Thriving Path

A Counseling Practice

Thriving Path, LLC
Dr. Nicole Tefera, PsyD

☐ Downtown
☐ Hyde Park

Client Information

Client Name (1): _____ Date of Birth: _____

Street Address: _____
Apt. No. (if any): _____
City, State, Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced

Legal Sex Designation* ☐ Male ☐ Female

*This information is required for insurance billing purposes only.
Thriving Path affirms all gender identities, presentations, and chosen pronouns.

Is there any other information about your gender identity that you would like to share with us at this point?

_____

Email Address: _____ Ok to send Correspondence/Statements?: ☐ Yes ☐ No

If minor (under 18) please write name of legal guardian: _____

Primary Phone: _____ Ok to call?: ☐ Yes ☐ No

Work Phone: _____ Ok to call?: ☐ Yes ☐ No

Employer Name: _____ City: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

How did you hear about Thriving Path?: ☐ Friends/Family ☐ Insurance ☐ Google ☐ Other: _____

Primary Insurance

Insurance Carrier: _____ Phone #: _____

Identification #: _____ Group #: _____

Is Patient Policy Holder?: ☐ Yes ☐ No

Policy Holder Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Secondary Insurance Available?: ☐ Yes ☐ No If Yes, attach second demo sheet

Please read the following carefully and sign below:

I authorize Dr. Nicole Tefera, PsyD and Thriving Path, LLC to submit required information to my insurance company(s) or my EAP. I am aware that I am placing my signature on file. I also understand that any unpaid balances such as co-pays, deductibles, and non covered services I will be responsible for. I understand there may be a fee if I fail to give notice for cancellations of my appointment. I understand that my insurance or EAP does not cover the cost of missed sessions. ***I give permission, in the event of concern for my safety or whereabouts, that Dr. Nicole Tefera, PsyD may contact my listed Emergency Contact.***

Signed: _____ **Date:** _____

I understand that typing my name on this field constitutes a legal signature confirming that I warrant the truthfulness of the information provided in this application

Thriving Path

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Thriving Path, LLC
Dr. Nicole Tefera, PsyD

☐ Downtown
☐ Hyde Park

Client Information

Client Name (2): _____ Date of Birth: _____

Street Address: _____
Apt. No. (if any): _____
City, State, Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced

Legal Sex Designation* ☐ Male ☐ Female

*This information is required for insurance billing purposes only.
Thriving Path affirms all gender identities, presentations, and chosen pronouns.

Is there any other information about your gender identity that you would like to share with us at this point?

_____

Email Address: _____ Ok to send Correspondence/Statements?: ☐ Yes ☐ No

If minor (under 18) please write name of legal guardian: _____

Primary Phone: _____ Ok to call?: ☐ Yes ☐ No

Work Phone: _____ Ok to call?: ☐ Yes ☐ No

Employer Name: _____ City: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

How did you hear about Thriving Path?: ☐ Friends/Family ☐ Insurance ☐ Google ☐ Other: _____

Primary Insurance

Insurance Carrier: _____ Phone #: _____

Identification #: _____ Group #: _____

Is Patient Policy Holder?: ☐ Yes ☐ No

Policy Holder Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Secondary Insurance Available?: ☐ Yes ☐ No If Yes, attach second demo sheet

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Signed: _____ **Date:** _____

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OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us. Please note that although there are other therapists in this suite and a shared waiting room, our practice is independent from the other practitioners in the suite.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves commitments of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Meetings

I normally conduct an evaluation that will last from 2 to 5 sessions. During this time, we can decide together if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will schedule sessions at a time and frequency we agree on. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. Please note that insurance companies do not reimburse for missed or canceled session fees. The late cancellation fee is $75.

Professional Fees

The fee for the initial evaluation session is $150. For subsequent appointments, our fees are as follows: $150 for 55-minute individual therapy sessions and $150 for 55-minute couples and family therapy sessions. We are willing to offer discounts to clients who are not able to use insurance and must pay out-of-pocket. Fees will be reduced at the discretion of the practice manager, Dr. Nicole Tefera, PsyD, and are also subject to increase at the discretion of Dr. Nicole Tefera, PsyD provided written notice is given to all affected parties 30 days in advance of the fee increase. In addition to weekly appointments, we charge $150 per hour for other professional services you may need, though we will break down the hourly cost for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing other services you may request. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time. Please see the Legal Policy form for additional information on fees.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Please bring a check (written out to Thriving Path, LLC), credit card or cash to your appointment. If we are not contracted with your insurance company and you would like to be reimbursed for payments made by you, Dr. Nicole Tefera, PsyD will provide you with a monthly statement to submit to your insurance carrier. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than thirty (30) days and arrangements for payment have not been agreed upon, we have the option of charging your credit card or using legal means to secure the payment. This may involve hiring a collection agency or going through the court system. If such legal action is necessary, costs of suit and attorney's fees will be included in the claim. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. We will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, Dr. Nicole Tefera, PsyD is willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that most insurance companies require you to authorize your therapist to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any submitted reports, if you request. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for our services yourself, without seeking insurance reimbursement, to avoid the problems described above.

Contacting Me

I am often not immediately available by telephone because I do not answer or return calls during sessions. When I am unavailable, I have a 24-hour voicemail for receiving calls. Messages are retrieved several times daily Monday through Friday 9am-5pm and calls will be returned as quickly as possible. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of times when you will be available. If you have not received a call back within the time frames above, please call back because there have been occasions when the phone system has failed. In addition, I do not check email regularly so please contact me by phone if you need me to be in touch within a 24-hour period or if you need to cancel/reschedule an appointment. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

If you are unable to reach me and feel that you can’t wait for me to return your call, contact the Northwestern Crisis line at 312-926-8100. Please note that our practice is not properly equipped to handle psychiatric emergencies. If you are in a crisis, especially if you are near harming yourself or someone else, call 911. If you need to speak with someone immediately, go to the nearest emergency room and ask for the psychiatrist/psychologist on call or call 911.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

Confidentiality

In general, the privacy of all communications between a patient and a psychotherapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person or disabled person is being abused, I must file a report with the appropriate state agency. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in our practice. If a situation such as this occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. The therapist and consultant are legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Consent for Treatment

I, the undersigned, do hereby consent to treatment by Dr. Nicole Tefera, PsyD. I recognize that I have the right to request all medical information including reports, notes, and invoices. I recognize that case notes will be maintained for a period of at least seven years and that the therapists in this practice may consult with one another while maintaining my confidentiality rights as a patient.

Printed name of client (1): _____

Signature of client (1): _____ Date: _____

Printed name of client (2): _____

Signature of client (2): _____ Date: _____

I understand that typing my name on this field constitutes a legal signature confirming that I warrant the truthfulness of the information provided in this application

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PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices/HIPPA and have been provided an opportunity to review.

Name of client (1):

Signature of client (1): _____

I understand that typing my name on this field constitutes a legal signature confirming that I warrant the truthfulness of the information provided in this application

Today's Date:

Date of Birth:

Phone:

Email:

Address:

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PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices/HIPPA and have been provided an opportunity to review.

Name of client (2):

Signature of client (2): _____

I understand that typing my name on this field constitutes a legal signature confirming that I warrant the truthfulness of the information provided in this application

Today's Date:

Date of Birth:

Phone:

Email:

Address:

Electronic Communication Guidelines and Social Media Policy

These guidelines have been written to inform you, the client, about the policy of Dr. Nicole Tefera, PsyD regarding therapist-client communications and use of social media. Please review it to understand what you can expect from your therapist regarding these communications.

Email, texting, use of social media, and video chatting are common forms of communication in our society today. At times, people are more comfortable utilizing these forms of communication as an alternative to in-person or telephone. Please be advised that electronic communication and social media sites are not secure and confidential, and at any time, a third party may be able to intercept these communications. Furthermore, any information you send to and receive electronically by your therapist becomes a part of your medical record. To preserve the confidential nature of therapeutic relationships, your therapist will not seek out clients on social media sites, nor accept requests on her own personal social media pages. Monitoring clients' activities on social media sites is also prohibited.

Accordingly, electronic communication sent to and received by Dr. Nicole Tefera, PsyD is not intended to be used for any mental health treatment, advice or counseling. Such services must be conducted in a therapy session either in-person or via telephone. Electronic communication, such as texting or email, is intended for basic information only and may be used to arrange appointments, advise of benefit information, and/or clarify billing questions.

In addition, electronic communication is not intended for a crisis situation. If you are experiencing a life threatening clinical emergency, please consider the following options: 1) dial 911; 2) go to your nearest emergency room; or 3) contact Dr. Nicole Tefera, PsyD based on the after hours communication method indicated.

Dr. Nicole Tefera, PsyD may revisit this policy during the course of your treatment, as appropriate, to ensure that the confidential nature of therapeutic services is preserved.

I will be happy to respond to your email or text message inquiry, but to do so you must provide your consent, recognizing that email and text messaging are not secure forms of communication. There is some risk that any protected health information that may be contained in such emails or text messages may be disclosed to, or intercepted by, unauthorized third parties. I will use the minimum necessary amount of protected health information to respond to your query.

Summary of risks of using email:

Email is a useful method of correspondence for clients. Transmitting confidential information by e-mail can create a number of risks, both general and specific that clients need to be aware of if they choose this method of correspondence.

A. General email risks include but are not limited to the following:

- Email can be immediately broadcasted worldwide and received by many intended and unintended recipients;

• Recipients can forward email messages to other recipients without the original sender's permission or knowledge;
• Users can easily send an e-mail to the incorrect address;
• Email is easier to falsify than handwritten or signed documents;
• Backup copies of email may exist even after the sender or the recipient has deleted his or her copy;
• Without the benefit of face-to-face interaction, emails can be misinterpreted in tone and meaning.

B. Specific email risks include but are not limited to the following:

• Email containing information pertaining to a patient's diagnosis and/or treatment must be included in the patient's medical records, thus, all individuals who have access to the medical record will have access to the email messages
• If you are sending your emails from your employer's computer, your employer does have access to your emails.
• While it is against the law to discriminate, an employer who has access to your email can use the information to discriminate against the employee. Additionally, the employee could suffer social stigma from a workplace disclosure.
• Insurance companies who learn of your PHI information could deny you coverage.
• Although therapists will endeavor to read and respond to email correspondence promptly, they cannot guarantee that any particular email message will be read and responded to within any particular time frame. The exception would be that the email is part of a scheduled time frame for a prepaid email counseling session.

C. Conditions for use of email: All email messages sent or received that concern your diagnosis or treatment or that are part of your medical record will be treated as part of your PHI. Reasonable means will be used to protect the security and confidentiality of the email. Because of the risk outlined above the security and confidentiality of email cannot be guaranteed. Your consent to email correspondence includes your understanding of the following conditions:

• All emails to and from you concerning your personal health information (PHI) will be a part of your file and can be viewed by health care and insurance providers and the therapist's office support staff.
• Your email will not be forwarded outside the office without your consent or as required by law.
• Though all efforts will be made to respond promptly this may not be the case. Because the response cannot be guaranteed please do not use email in a medical emergency.
• You are responsible for following up with the therapist or support staff if you have not received a response.
• Medical information is sensitive and unauthorized disclosure can be damaging. You should not use email for communications concerning diagnosis or treatment of AIDS/HIV infection, other sexually transmissible diseases, mental health, and developmental disability or substance abuse issues.
• Since employers do not observe an employee's right to privacy in their email system, you should not use their employer's email system to transmit or receive confidential emails.
• The clinician will take reasonable steps to ensure that all information shared through emails is kept private and confidential. However, Dr. Nicole Tefera, PsyD

is not liable for improper disclosure of confidential information that is not a result of our negligence or misconduct. Client information is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320 et seq. 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2 Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate any Alcohol or Drug abuse.

INFORMED CONSENT

- If you consent to the use of email and text messaging, you are responsible for informing your therapist of any type of information that you do not want sent to you by email other than the information detailed in Section B.
- You are responsible for protecting your password and access to your email account and any email you send or you receive from Dr. Nicole Tefera, PsyD. to ensure your confidentiality. Your clinician cannot be held liable if there is a breach of confidentiality caused by a breach in your account security.
- Any email that you send that discussed your diagnosis or treatment constitutes informed consent to the information being transmitted. If you wish to discontinue emailing information, you must submit written consent or an email informing your clinician that you are withdrawing consent to email information.

By signing below, you indicate your understanding of the disclosures listed above regarding electronic communication and the use of social media.

Your signature also indicates your agreement to refrain from utilizing electronic communication for a crisis situation, mental health treatment, advice or counseling.

Client Signature (1): _____ Date: _____

Client Signature (2): _____ Date: _____

Witness Signature & Credentials: _____ Date: _____

I understand that typing my name on this field constitutes a legal signature confirming that I warrant the truthfulness of the information provided in this application

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Tele-Therapy Consent Form

I, _____ and _____, hereby consent to engage in tele-therapy with Dr. Nicole Tefera, PsyDW. I understand that "tele-therapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that tele-therapy also involves the communication of my medical/mental information, both orally and visually. The program that is used for all sessions is HIPPA compliant to ensure confidentiality in transmission of information online.

I understand that I have the following rights with respect to tele-therapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical information also apply to tele- therapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the Therapy Agreement I received with this consent form.

2. I understand that there are risks and consequences from tele-therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Dr. Nicole Tefera, PsyD, that the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

3. In addition, I understand that tele-therapy based services and care may not be as complete as face- to-face services. I also understand that if Dr. Nicole Tefera, PsyD believes I would be better served by another form of therapeutic services (e.g. face- to-face services) I will be referred to a professional who can provide such services in my area.

4. I accept that tele therapy does not provide emergency services. During our first session or prior, Dr. Nicole Tefera, PsyD and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

5. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my tele-therapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my tele- therapy session.

6. I understand that while email may be used to communicate with Dr. Nicole Tefera, PsyD, confidentiality of emails cannot be guaranteed.

7. I understand 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.

8. I understand that disclosure of the location where I chose to conduct therapy online is required and if the location changes, it is the patient's responsibility to notify the provider to ensure compliance with State regulations. This is in place to ensure that appropriate emergency contacts/providers are accessible in the event of an emergency.

I have read, understand and agree to the information provided above.

Printed Name (1): _____

Client Signature (1): _____ Date: _____

Printed Name (2): _____

Client Signature (2): _____ Date: _____

I understand that typing my name on this field constitutes a legal signature confirming that I warrant the truthfulness of the information provided in this application

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Policy on Legal Proceedings

Dr. Nicole Tefera, PsyD, will assist clients in certain legal matters should it be requested by the client or if the therapist is subpoenaed by a judge. These legal proceedings are often related to a personal injury, divorce, child custody or criminal matters. Prior to Dr. Nicole Tefera, PsyD being deposed or testifying in court on behalf of a client, the client must agree in writing to waive his/her right to confidentiality. By doing so, the client is allowing his/her records to be reviewed and scrutinized by non-clinical persons involved in the legal case. Additionally, it is understood that a therapist's testimony may not always work in favor of the client's case.

Court and legal proceedings are very time consuming and may require preparation by the therapist. Due to this, there are fees allotted to each type of legal involvement which are due **PRIOR** to the service. If the therapist is asked or required to appear for a deposition, the client is required to pay $600.00 at least 96 hours prior to the deposition. This fee covers three (3) hours of time in a deposition and one (1) hour of travel. If the deposition and travel equate to more than four (4) hours of the therapist's time, the client will be billed at the rate of $150.00 per hour, including any time the therapist needs to review your file and prepare for the deposition.

If the therapist is asked or required to appear in Court, the client will be required to pay $1,200 at least seven (7) days prior to the Court appearance. This fee represents an eight (8) hour day. The client will be billed at the rate of $150.00 per hour for any time over eight (8) hours spent by the therapist for travel, preparation, waiting, or to testify in court.

I, _____ and _____ ,
have read the above policy and hereby agree to the terms of payment and confidentiality:

Client Signature (1): _____ Date: _____

Client Signature (2): _____ Date: _____

Witness Signature & Credentials: _____ Date: _____

I understand that typing my name on this field constitutes a legal signature confirming that I warrant the truthfulness of the information provided in this application