



Patient Name: _____

INFORMED CONSENT

Thank you for choosing Behavioral Innovations, LLC. Today's appointment will take approximately 45 – 50 minutes unless stated otherwise previously. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Patricia Dunsha, LPC, has earned a Bachelor of Social Work, a Masters Degree in Psychology, and is a doctoral candidate in Behavioral Medicine / Health Psychology. She is licensed by the State of Georgia as a Professional Counselor. She has over 6 years of clinical experience in treating children, adolescents, adults and families using individual and family therapy; practicing standard cognitive-behavior therapy for most conditions, although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information shared with a staff psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Georgia State Law, I am obligated to report this to the Department of Family & Children's Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others, information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary and I am unable to return your call within 15 minutes, the client or guardian understands that they are to contact the emergency in the community (911) for those services.*

Signature(s) _____ **Date:** _____

FINANCIAL/INSURANCE ISSUES: *As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. Payment is due at the time of services. After 60 days any unpaid balance will be charged late fees. In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Behavioral Innovations, LLC.*

If you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested.

Signature(s) _____ **Date** _____



Patient Name: _____

Patient Notice of Privacy Practices

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

I respect the privacy of your personal medical records and will do all I can to secure and protect that privacy. I strive to always take reasonable precautions to protect your privacy. When appropriate, I provide the minimum necessary information to only those I feel are in need of your health care information. This includes information about treatment, payment, and/or health care operations in order to provide health care that is in your best interest.

I support appropriate access to medical records. With your consent, I may disclose personal health information for purposes of treatment, payment, or health care operations such as communication with hospitals, co-treaters, and health plans. If you signed the consent form and you see Dr. Plaster or Dr. Sial, this also means the three of us have permission to discuss your care as needed. This can be especially beneficial to you.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, if you refuse to disclose your personal health information, I have the right to refuse to treat you. If you choose to give consent in this document, at some future time you may request to refuse to disclose all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You may request a restriction on any authorization to disclose personal health information. I am not required to agree with this restriction request. You have the right to have your clinician amend your protected health information. If the request is denied, you may file a disagreement with me and prepare a rebuttal, which will be added to your personal health information. You have the right to receive accounting of any disclosures I have made.

I continually undergo training to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the “Privacy Rule.” I strive to achieve the very highest standards of ethics and integrity in providing services to my patients.

If you have any questions or problems, please speak with me directly, as I welcome your feedback. You may also file a complaint with the Secretary of Health and Human Services if you believe that I have violated your privacy rights.

Patricia Dunsha, LPC, NCC, DCC



Patient Name: _____

Consumer Notice of Rights and Responsibilities

Dignity and Respect

You have the right to be treated with consideration, dignity, and respect, and the responsibility to respect the rights, property, and environment of all health care providers, employees, and other patients. You have the right to have the privacy and confidentiality of your health records maintained. You are also entitled to these rights regardless of gender, age, sexual orientation, marital status, or culture, or economic, education, or religious background.

Knowledge and Information

You have the right to receive information about your practitioner's services and any treatment recommendations. You have the right—and the responsibility—to know about and understand your health care and your coverage, including the following: participating with your practitioner in decision-making regarding your treatment planning; your clinical condition; any services and procedures involved in your recommended course of treatment; and how your health plan operates as stated in your policy.

Eligible Employee Accountability/Autonomy

As a partner in your own health care, you have the right to refuse treatment, providing you accept responsibility for the consequences of such a decision. You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and in developing mutually agreed upon treatment goals. You also have the responsibility to identify yourself and insurance coverage or changes in coverage when receiving behavioral health services. You have the responsibility to provide your current provider with previous treatment records, if requested, as well as to provide accurate and complete medical information to any other health care professionals involved in the course of your treatment. You have the responsibility to be on time for your appointments and to notify your provider as far in advance as possible if you need to cancel or reschedule an appointment. You have the responsibility to notify your behavioral health plan within 48 hours—or as soon as possible—if you are hospitalized or receive emergency care. And, you have the responsibility to pay all required co-payments and deductibles as the time you receive behavioral health care services.

Filing a Complaint

I welcome direct feedback if you have a grievance. You also have the right to file a complaint with the state. If you have a grievance against your health insurance plan, you should contact the plan and use the plan's grievance process. If you are not satisfied with the plan's resolution, you may appeal the decision by contacting the consumer services division of the Office of Insurance Commissioner at 404-656-2070.