Ashley Johnston, MS, LPC-MHSP

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PRACTICE POLICIES AND CONSENT TO TREATMENT

PROFESSIONAL BACKGROUND:

I am a Licensed Professional Counselor and Mental Health Service Provider with the Tennessee Board for Professional Counselors. This license allows me to practice counseling independently in the state of Tennessee. I am also a Certified EMDR Therapist (Eye Movement Desensitization and Reprocessing). I have worked in the counseling field since 2004 and my scope of practice has included crisis and brief counseling, inpatient admissions, substance abuse psycho-education classes, group counseling, school counseling, individual and group counseling with adolescents and adults and EMDR trauma therapy. Additionally, I have worked as a program supervisor for a Nashville mobile crisis program, a director for a school's personal counseling department, and a supervisor for other counselors in their professional and clinical development.

WHAT I AM ASKING OF YOU AS MY CLIENT AND WHAT YOU WILL RECEIVE FROM ME AS YOUR COUNSELOR:

1. Counseling can be of great benefit when you fully commit to being open, honest, and willing to do the things you need to do to move forward even if those things are painful and difficult. I will ask you to come in with your own personal goals for counseling. I cannot create change in your life… YOU are the change agent in your own life. I cannot guarantee a specific outcome from our time together… YOU are ultimately responsible for your own growth and direction in counseling.
2. I will maintain a holistic approach in our work together because I believe that sum of our mind, body, and spirit all work together to form the wholly healthy and "perfectly imperfect" person. I am currently in school to become a Certified Integrative Nutrition Health Coach and am excited to share my new knowledge with you!
3. During our sessions, we may discuss additional resources or activities that, when added to counseling, may help further your change and growth. These may include referrals to a psychiatrist for a medication evaluation, directions for a specific activity plan of exercise, referrals to a nutritionist, referrals to 12 step meetings, etc. You may also be asked to do certain "homework exercises" such as reading, writing, changing behaviors, etc. Remember that you are entirely responsible for your own actions and will always make your own final decisions regarding counseling.
4. As your counselor, you honor me by sharing your life and growth with me. I will not hide myself behind silence or position and will have high regard for you as a person. I will bring the best that I know from my education, experience, and ongoing studies and I will bring you the highest of my insight, wisdom, and spiritual guidance.
5. You can expect the truth from me even when you may not want to hear it. I will always have compassion and empathy for you in all that we do. I value you as a person in need of care, understanding, and support and I will do my best to honor that.

OVERVIEW:

Welcome and thank you for scheduling an appointment. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

CONFIDENTIALITY:

Below is a description of confidentiality as it applies to discussions between us - mental health provider and client. The limits placed on the confidentiality of disclosures made to me by Tennessee State Law are also explained. Additional information is provided on my website (www.ashleyjohnstonlpc@gmail.com - read the document entitled, "Patient Notification of Privacy Rights"). This information is important, so please read it carefully.

Your identity as a client as well as the disclosures that you make during therapy are private and protected. This means that I will not reveal to others that you are my client, and will not share anything that you say during your treatment with anyone else. If you would ever like me to reveal your status as a client, or you would like me to share information with a third party, you will be asked to sign a release of information.

FOR THOSE UNDER THE AGE OF 18:

Be aware that if you are under the age of 18 the law provides your parents the right to examine your records and to be informed about your treatment. It is policy for you to be aware if I talk to or meet with your parents. If I believe there is a high risk that you may threaten the safety of yourself or someone else, your parents will be notified.

LIMITS OF CONFIDENTIALITY

There are certain situations that can arise in which disclosures you make to me cannot be kept private due to Tennessee State Law. They are as follows:

1. If you indicate that you are in serious and immediate risk of harming yourself or someone else. The most typical situation would be when the threat of suicide is such that I cannot be assured of your safety once you leave the session. It is important to note that this does not apply to talking about thoughts of harming yourself that you may be experiencing. Many people who are feeling discouraged and hopeless think about harming themselves, and it is very important to talk openly about this with me. Talking about suicide or other thoughts of self-harm would not automatically require me to breach confidentiality. However, in the event you intended to act on any thoughts to kill or harm yourself, I would be required to act to protect you even if that involved breaching confidentiality. If you reveal a serious intention to harm someone else, I would be required to take action to protect that person.
2. If you indicate that you are involved in the abuse of a child, minor, elderly adult, disabled person, or animal, I am required by law to report these activities to the appropriate office. I am also required to report cases of domestic abuse. Once filed, I am unable to safeguard the privacy of the information released.

3. In group therapy, the other members of the group are not therapists. They do not have the same ethics and laws that I have to work under. You cannot be certain that they will always keep what you say in the group confidential.
4. If you become involved in a court proceeding, the court may use the power of subpoena to gain access to information that you have shared with me. Although it is my policy to limit our involvement in legal proceedings as much as possible, under court order I may be required by law to provide written or verbal testimony to the court.
5. If a government agency is requesting information for health oversight activities, I may be required to provide it for them.
6. If you file a complaint against me, I may disclose relevant information regarding that client in order to defend myself.
7. If your fees are being reimbursed by an insurance or managed care company, you should know that such companies often ask that treatment information be shared with them as part of their review of services. Typically, these companies have their own policies and procedures for safeguarding your privacy. However, once I have released the required information to any such company, I can no longer assume responsibility for preventing the dissemination of the information that has been released.

Be assured that your right to confidentiality is VERY important to me. In the unlikely event that I must breach confidentiality, I will make every effort to use care and discretion while meeting legal and ethical obligations.

OFFICE HOURS AND CONTACTING ME:

My office hours are by appointment Sunday thru Thursday, 12pm-7pm. If you need to contact me regarding an appointment, billing questions or for general needs please call during these hours. My office phone number is 615-715-6676 - please leave me a voicemail. You may also email me if you need to cancel/reschedule a session or if you have any billing questions or other general needs. I will make every attempt to call or email you back within 48 hours.

If you call me and the discussion becomes clinical in nature, I do bill for phone time, ($35 per 15-minute increments). The same principle applies to any email exchanges that you initiate and letters you request that I write on your behalf. I estimate the cost based on the time I spend reading and responding to your emails and writing letters **($35 per 15 minute increments). If we agree to talk via telephone between sessions, the same rate applies.**

EMERGENCIES:

In the event of a life-threatening emergency or a situation that presents imminent risk or harm, **please bypass calling me and (1) call 911 or the Crisis Line at 1-855-274-7471 or (2) go to the emergency room.** Please remember that I will not be checking my phone or email outside my office hours.

PAYMENT INFORMATION:

Therapy sessions are **$150 per clinical hour** (a clinical hour = 50 minutes)**.** Payment is expected at the time of service in the form of cash, check or credit card (Visa, Master Card, Discover, and American Express). For EMDR sessions, 80-minute sessions are recommended (1.5 clinical hours) and are $200. Other services, including inpatient visits, depositions,

mediation or other court-related services, are double the normal per-session fee. Any balances will be due upon receipt of the monthly statement. Accounts over 30 days are subject to a late fee. In the case of a bounced check, a $25 fee will be charged.

I am considered an out of network provider with insurance. However, I can provide you with a receipt for you to file with your insurance company. If you are interested in using insurance you should carefully check how your plan handles out-of-network providers. People using insurance will pay the session fee directly to me and then submit their receipts to their insurance carrier for reimbursement. Many companies will reimburse for services provided by a counselor holding a license. One consideration when using insurance is that **I will be required to give you or your child a formal diagnosis, which will become part of your/their medical record.** Some people choose to pay out of pocket to avoid this information becoming part of their record.

To save an initial appointment time, credit card information will be required. In the event you do not come to your initial appointment and do not give at least 24 hours notice, the full appointment fee will be charged to your credit card. If you cannot come to your initial appointment, please call to cancel or reschedule as soon as possible. At the time of your appointment, you may choose another payment method if you do not wish your credit card to be charged.

CANCELLATIONS:

Appointments are scheduled individually. With the exception of unforeseen emergencies, **notification of cancellation is expected 24 hours in advance; otherwise you will be billed for your missed appointment.** Requests for changing appointment times should be discussed in advance.

ELECTRONIC MAIL (EMAIL) POLICY:

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to- face). I cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, I will save email correspondence with you and these communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Please do not send confidential information via email. **It is most beneficial to all to discuss confidential issues in session.** Please refrain from sending emails of an urgent or emergent nature and refer to the "Emergencies" section discussed above.

TERMINATION OF TREATMENT:

You are not obligated to continue treatment. If you decide to terminate at any time, please discuss your decision to terminate care with me. **Your medical chart will be automatically closed if I do not hear from you or see you after three months.**

CONSENT TO TREATMENT AND PATIENT/GUARANTOR PAYMENT RESPONSIBILITY:

(PLEASE PRINT THIS PAGE, SIGN, AND GIVE TO ASHLEY DURING THE INTAKE SESSION)

I have read the policies listed above and I understand and agree to them. I agree to be treated by Ashley Johnston, MS, LPC-MHSP and when necessary, any provider covering in her absence. I agree that I am responsible for all charges for services rendered and I agree to adhere to the payment policies.

I hereby authorize my individual provider to release to my insurance company any and all information they may require concerning patient care.

Your signature below indicates that you have read this Agreement (including the section regarding patient payment), have received the New Patient Notification of Privacy Rights (located on her website, www.ashleyjohnstonlpc.com), and agree to the terms of both.

_____	_____	_____
***Patient* (print)**	***Signature***	***Date***

IF PATIENT IS A MINOR:

_____	_____	_____
Parent / Legal Guardian (print)	*Signature*	*Date*

IF OTHER PERSONS ARE PARTICIPATING IN TREATMENT:

_____	_____	_____
Participating Spouse, Child, etc. (print)	*Signature*	*Date*

_____	_____	_____
Participating Spouse, Child, etc. (print)	*Signature*	*Date*

CREDIT/DEBIT CARD PAYMENT FORM

Please note that this form will be securely stored in your clinical file.

Payment is expected at the time of service and may be made by cash, check or credit card. Any balances will be due upon receipt of the monthly statement. Accounts over 30 days are subject to a late fee. In the case of a bounced check, a $25 fee will be charged.

Professional Service Rendered:	Fee:
50 minute session (1 clinical hour)	**$150**
80 minute session (1.5 clinical hours) (Recommended for EMDR or per client request)	**$200**
Phone Consultations (per 15 minute increments)	**$35**
Reading and Responding to Emails (per 15 minute increments)	**$35**

To save a session time, credit card information is <u>required</u>. In the event you do not come to your appointment and do not give at least 24 hours notice, the full session fee will be charged to your credit card - **$150 or $200. <u>At the time of your session, you may choose another payment method if you do not wish your credit card to be charged.</u>**

Cardholder Name [print]: _____
Relationship to client: _____
Credit/Debit Card Billing Zip Code: _____
Card Type (circle one): 1.Visa 2.Mastercard 3. American Express 4. Discover
Card Number: _____
Exp. Date: _____/_____ 3 Digit Security Code: _____

If you would like payment receipts sent to you, please provide your email address:
□ Email: _____

Would you like a monthly superbill sent to you to submit to insurance for reimbursement purposes? □ Yes □ No

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Credit/Debit Card Payment for Professional Services (REQUIRED):

I authorize Ashley Johnston, MS, LPC-MHSP to bill the above credit/debit card for professional services at the time the services are provided for _____ (client name) in addition to any phone consultations or client initiated email exchanges outside of sessions.

I also authorize Ashley Johnston, MS, LPC-MHSP to charge the above credit/debit card when _____ (client name) does not give advance notice for a late-cancellation or is a no-show for his/her session, as per the policy.

Signature of Cardholder: _____
Date: _____