Donna Zinn LCSW LLC
600 N. Weinbach Ave.
Suite 730
Evansville, IN 47711
812-431-3295
812-401-1314 (f)

Informed Consent Service Agreement

Thank you for choosing to work with Donna Zinn LCSW LLC. 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 may take time to complete, it is very important that you understand them. Signing this document represents an agreement between us. We can discuss any questions you have when you sign or at any point in the future.

I. PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each party. There are also legal limitations to those rights you should be aware of. As your therapist, I have responsibilities to you, as well. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. As psychotherapy often requires discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as: sadness, guilt, anxiety, anger, and frustration. However, psychotherapy has also been shown to have benefits for individuals who undertake it such as: a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems although outcomes are varied and individualized. Psychotherapy requires a very active effort on your part. In order to be most successful, you may be provided between session work to gain the most from your time in therapy.

The first session will involve a comprehensive evaluation toward gathering an initial impression of what our work might include. At that point, we will discuss your goals for therapy, and create a plan to work toward accomplishing these goals. We can discuss any questions you may have as they arise, and at any time you feel this is not a good fit, I will be happy to help you with referrals for another provider.

Initial _____

Donna Zinn LCSW LLC
600 N. Weinbach Ave.
Suite 730
Evansville, IN 47711
812-431-3295
812-401-1314 (f)

II. APPOINTMENTS

Appointments are ordinarily 50 minutes in duration, once per week, or at an agreed upon frequency, at a time that is available. I may not always be able to accommodate the time most convenient for you as afternoon and evening appointments book quickly. In this regard, your flexibility is appreciated as the time scheduled for your appointment is assigned to you and you alone.

If you need to cancel or reschedule a session, I ask that you provide 24 hour notice. If you miss a session without canceling, or cancel with less than 24 notice, my policy is to collect a $40 cancellation fee (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to find another time to reschedule the appointment. Initial _____

Please arrive on time for your appointment; if you are late, your appointment will still end at the scheduled time.

III. PROFESSIONAL FEES

The standard fee for the initial intake is $150.00 and each subsequent session is $110.00. Payment is due at the time of your session unless prior arrangements were made. If you have a copay or coinsurance, please know that I am contractually obligated with insurance to collect these payments at this time as well. Any checks returned to my office are subject to an additional fee of up to $40. Initial _____

In addition to weekly appointments, it is my practice to charge an hourly rate for other professional services that you may require such as: lengthy insurance calls for benefits and eligibility, contact with other providers, consultations, and legal issues.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

IV. INSURANCE

To set realistic goals and priorities, it is important to evaluate the resources available to pay for your treatment. If you have a health insurance policy, it may provide some coverage for mental health treatment. I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are ultimately responsible for knowing your coverage, eligibility, benefits, and copays, and for letting me know if/when your coverage changes.

Insurance 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 prior approval for extending the number of allowed sessions.

Donna Zinn LCSW LLC
600 N. Weinbach Ave.
Suite 730
Evansville, IN 47711
812-431-3295
812-401-1314 (f)

Insurance companies require your authorization to provide a clinical diagnosis and may request additional clinical information such as treatment plans or summaries for insurance purposes. This information will become part of the insurance company files. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance. Initial _____

If you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee.

Many policies leave a percentage of the fee (co-insurance) or a flat dollar amount (co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by credit/debit card, cash or check. Some insurance companies may also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Initial _____

It is important to remember that you always have the right to pay for my services yourself. My private pay fee is as listed above. If I am not in network with your insurance, and you prefer to use a participating provider, I will refer you to a colleague.

V. PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained electronically with a secure server including: brief records noting that you were here, your reasons for seeking therapy, the goals and progress we established, your diagnosis, topics we discussed, your medical, social, billing records, and treatment history. Records I receive from other providers, copies of records I send to others, such as fax or medical and treatment history, are kept in a secure and locked location in my office.

Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your professional records or have them forwarded to another mental health professional, or healthcare provider.

VI. CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices provided to you and extend to your professional records. Please remember that you may reopen the conversation at any time during our work together.

VII. PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent.

Donna Zinn LCSW LLC
600 N. Weinbach Ave.
Suite 730
Evansville, IN 47711
812-431-3295
812-401-1314 (f)

For children 14 and older, I request an agreement between the child and parents to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication requires the child's agreement, unless I feel there is a concern for your child's safety (threat of harm to self or others, or other behaviors which could put the child in harm's way.) In this case, I will make every effort to notify the child of my intention to disclose information and handle any objections raised.

VIII. CONTACTING ME

The best way to contact me is through my business phone number 812-431-3295, my Psychology Today listing, and business email zinnd12@gmail.com.

I am often not immediately available by telephone as I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voicemail and your call will be returned as soon as possible. It may take a day or two for non-urgent matters.

If, for unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or feel unable to keep yourself safe, please go to your local hospital Emergency Room or call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my practice.

IX. OTHER RIGHTS

You are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not participate in social media with current or former clients.

X. CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____
Patient Name

_____ _____
Signature of Patient Date