currently maintaining- my office location and/or current contact information will also be kept updated with the board of behavioral health examiners (http://ww.bbhe.state.az.us/)

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on the therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon

CONSULTATION: Your therapist consults regularly with other professionals regarding his/her clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained. E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted e-mail, texts,

and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes are vulnerable to such unauthorized access since servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on your therapist's laptop is encrypted, e-mails and e-fax are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. The therapist's laptop is equipped with a firewall, a virus protection and a password, and he backs up all confidential information from his computer on a regular basis onto a HIPPA compliant cloud storage service. Also, be aware that phone messages are transcribed and sent to the therapist via unencrypted e-mails. Please notify your therapist if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and he will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

PROVISIONS FOR SERVING AS A TREATING CLINICIAN WITH MINORS: When caretakers bring their children for assessment and treatment of psychological problems it is preferable that both parents consent to treatment knowing that the role of the clinician is as the family or child therapist and not as an expert witness. Prior to beginning treatment, it is important for you to understand my approach to child and adolescent therapy and agree to some rules about your minor's confidentiality during his/her treatment. The information herein is important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. I will encourage your child to regularly provide you with a summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future. In addition, I will periodically request that you provide supportive information for me to best help your child and the family. If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you. Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. I need your agreement that in any

such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs. In signing this agreement, I acknowledge that there is a difference between the roles of treating clinician and expert witness, and I agree not to subpoena the clinician, nor the clinician's records for use in litigation. I understand that the boundary between treating clinician and expert witness is necessary so that the treating clinician may maintain the integrity of the therapeutic relationships established through therapy. In addition to the information contained in the Outpatient Services Contract, under HIPAA and my Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact your therapist between sessions, please leave a message at (602) 317-9391 and your call will be returned as soon as possible. Your therapist checks his/her messages a few times during the daytime only, unless s/he is out of town. If an emergency arises, indicate it clearly in your message and if you need to talk to someone right away call Psychiatric Emergency Services. LA Frontara EMPACT: (480) 784-1514, 24-hour crisis line Banner Behavioral Health at (888)698-2727, or the Police: 911. Please do not use email, text or faxes for emergencies. Your therapist does not always check his/her email or faxes daily.

MEDIATION & ARBITRATION: All disputes arising out of, or in relation to, this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of the therapist and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. If mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Arizona in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, if your account is overdue (unpaid) and there is no agreement on a payment plan, the therapist can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Participation in therapy can result in many benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness to change your thoughts, feelings, and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry,

fear, etc., or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, adaptive information processing used when employing EMDR, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. Your therapist provides neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within his/her scope of practice.

TREATMENT PLANS: Within a reasonable period after the initiation of treatment, your therapist will discuss with you his/her working understanding of the problem, treatment plan, therapeutic objectives, and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used during your therapy, their possible risks, your therapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. TERMINATION: As set forth above, after the first couple of meetings, the therapist will assess if he/she can be of benefit to you. The therapist does not work with clients who, in his/her opinion, he cannot help. In such a case, if appropriate, he will give you referrals that you can contact. If at any point during psychotherapy your therapist either assesses that he is not effective in helping you reach the therapeutic goals or perceived you as non-compliant or non-responsive, and if you are available and/or it is possible and appropriate to do, he will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, he would give you a couple of referrals that may be of help to you. If you request it and authorize it in writing, the therapist will talk to the psychotherapist of your choice to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will give you a couple of referrals that you may want to contact, and if he has your written consent, he will provide her or him with the essential information needed. You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request and if appropriate and possible, your therapist will provide you with names of other qualified professionals whose services you might prefer.

DUAL RELATIONSHIPS: Despite a popular perception, not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. Your therapist will assess carefully before entering nonsexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, military bases, university campus, etc., multiple relationships are either unavoidable or expected. The therapist will never acknowledge working with anyone without his/her written permission. Many clients have chosen one as their therapist because they knew him/her before they entered therapy with him/her, and/or are personally aware of his/her professional work and achievements. Nevertheless, the therapist will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know which ahead of time. It is your responsibility to advise your

therapist if the dual or multiple relationship becomes uncomfortable for you in any way. The therapist will always listen carefully and respond to your feedback and will discontinue the dual relationship if s/he finds it interfering with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time.

Treatment Planning

I understand that I will be able to participate in treatment planning. I will be able to participate in treatment decisions. I will be able to revise my treatment plan at any time.

Client:_____

Family Member_____

Friend_____

Parent_____

Purpose of Treatment:

I understand that the purpose of treatment is for the client to improve mental health symptoms and relationships.

Client_____

Family Member_____

Friend_____

Parent_____

Refusal/ Withdrawal of Treatment:

I understand I have the right to refuse any recommend treatment and the right to withdrawal. The client will be informed of advised of the consequences for refusal or withdrawal.

Client: _____

Family Member_____

Friend:_____

Parent_____

Risk, Benefits and Consent to Treatment:

I understand that there are risks associated with treatment such as changing the way I see the world and relationship disruption. I understand the benefits of treatment as improved quality of life and improvements in all areas of importance to client. I have received this information and will consent to treatment.

Client _____

Family Member_____

Friend_____

Parent_____

Collections/ Cancelations Policy:

I understand the collections policy outlined in the last page of intake packet. I understand that all payments are due within 45 days of receiving notice and that any uncollected fees will be sent to collections. I understand that as of 1/1/18 any cancelation made within 24 hours will have a fee of 70 dollars.

Client_____

Family Member_____

Friend_____

Parent_____

After 5 pm appointments:

I understand that any appointment after 5 pm that is scheduled includes a 20-dollar additional fee due at time of service.

Client_____

Family Member_____

Parent_____

Telephonic/Electronic Counseling

I understand that any form technology driven counseling has its limits in confidently due to potential technology errors and not being face to face with provider. I understand that I can call crisis in AZ 602-222-9444 or the state that you are visiting. I understand that I will be asked to verify personal information when called and when appropriate FaceTime will be used to verify identity.

Client_____

Family Member_____

Parent_____

Spouse_____

All clients:

With my signature, I acknowledge that I have read the information above information, or it has been read to me. I acknowledge that I have received answers to my questions I may have had and that I understand the content of the information above and agree to abide by items above and agree to abide by its terms during our professional relationship. I hereby authorize the release of any medical information necessary to process medical claims on my behalf. I also authorize the payment of any governmental or private insurance benefits directly to Ron Gluff LPC LLC. I acknowledge that I am responsible for all services rendered to me/and or members of my family. I also understand that I am obligated to pay for all services should my insurance eligibility be denied.

Your signatures below indicate that you have read this agreement and agree to its terms and services as an acknowledgement that you have received the Hippa Notice. Your signature indicates that you consent to treatment for yourself and/ or your child (children).

_____ _____

Signature of Client or Parent/Guardian Date

_____ _____

Signature of Client or Parent/ Guardian Date

_____ _____

Therapist's signature Date

Collections Policy

It is the policy of Ron Gluff CPC LLC, to obtain and maintain record of a valid Mastercard, Visa, American Express, or Discover Card and authorizing signature.

This will remain a part of' your confidential file as a guarantee of payment and allows the company avoid having to take collections actions against any client. No charge will bill to this unless the owner of the card fails to reconcile debts to Ron Golf LPC LLC. If you do not wish to fill out this form, you can seek services elsewhere and I will assist you with a referral. If you elect to use your insurance/EAP benefits to pay for services, then you will need to complete this form in its entirety as having benefits is not a guarantee of payment. If I have a contract with your managed care company/Eap the billing producers of that company will be followed. Our staff will make several attempts to collect from your insurance company/eap including a telephone call to said company, if necessary; however, in the event that any insurance/ EAP obligated by contractual agreement to make payments on your behalf for services provided, refuses to make such payment then you will become personally responsible for account and is not cleared within 45 days you herby authorize me to collect my outstanding debt with the credit card listed below, I will attempt to notify you of the debt in order to provide you the opportunity of calling your insurance company and/or clearing your account. In the event that charges are billed to this account, you will be sent a copy of credit card charge and reconciled bill in the mail within 7 to 10 business days, In the event this policy does not result in the reconciliation of your account Ron Glutf LPC LLC, reserves the right to send the account to an attorney or collections agency and you will become responsible for the fees incurred as a result. The collection agency fee is $50 per claim, the credit card can be used at the time of service of a no-show or cancelation that does not occur within 24 hours. The fee is 70 dollars.

This signed credit card collections policy is for use only for services rendered at (be offices Ron GluffLPC LLC.

Client's name:

_____

Visa

MasterCard

Discover

American Express____

Cård Member name:

_____

Card Number ExpirationDate

_____

_____

Security Code

_____

Card member Signature

_____

Date

_____

Therapist signature

_____