

DEBRA K. SOWALD, PSY.D. PSYCHOLOGIST
28 E. RAHN RD., SUITE 105
KETTERING, OHIO 45429
(937) 434-6840

Individual, Family, & Group Therapy
Imagery & Senoi Dreamwork

Client Information and Acknowledgment of Informed Consent to Treatment

I am an Ohio Licensed Psychologist and am engaged in private practice providing mental health services to the public.

Mental Health Services

The purpose of mental health services is to help you better understand your situation, change your behavior, or move toward resolving your difficulties. Using my knowledge of human development and behavior, I will make observations about situations and help you to develop new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur.

The services offered can have risks as well as benefits. Treatment often involves discussing unpleasant issues, and you might experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health care may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Appointments

Appointments are made by calling (937) 434-6840. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged the full rate for the missed appointment unless I determine an emergency was involved. Third party payers will not cover or reimburse for missed appointments. Appointments are approximately 45 minutes in length, but session length may vary for clinical reasons. The number of appointments depends on many factors and we will discuss this as part of your treatment planning. Since there is no way a therapist can see another client when they have a late arrival, no reductions are provided

when a client arrives late for an appointment. Some insurance companies will only pay for the actual time during which services are rendered. In that case you, the client, will be billed for the portion of the appointment time when no services could be rendered. In some cases governmental insurance or employee assistance programs do not allow billing for missed or partially missed appointments and if that is the case you will be billed in accordance with those programs' rules.

Access to Office Waiting Room

If you have an evening appointment, the building is usually open. However, occasionally a new tenant locks the entrance door without realizing that they have locked you out. You can ring the doorbell to my office on the top left hand side of the outside door frame, and I will come and unlock it. If I do not come within a few minutes of your ringing the doorbell, I may have been temporarily out of the office. Please ring again.

Relationship

My relationship with clients is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Please do not attempt to “friend” me on Facebook or on any other social media site. You always have the right to terminate services with me at any time and for any reason.

I may publish content on various social media websites or blogs. There is no expectation that you will follow, comment on, or otherwise engage with any content. If you do choose to follow me on any platform, I will not follow you back.

If you see me on any form of review website, it is not a solicitation for a review. Many such sites scrape business listings and may automatically include me. If you choose to leave a review of me on any website, I may respond only in a general way about the practice. While you are always free to express yourself in the manner you choose, please be aware of the potential impact on your confidentiality prior to leaving a review. It is often impossible to remove reviews later, and some sites aggregate reviews from several platforms leading to your review appearing other places without your knowledge.

Goals, Purposes and Techniques

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment I recommend and to have input into setting the goals of your therapy. As therapy progresses these goals may change. You and I will jointly determine how to effect the changes you are seeking to make for yourself. You always have the opportunity to seek either another opinion or a different therapist. I will let you know if I feel that we are not a good fit or if you might obtain better help elsewhere. I will always retain the right to terminate my therapy with you in the event that I feel you would be better served elsewhere, if I feel you are not complying with treatment requests, or if payments due to me remain unpaid. In the event that I terminate services with you I will offer you referrals. You will automatically be considered terminated in the event that you do not schedule an appointment for a one month period. If you are terminated for that reason, you may request referrals or return for future work with me.

Psychological Testing

I may suggest psychological testing as a brief and efficient method of gaining information about important aspects of your personality and/or current psychological status, or you may request psychological testing. I will refer you to a colleague of mine if psychological assessment is needed.

Confidentiality

Laws protect the privacy of all communications between a client and a therapist. In most situations I can only release information about your treatment to others if you sign a written authorization. There are some situations where I am permitted or required to disclose information either with or without your consent or authorization. For example:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, I cannot provide such information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order me as your therapist to disclose information;
- If a government agency is requesting the information, I may be required to provide it;

- If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend myself;
- If you file a worker's compensation claim, I may be required, upon appropriate request, to provide a copy of your records, or a report of your treatment.

There are some situations in which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm, and in such cases I might have to reveal some information about your treatment. If such a situation arises, I will make every effort to fully discuss it with you before taking any action, if I deem that to be appropriate under the circumstances and will limit disclosure to what is necessary. For instance:

- If I have reason to believe that a child, a developmentally or physically disabled or elderly adult has been or is being neglected or abused, the law may require me to report that information to the appropriate state or local agency;
- If I believe you present a clear and substantial danger of harm to yourself and/or others, I may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and/or notifying the police.

You agree that I may release information to the Ohio Department of Insurance if there is a problem with insurance company payments, as well as to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.

You agree that from time to time I may have the need to consult with my practice attorney regarding legal issues involving your care (this is an infrequent occurrence, but does happen from time to time). My practice attorney is bound by confidentiality rules also. In addition, I will reveal only the information that I need to reveal to receive appropriate legal advice in connection with those contacts.

You should be aware that I may practice with other health professionals and that I may employ administrative staff or I may need to consult with outside medical professionals. In addition, I may need to coordinate your care with your other healthcare providers. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as typing, scheduling, billing, quality assurance and for other reasons associated with providing you with the best care, including coordinating your care with other

providers. If I do that, I will only release the information necessary in order for me to provide help to you, the client and you agree that I may do that. All of the health professions will be bound by the same rules of confidentiality. All staff members will have been given training about protecting your privacy and will have agreed not to release any information outside of the practice without the permission of a professional staff member.

Also, I may have a contract with a collection agency and/or a billing service. I will have a formal business contract with these businesses, in which they promise to maintain the confidentiality of this data except where release of certain information is allowed or is required by law.

This summary is designed to provide an overview of confidentiality and its limits. It is important that you read the Notice of Privacy Practices form that has been provided to you for more detailed explanations, and that you discuss with me any questions or concerns that you have.

Legal Situations

Please be aware that I **do not** voluntarily do any Court related work. However, if you or the client (if the client is a minor or a ward of a guardian) become involved in legal proceedings that require my participation you will be expected to pay for all of my professional time, even if I am called to testify by another party. I will ask that a retainer be paid of half of the expected fees at least one week prior to providing these services, and the second half of expected fees and any additional fees that may have been accrued be paid within one week after services are delivered. Any unused amounts will be refunded. My professional time for legal proceedings may include preparation, document review or letter preparation, phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that I wait in court prior to or after I may be called to testify. Due to the time-consuming and often difficult nature of legal involvement, I charge \$300.00 per hour for these services. You will also be responsible for any legal fees that I may incur in connection with the legal proceeding, which may include responding to subpoenas.

Please be advised that as a treating therapist I cannot ethically provide any recommendations on guardianship, custody, visitation, parenting capacity or abilities or what is in the best interest of the child(ren) if you or your child(ren) are involved in custody/divorce/guardianship proceedings.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information about you in your client file. Your client file may include information about your reasons for seeking therapy, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of all of your records that I have prepared in connection with your treatment if you request them in writing, unless I determine for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, and in that event under Ohio law I may exercise the option of turning the records over to another mental health therapist designated by you, unless otherwise required by federal law. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, I therefore recommend that you initially review them with me or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so I will let you know what the charge is at the time that a records request is made. If you desire to have the information sent to you electronically, if I maintain the information in an electronic format, I will provide the information in that format if you agree to accept the potential risks involved in sending the information that way.

As your therapist, I may also keep a set of psychotherapy notes which are for my own use and which are designed to assist me in providing you with the best treatment. These notes are kept separate from the rest of your records. In order for psychotherapy notes to be released to third parties, you must sign a separate authorization in addition to one for the rest of your records. I will discuss with you whether or not I am maintaining psychotherapy notes on you.

Fees, Payments, and Billing

Payment for services is an important part of any professional relationship. This is even more true in therapy; one treatment goal is to make relationships and the duties and obligations they involve clear. You are responsible for seeing that my services are paid for. Meeting this responsibility shows your commitment and maturity.

My current regular fees are as follows. You will be given advance notice if my fees should change. Regular therapy services are \$150.00 for the first diagnostic session, and \$200.00 for subsequent 60 minute sessions, \$125.00 for subsequent 45. **Payment is due at the time of service.** Other financial arrangements can sometimes be negotiated at the client's request, which should be done at the initial session. **For clients who have insurance co-payments: In some cases, you may be able to pay only your co-payment at the time of service. If this is the case, be certain to pay the co-payment at the beginning of the session. YOU SHOULD ALWAYS COME PREPARED TO PAY YOUR CO-PAY.** Payment may be made by cash or check.

The "Women's Psychotherapy Group for the Treatment of Anxiety and Depression," which meets every other Thursday evening from 7:00 P.M. to 9:00 P.M., is \$50.00 per session. A \$50.00 charge will be made unless a member's attendance is canceled 24 hours in advance.

Telephone consultations: I believe that telephone consultations may be suitable or even needed at times in our therapy. If so, I will charge you my regular fee, prorated for the time needed at the rate of \$50.00 for each 15 minutes of time. If I need to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about this, please be sure to discuss it with me in advance so we can set a policy that is comfortable for both of us. Of course, there is no charge for calls about appointments or similar business issues. Insurance companies will typically not provide reimbursement for telephone consultations.

Extended sessions: Occasionally it may be better to go on with a session, rather than stop or postpone work on a particular issue. When this extension is more than 10 minutes I will tell you, because sessions that are extended beyond 10 minutes will be charged on a prorated basis. Insurance may not pay for the extended portion of a session.

Reports: I will not charge you for my time spent making routine reports to your insurance company, but will charge fees on a prorated basis for other types of written reports that you request. I will let you know what the charge is and payment will be due ahead of time.

If you think you may have trouble paying your bills on time, please discuss this with me. I will also raise the matter with you so we can arrive at a solution. If your

balance remains unpaid, I may stop therapy with you if we cannot agree on a payment plan. Fees that continue unpaid after this may be turned over to small-claims court, a collection service or a credit reporting bureau and you agree to allow me to do that. If you challenge a credit or debit card fee, then you allow me to respond to the credit or debit card company. If I choose to do that I will report only enough information to collect fees due to me.

A late payment fee of \$25.00 will be charged each month that a balance remains unpaid, since I will incur costs to rebill and other accounting costs. A returned check fee of \$35.00 will be charged if your check bounces.

Because I am a licensed mental health therapist, many health insurance plans will help you pay for therapy and other services I offer. Because health insurance is written by many different companies, I cannot tell you what your plan covers. Please read your plan's booklet under coverage for "Outpatient Psychotherapy" or under "Treatment of Mental and Nervous Conditions." Or call your employer's benefits office to find out what you need to know.

If your health insurance will pay part of my fee, I will help you with your insurance reimbursement. However, please keep some things in mind: I had no role in deciding what your insurance covers. Your employer or you (if you have individual coverage) decided which, if any, services will be covered and how much you have to pay. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth. Your insurance contract is between you and your insurance company; it is not between me and the insurance company, unless I have contracted with the insurance company to accept a certain level of payments. You are responsible for paying the fees we agree upon. If you ask me to bill a separated spouse, a relative, or an insurance company and I do not receive payment on time, I will then expect this payment from you and you agree to pay amounts due.

I will supply you with an invoice for my services with the standard diagnostic and procedure codes for billing purposes, the times we met, my charges, and your payments. You can use this to apply for reimbursement unless I am contracted with your insurance company, in which case I will file for reimbursement. By signing this form you agree to allow me to do that and to assign any reimbursement you receive from your insurance company to me.

If you have more than one insurance company, we will bill the first insurance company. While we are willing to bill the secondary insurance company, it is

preferable for you to pay your co-pay to us, then for you to bill your secondary insurance company to reimburse you, as you can keep better track of your own account. If you wish to file for secondary insurance benefits yourself, my secretary will prepare insurance billing forms for you to submit at your request.

If you are on Medicaid, you do not have a co-pay. You must be currently covered on Medicaid for the month that services are rendered. If coverage has ceased, you will be expected to pay the full fee out-of-pocket or through a medical insurance company. Medicaid may cover a limited number of sessions per year, plus up a limited number of psychological testing sessions per year. I will refer you elsewhere if you need psychological testing in addition to the psychotherapy that I will do with you. Please keep track of your sessions, so that you do not exceed whatever you are allowed.

If you choose to not have me send information to your insurance company, you must select this option before each session and then pay for the session in full. I will then not report any information to your insurance company about that session. Although insurance companies say that they maintain confidentiality, oftentimes they report information to a national data bank that may later affect your ability to obtain other types of insurance.

Minors

If you are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order or if I feel that the release of your records to your parents might have an adverse effect on you, in which case under Ohio law they can name another mental health therapist that I will have to turn them over to, unless otherwise required by federal law. Before giving parents any information I will discuss the matter with you, if possible, and do my best to handle any objections you may have. Except in unusual circumstances, I like to make both parents aware of and involved in the treatment. In addition, if one parent brings in a child and the therapy only involves the child, under Ohio law since generally both parents have access to the child's records unless that access is blocked by a court order, anything that either parent communicates in connection with the minor's therapy is available to both parents. Legal documents need to be provided in cases where custody, visitation, shared parenting, guardianship or other matters which are covered by court documents are involved before I see a minor for treatment. Minors 14 years of age and older should be aware that they have an option to see me on a limited basis without their parents' knowledge, except where there is a compelling need for disclosure based

on a substantial probability of harm to the minor or to other persons, and if the minor is notified of my intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option.

Emergencies and After-Hours Care

I may be reached at (937) 434-6840. When you call this number, the call will be answered by my secretary during normal business hours, and by my answering machine or voicemail after normal business hours. When trying to reach me, please leave your name and one or more numbers and times when I can return your call. For non-emergency telephone calls, if my secretary or I do not return your call within 24 hours, please assume that we did not get your message and call again. I will make every effort to return messages within 24 hours; however, I may not always be able to do that. Current clients will be notified during sessions of upcoming travel or vacation.

If you have an emergency you should go directly to a hospital emergency department or call 911. The National Suicide Prevention Lifeline number is 1-800-273-8255 or you can call or text 988 for help. Montgomery County Crisis Center's number is (937) 299-3667. After business hours and on weekends, I may sometimes be able to be reached on my cell phone (937) 307-5951 in case of an emergency, but that can't be guaranteed. Emergencies are urgent situations and typically require your immediate action.

Incapacity or Death of Therapist

In the event that I am incapacitated or die, it will be necessary for another therapist to take possession of your file and records. By signing this form you consent to allow another licensed mental health professional or another person who will be under an agreement to maintain the confidentiality of the records whom I designate to take possession of your file and records, provide you with copies, upon request, or to deliver them to a therapist of your choice.

Disclosing Information to Family Members, Relatives, or Close Friends

By signing below, you agree to allow me, if you are incapacitated, in an emergency situation, or are not available, to contact a family member, a relative, a close friend or any other person you identify, and disclose your personal health information that directly relates to that person's involvement in your healthcare. This information will be disclosed as necessary only if I determine that it is your best interest based

on my professional judgment. If you object to me doing this, please let me know at our first session.

Email, Texting, and Electronic Communications

I do not like to use unencrypted e-mail, texting, or electronic communications unless we both agree that is appropriate. If you decide you want to utilize any form of unencrypted electronic communication you acknowledge that there are confidentiality risks inherent in such communications if they are unencrypted and you agree to accept those risks.

By signing below, you agree that you understand the risks involved in unencrypted electronic communications and agree to accept such risks in communications from either me to you or you to me that involve scheduling and/or therapy.

If you do not want me to contact you at a certain address or phone number, please let me know at our first meeting.

Links for licensure verification to facilitate consumer protection can be found at: <https://elicense.ohio.gov>. I am licensed by the Ohio Board of Psychology.

Acknowledgment of Informed Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize you to provide such care, treatment or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company or third party payer, to obtain reimbursement unless I direct otherwise.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through you at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor or an adult with a court appointed guardian is the client I am signing on behalf

of the minor or ward as the authorized parent/guardian. (Information will be shared with the minor or the ward as appropriate.)

I also acknowledge that I have received a copy of the Notice of Privacy Practices for the mental health therapist listed at the top of this form.

Client Name(s) (please print)

Client(s) Signature

Date

Parent(s) or Guardian Signature (for minor child or children or disabled adults)

Date