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COUNSELING, LLC

Welcome to Be Inspired Counseling, LLC. We are thrilled that you have chosen our group practice for your mental health needs. Here are a few guidelines to ensure that our day to day operations run smoothly.

- Each clinical session is 45 minutes, with the exception of the initial appointment. We understand that life happens and sometimes you may be late. Unfortunately, our clinicians cannot run over the allotted time frame as we schedule our patients back to back. Copay is due at the time of service; If you need to make other arrangements, please contact Marci directly ahead of your appointment.

- Our waiting room is a shared space. As a reminder, we ask you to remain as quiet as possible, not take phone calls or watch loud programs on your phones. Additionally, we ask that you please clean up any snacks that you have brought in with you.

- All clients under the age of 13 are required to have a responsible adult present in the waiting room during his/her session.

- Cancellations: Notice of cancellations more than 24 hours in advance should be directed to your individual clinician; Email is typically the best method. If you cannot reach your clinician OR if you need to cancel in under 24 hours, the procedure is as follows: Either call, text or email Marci and she will get in contact with your assigned clinician; All of Marci's methods of contact are HIPAA compliant and are at the bottom of this letter. As a reminder, we reserve the right to charge the $80 fee as outlined in the Treatment Agreement signed at the onset of treatment for any cancellations under 24 hours.

- Crisis: If you/your child is experiencing a mental health crisis, we advise that you head to your local emergency room for a screening. For individuals under the age of 18, we suggest heading to either South Shore Hospital in Weymouth, Boston Children's Hospital or Hasbro Hospital, as they all have pediatric waiting rooms. If you do head to the hospital, please call our new main number (508-930-0154) and press 9. This will connect you to the on-call clinician and ensure that a member of our team can speak with the crisis clinician to help you obtain the correct level of care needed.

- Bi-weekly emails are sent out on Mondays with lots of great practice information. We encourage you to take a peek and to also follow our Facebook page where we have articles, tips, and more.

Please reach out to Marci or your assigned clinician with any questions or concerns. We thank you for entrusting your care with our team.

Sincerely,

Marci

Marci daCamara, LMHC
Owner, Be Inspired Counseling, LLC
marci@beinspiredcounseling.com
508-930-0154 x101 (office)
508-944-0231 (cell)

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CLIENT DEMOGRAPHIC INFORMATION

NAME _____ **NICKNAME** _____

PRONOUNS: _____ **DATE OF BIRTH** _____

STREET ADDRESS, TOWN, ZIP CODE _____

PHONE NUMBER (H) _____ (C) _____ (W)_____

Is it ok to leave a voicemail? __ YES __ NO If yes, which number(s) _____

Is it ok to text? __ YES __ NO

EMAIL _____

GUARDIAN INFORMATION

NAME(S) _____

PHONE NUMBER(S)_____ voicemail y/n text y/n

EMAIL(S)_____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP _____

PHONE NUMBER _____

MEDICAL INFORMATION

ALLERGIES/MAJOR MEDICAL ISSUES _____

CURRENT MEDICATIONS _____

INSURANCE INFORMATION

INSURANCE COMPANY _____ POLICY NUMBER _____

POLICY HOLDER NAME _____ DATE OF BIRTH _____

How did you learn about Be Inspired Counseling? _____

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Treatment Agreement – effective 1/1/2024

I acknowledge that I have received, have read (or have had read to me), and understand the Privacy Practices and/or other information about the therapy I am considering. I have had all my questions answered fully. ___

I do hereby consent to take part treatment at Be Inspired Counseling, LLC. I understand that developing a treatment plan and regularly reviewing the work toward meeting my treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment. ___

I am aware that I may stop treatment at any time. I will be responsible for paying for services already received. ___

I am aware I must cancel any appointment at least 24 hours in advance. Messages may be left via voicemail or email. If I do not cancel on time or miss my appointment, I will personally (not covered by insurance) be charged for that appointment at the rate of $80, which must be paid before my next scheduled session. ___

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that my insurance company will be given a diagnosis and treatment goals to authorize payment for services. I understand that I am responsible for any services not covered by my insurance. Rates for licensed clinicians are: $150 for an individual session, $200 for couples/family therapy, $300 for intake. Rates for pre-licensed clinicians are: $135 for an individual session, $175 for couples/family therapy, $250 for an intake.

In addition, I am aware that I may be personally charged for extensive collateral phone contacts regarding my care, for extensive paperwork to completed at my request, and for legal proceedings. These fees are at the rate of $150/hour and may be required to be paid prior to completion/attendance. ___

I am aware that my family may not maintain a balance of over $250 and that all payments must be paid within 30 days of the date of invoice. All services will be postponed until all financial obligations are current. ___

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or guardian or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I have discussed the issues above with the client (and/or other representative). My observations of this person's behavior and responses allow me to believe that this person is competent to give informed and willing consent.

_____ _____

Signature of staff member Date

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CONSENT FOR TREATMENT OF A MINOR

I,_____ authorize Be Inspired Counseling, LLC to provide counseling services to my child _____, DOB _____. I understand that certain information may remain confidential. Below is a Confidentiality Agreement set between myself, my child and our clinician.

_____ _____
Parent/Guardian Signature Date

_____ _____
Client Signature Date

_____ _____
Clinician Signature Date

The following information will be shared with my parent/guardian:

(1)

(2)

(3)

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READ FIRST: Before you decide if you will allow Be Inspired Counseling, LLC to share some of your confidential information with another agency or person, your clinician will discuss all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide to allow Be Inspired Counseling, LLC to release some of your confidential information, you can use this form to choose what is shared, how it is shared, with whom, and for how long.

I understand that Be Inspired Counseling, LLC has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to release some of my personal information to certain individuals or agencies.

I, _____, DOB _____ authorize Be Inspired Counseling, LLC to share the following specific information:

Who I want to have my information:	Name: Specific Office at Agency: Phone Number:

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

What info about me will be shared:	*(List as specifically as possible, for example: name, dates of service, any documents).*
Why I want my info shared: (purpose)	*(List as specifically as possible, for example: to receive benefits).*

This release expires on _____ _____
Date (1 year max) Time

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Client Signature::_____ **Date:** _____

Guardian Signature (if minor): _____ **Date:** _____

Witness:_____ **Date:** _____

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Consent to Treat for In-Person Services

The staff at Be Inspired Counseling, LLC are taking all reasonable steps as recommended by the CDC to reduce the spread of COVID-19, as well as other illnesses within the office. I hereby agree to the following:

I agree to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, I may resume to meet via Telehealth. If I decide at any time that I would feel safer staying with, or returning to, Telehealth services, my therapist will respect that decision. Reimbursement for Telehealth services, however, is also determined by the insurance companies and applicable law. I will be responsible for any fees not covered by my insurance company. ___

I understand that by coming into the office, I am assuming the risk of exposure to illness. This risk may increase if I travel by public transportation, taxi or other ride-sharing service. ___

I understand that to obtain services in person, I agree to take certain precautions to help keep everyone safe from exposure and sickness. If I cannot adhere to these safeguards, it may result in starting or returning to a Telehealth arrangement or being terminated from the practice. ___

I will not hold Be Inspired Counseling liable if I contract COVID-19 or another ilness after having been in the building. ___

I will adhere to the following safeguards:

-I will only keep my in person appointment if I and/or my child and/or other family members that I live with are symptom free as identified by the CDC and for a minimum of 48 hours, without the aide of fever-reducing medications. ___

-I will use alcohol based hand sanitizer upon my arrival to the building, according to the practice's protocols. ___

-I will adhere to safe distancing precautions and will have no physical contact with others in the waiting room and therapy room. ___

-If I have a job, commute, or other responsibilities/activities that potentially exposes me to people infected with COVID-19, I will immediately inform my therapist. ___

-If I, or another family member/resident of my home, tests positive for infection, I will immediately let my therapist know, and we will discuss appropriateness of resuming treatment via Telehealth until the previously noted time-period has been reached. ___

-I understand that I will be asked to leave the office if temperature check upon entry is over 100° and/or other symptoms are present. ___

- I will follow state guidelines regarding quarantine upon re-entry if I travel out of state. ___

Your Confidentiality in the Case of Infection

If you have tested positive for COVID-19, your therapist may be required to notify local health authorities that you have been in the office. If we are required to report this, your therapist will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that Be Inspired Counseling, LLC staff may do so without an additional signed release.

I have read, understand and agree to the information provided above. This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below shows that you agree to these terms and conditions.

Client/ Guardian Printed Name	**Therapist Signature**
Client/Guardian Signature	**Date**

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Telehealth Consent to Treat

The purpose of the following is an agreement for consent to treat through Telehealth services.

I do hereby seek and consent to take part in Telehealth through Be Inspired Counseling, LLC. I understand that online counseling/Telehealth includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that Telehealth also involves the communication of my medical/mental information, both orally and visually. Be Inspired Counseling utilizes the HIPAA secure platform thru Therapy Notes. ____

I acknowledge that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. ___

I understand that the laws that protect the confidentiality of my medical information also apply to online counseling/Telehealth. I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are limits and exceptions to confidentiality with Telehealth, just as there are with in-person therapy. I am in agreement with these limits/exceptions, and have a previously signed agreement on file regarding my understand of these. ____

I understand that there are risks and consequences from online counseling/Telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures. I understand that if the Telehealth session does get disconnected, my therapist will call me back by phone, to complete our session. ____

I understand that although insurance reimbursement for Telehealth services may have been mandated during the COVID-19 pandemic, such mandates may no longer be in effect, and Telehealth may no longer be reimbursed or fully reimbursed by your insurance company. I understand that I will be responsible for any charges not covered. ___

In addition, I understand that online counseling/Telehealth based services and care may not be as complete as face-to-face services. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not be improve. ____

I know that if I am experiencing an emergency situation, I will continue to follow normal practice protocol, can call 911, and/or proceed to the nearest hospital emergency room for help. ___

I understand that I am responsible for (a) providing the necessary computer or telecommunications equipment and internet access for my Telehealth sessions, (b) using the Telehealth platform provided by Be Inspired Counseling, LLC, and (c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my Telehealth session. ___

I acknowledge that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law, as outlined in the privacy practices provided to me at intake. ___

I have read, understand and agree to the information provided above. This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below shows that you agree to these terms and conditions.

_____ _____

Client/Guardian Printed Name **Therapist Signature**

_____ _____

Client/Guardian Signature **Date**