Welcome to Be Inspired Counseling, LLC. We are thrilled that you have chosen our group practice for your mental health needs. We request your assistance in ensuring 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 reserved time frame. Copay is due at the time of service; If you need to make other arrangements, please contact the office directly ahead of your appointment.

- Our waiting room is a shared space and we ask you to remain as quiet as possible. Additionally, please do not bring food, drinks, or toys into the space. Due to our new COVID procedures, we ask that you remain in your car until we contact you to come into the office.

- All clients under the age of 13 are required to have a responsible adult present in the parking lot during sessions.

- 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: 1) Email your clinician and/or send a text. 2) Contact the practice at 508-930-0154. Clients being seen in Stoughton will press 3; clients being seen in Mansfield will press 4. If no one is available to take your call, please leave a message on that secure line.

As a reminder, we reserve the right to charge the $80 fee as outlined in the Treatment Agreement 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 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 our team with any questions or concerns. We thank you for entrusting your care with our us.

Sincerely,

Marci daCamara, LMHC
Director/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** _____

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 _____ HOLDER DATE OF BIRTH _____

How did you learn about Be Inspired Counseling? _____

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Treatment Agreement – effective 1/1/2023

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 know that I must cancel any appointment at least 24 hours before the time of the appointment. Messages may be left on the practice voicemail or via 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. ___

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 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, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, 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

CONSENT FOR TREATMENT OF A MINOR

I,_____ authorize Be Inspired Counseling, LLC to provide counseling services to my son/daughter_____, 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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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment - Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members within our practice. We may disclose PHI to any other provider only with your authorization.

For Payment - We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations - We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law - Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization - The following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect - If we have reasonable cause to believe that a minor child is suffering from physical or emotional injury resulting from (i) abuse inflicted upon him/her causing harm or substantial risk of harm to the child's health or welfare, including sexual abuse, or (ii) neglect, including malnutrition, we are required as a mandated reporter to immediately report such information to a state or local agency that is authorized by law to receive reports of child abuse or neglect (Department of Children and Families in Massachusetts).

Disabled and Elder Abuse - If we have reasonable cause to believe that a disable person or an elderly person (age 60 or older) is suffering from, or has died as a result of, abuse, we must immediately report this to the Disabled Persons Protection Commission or a state or local agency (i.e.: Massachusetts Department of Elder Affairs).

Serious Threat to Health or Safety - If you communicate an explicit threat to kill or inflict serious bodily injury upon an identified person, and you have the apparent intent and ability to carry out the threat, we must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. We must also do so if we have knowledge that you have a history of physical violence or believe that there is a clear and present danger that you will attempt to kill or inflict bodily injury upon and identified person. Furthermore, if you present a clear and present danger to yourself and refuse further appropriate treatment, and we have a reasonable basis to believe that you can be committed to as hospital, we must seek said commitment and may contact members of your family or other identified individuals if it would assist in protecting you.

Judicial and Administrative Proceedings - We may disclose your PHI pursuant to a subpoena (with written consent from you or your legally appointed representative), court order, administrative order or similar process if the information requested is not deemed privileged under state law.

Deceased Patients - We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies - We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm.

Health Oversight - If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement - We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions - We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health - If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety - We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

With Authorization - Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to the practice director, Marci daCamara, LMHC.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is

compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement. We may prepare a rebuttal to your statement and will provide you with a copy.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we am required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with us, with the Massachusetts Division of Professional Licensure, Office of Investigation at 617.727.7406 and www.mass.gov/ocabr/docs/dpl/complaint.pdf, or with the Secretary of Health and Human Services by calling 202.619.0257. **We will not retaliate against you for filing a complaint.**

To file a complaint within the practice, please contact our Human Rights Officer: Hollie Badger,LICSW at Hollie@beinspiredcounseling.com

The updated effective date of this Notice of Privacy Practices is September 8, 2020.

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Consent to Treat for In-Person Services During COVID-19 Public Health Crisis

The purpose of this consent to treat contains information about our decision (client and therapist) to resume in-person services in light of the COVID-19 public health crisis. The staff at Be Inspired Counseling, LLC are taking all reasonable steps as recommended by the CDC to reduce the spread of COVID-19 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 COVID-19. 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 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 for at least 10 days since symptoms first appeared and for a minimum of 48 hours, without the aide of fever-reducing medications. ___

-I will wait in my car or outside until I am notified to come into the practice. ___

-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. ___

-I will wear a mask or face covering in all areas of the office (as will your therapist/other staff). ___

-I will take steps between appointments to minimize my exposure to COVID-19. ___

-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 following HIPAA secure platforms: Doxy.me and Zoom. ____

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