www.Oasislcsw.com (757) 271-9030

Office Policies & Informed Consent for Psychotherapy

This form provides you, the client, with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA preemptive analysis.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony from Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. OCCS will use clinical judgment when revealing such information. OCCS will not release records to any outside party unless we is authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

EMERGENCY: If there is an emergency during therapy, or in the future after termination, where any Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, we will do whatever we can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, we may also contact the person whose name you have provided as an emergency or on the biographical sheet.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff have no control over, or knowledge of, what insurance companies do with the information we submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that

mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access.

CONSULTATION: Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff consults regularly with other professionals regarding clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

PAYMENTS & INSURANCE REIMBURSEMENT: Regarding insurance, please see our financial and office policy. We will file your insurance claim as a courtesy to you. Please notify OCCS if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Insurance companies do not reimburse all issues/conditions/problems that are dealt with in psychotherapy. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, OCCS can use legal or other means (courts, collection agencies, etc.) to obtain payment.

Financial Policies

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy:

- Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all the costs.
- What your health insurance covers is based on an agreement between the company, or person who employs you, and the insurance company.
- It is the patient's responsibility to contact their insurance company with any questions about what they will cover.
- We know that temporary financial problems can sometimes prevent you from making a payment on your account on time. If this happens, you need to contact us at 757-271-9030 at once so we can help you with this problem. The billing department will help to arrange a payment plan.
- Any bill not paid by the date it is due will be sent to a collections agency

******If you have insurance and begin services with us without informing us you would like to bill your insurance company we will accept your cash payment for services. However, if later you decide to use your insurance we will bill the insurance company moving forward for future sessions only.*****

a. **IF YOU DO NOT HAVE HEALTH INSURANCE**

Your Responsibility:

- You must pay your entire bill at the time of service or inform us of your inability to pay.

Our Responsibility:

- The OCCS billing department is available to discuss financial options with you at 757-271-9030

b. **IF YOU HAVE HEALTH INSURANCE**

We participate with several insurance companies. This means we have signed a contract with them to provide care for the people they cover. The contracts are not all the same, and certain services may not be covered depending upon your benefits.

If we DO participate with your insurance plan:

Your Responsibility:

- You must pay any co-payment at the time you receive the service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service.
- You must pay the amount not paid by your insurance. Payment is due upon receipt of the statement. If you do not pay we will begin collection efforts.

Our Responsibility:

We will send a bill to your insurance company for all services done in our office.

c. **If we DO NOT participate with your insurance plan**:

Your Responsibility:

You must pay for the service at the time it is given. Our office accepts cash, Ivy Pay, HSA, VISA, MasterCard, Discover, and American Express.

Our Responsibility:

After you have paid us, we will provide you with a detailed receipt (Super Bill) upon your request.

You will then submit the Super Bill to your insurance for reimbursement.

All clients are required to have a credit/debit card on file through our secure card processing service. This will allow charges to be made on the day of your appointment. If you have purchased a monthly package or in the event of late cancellation or no show.

Financial Policies Agreement

STATEMENT OF FINANCIAL RESPONSIBILITY

In accordance with the OCCS financial policies above, the patient (or patient's legal guardian) (hereinafter I, me, my, etc.) hereby understands and agrees to the following terms:

1. I accept financial responsibility for all clinical and administrative services provided by Oasis Clinical Counseling Services.

2. I authorize payment to Oasis Clinical Counseling Services for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

3. I understand and agree that all ancillary services that are provided will be billed at the provider-specific hourly rate as noted below. Ancillary Services are defined as patient-initiated services which are not part of an initial assessment nor provided as part of a scheduled appointment. These services are not covered by insurance and involve an exchange of information, performed by the physician, psychologist, social worker, nurse practitioner, or therapist at OCCS. Examples of ancillary services include but are not limited to: All patient related phone calls including phone consultations with patient or family members, physicians, therapists, psychologists, school officials (administrators, teachers, counselors, etc.), attorney, etc., crisis counseling on the phone, email correspondence, time associated with preparing for non-appointment medication refills, completion of any forms during non-appointment times, etc. This does not include communication with the administrative staff. Legal and court related matters are billed at a higher rate and require a prior contract and retainer.

ANCILLARY SERVICE RATES:

Master's Level Clinicians $150/53 mins

Supervisees/Residents/Sliding scale fee $100/53 mins

- Legal services are billed with a 4 hour minimum requirement (including travel and wait time), and billed in 15 minute increments.

4. I understand and agree that if my account goes to a third party for collections; I am responsible for all fees incurred.

5. I understand and agree that if I have a balance on my account that it needs to be paid before my appointment and that failure to pay the debt may result in me not being seen and a missed appointment fee being added to my account. PLEASE NOTE: If you are unsure of your balance you may call OCCS.

By signing this form, I acknowledge that I have read, fully understand and agree to abide by the policies and fees in this agreement.

Patient / Guardian's Name: ___________________ Signature: ______________________ Date_________

Fee List for Services

There are times in which Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff must charge for services, in addition to what is billed to your insurance or if you have a self-pay agreement. While we understands this is not always convenient for you, the time it takes to prepare a letter, score and interpret a test, or make a court appearance, is time for which insurance does not reimburse. Telephone conversations, site visits, writing and reading of reports, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same hourly rate as session times, unless indicated and agreed upon otherwise.

1.	Initial Office Visit	$200.00
2.	Individual/Family Session	$150.00/per 53 min
3.	Group Session	$40.00-$60.00
4.	Letters	$50.00 per letter
5.	Late Cancellation Fee/ No Show Fee	$75.00 (If you do not give a 24hour notice)
6.	Reading documents and preparing for testimony	$150.00/hour
7.	Preparation of reports	$150.00/hour
8.	Testimony in Court, Commissioner's Hearing, or Deposition, including Transportation	$250.00/hour
9.	Standing "On Call"	$250.00/hour
10.	Retainer for Testimony	$800.00
11.	Sliding Scale Fee	$100.00

CANCELLATION POLICY AGREEMENT

Appointments scheduled at OCCS are blocks of time set aside exclusively for the benefit of the scheduled patient. A patient's failure to attend a scheduled appointment without providing adequate notice affects both the patient's behavioral health provider and other patients. The provider is deprived of income, and other patients are deprived of the opportunity to see that provider, because of the difficulty of filling the vacated time slot when inadequate or no notification is given. In an effort to accommodate all OCCS patients and providers, OCCS has implemented the following cancellation policy.

PLEASE NOTE: All OCCS patients must read, sign, and agree to the OCCS cancellation policy at the first scheduled appointment. Failure to do so may result in denial of treatment.

As a OCCS patient (or patient's legal representative) (hereinafter me, my, I etc.), I agree to the following terms of OCCS' cancellation policy:

I. I understand and agree that I must call OCCS **<u>24 hours prior to my scheduled appointment</u>** to notify OCCS of my intent to cancel my scheduled appointment.
   a. To cancel an appointment at OCCS call: 757-271-9030
   b. I understand that, due to high call volume, I can sign into my Therapy Appointment account and cancel via the system.

II. I understand and agree that should I arrive late past the time of **15 minutes**, I will not be seen and will be charged a missed appointment fee of $75.00.

III. I understand and agree that I will be charged a missed appointment fee to correspond with the chart below if I miss an appointment without making a timely cancellation (as described in Sections I and II above). I understand and agree that failure to pay any balance of missed appointment fees may result in the denial of treatment including termination of services.

IV. Provider / Visit Type Missed Appointment Fee

Master's Level Clinician (LCSW or LPC) $75.00

Supervisee/Resident $75.00

By signing this form, I acknowledge that I have read, fully understand, and will abide by the policies and fee indicated in this OCCS Cancellation Policy Agreement.

Patient/Guardian Name:_____________________ Signature: _____________________Date________

Informed Consent for Treatment

I, _____________________________ (name of patient), agree and consent to participate in behavioral health care services offered at and provided by Oasis Clinical Counseling Services, providers via telehealth or in person and I understand the office policies, risk involved and precautions to take to protect my privacy.

I understand that I am consenting and agreeing only to those services that the provider is qualified to provide within: (1) the scope of the provider's license, certification, and training: or (2) the scope of the license, certification and training of the behavioral health care provider directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent to treatment, and I am legally authorized to initiate and consent to treatment on behalf of this individual.

Length of Services

Initial Evaluation and Diagnosis: 50-60 minutes

Counseling Sessions: 53 minutes

Guardian's Name: ______________________ Signature: ______________________Date__________

Self: _____________________________ Signature: _______________________Date__________

Name: ____________________________________**Date of Birth:** _______________________

Address: __________________________________ **City, State, Zip:** ______________________

Phone Number:________________
☐ **Authorization is given by self** ☐ **Is given by:** _____________________ **(Name)** __________ **(Relationship)**

☐ **I authorize Oasis Clinical Counseling Services to release information to:**
☐ **I authorize Oasis Clinical Counseling Services to obtain information from:**

____
Name of the Person, Provider or Facility

____
Address

____
Phone # / Fax #
Purpose of Request: ____

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments** ☐ **Progress Notes** ☐ **Drug/Alcohol Evaluations and/or treatment**

☐ **Diagnostic Impression** ☐ **Discharge Summary** ☐ **Treatment Plans**

☐ **Treatment Summary** ☐ **Educational Information** ☐ **Medical**

☐ **Other: (please describe)** ____

Disclosure: I authorize the disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.
My authorization will expire:
☐ 30 Days after I terminate services with **Oasis Clinical Counseling Services**
☐ One year from this date. ☐ Other: ____________________

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to Miranda Dennis, LCSW except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.

Signature of client: ____ Date: __________________

Signature of Parent: ____ Date: __________________
Signature of Witness: ____Date: __________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice covers all information in our written or electronic records which concerns you, your care and payments for your care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing your care, or manage some of our administrative operations.

Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff may use and disclose medical information (protected health information or PHI) about an individual for:

a. Mental Health Treatment – i.e.; providing mental health care services, sending/coordinating care information with other health care providers caring for you, ordering and obtaining off site tests/results, writing prescriptions, etc.

b. Payment – i.e.; submitting insurance claims on your behalf for treatment rendered.

c. Health Care Operations – i.e.; internal business planning activities and quality of care evaluation.

Oasis Clinical Counseling Services is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization, including, but not limited to:

a. Disclosures required by law

b. Disclosures to avert serious threats to health and safety

c. Disclosures with reference to Workers' Compensation or Food and Drug Administration

Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization. (Please see below for identifying persons to whom you would allow disclosures of otherwise protected information).

Oasis Clinical Counseling Services (OCCS) may contact the individual to provide appointment reminders or information about treatment or other health-related benefits and services that may be of interest to the individual or patient. (OCCS) will routinely contact patients via telephone or secured e-mail at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments, test results, etc.

Our patients have the following rights regarding their protected health information:

a. The right to request restrictions on certain uses and disclosures of protected health information. OCCS is not required to agree to a requested restriction, however.

b. The right to receive confidential communications of protected health information, as applicable.

c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.

d. The right to amend protected health information, as provided in the Privacy Regulation.

e. The right to receive an accounting of disclosures of protected health information.

f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically. OCCS is required by law to maintain the privacy of the protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. OCCS is required to abide by the terms of the Notice currently in effect. OCCS reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains. OCCS will provide individuals or patients with a revised Notice by posting new regulations in each office.

Individuals may complain to OCCS and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. OCCS 's contact person for matters relating to complaints is:

Miranda Dennis LCSW, 757-271-9030

OCCS SUPERVISION AND ASSISTANCE AGREEMENT

Oasis Clinical Counseling Services employees, providers and staff do not provide direct supervision of patients, nor any adults or minors in the waiting room, and cannot assume responsibility for supervision prior to, during, or following a scheduled appointment. If the individual requires such supervision and/or assistance with toileting or medication management during their appointment, a parent or guardian must remain in the waiting room to assist the individual or to provide necessary supervision immediately prior to or following the completion of the patient's appointment. Because of this, it is highly recommended that no minor be left unattended in the waiting room.

By signing this form, I, the patient or the patient's parent/guardian, acknowledge that I have read, fully understand, and will abide by the policies indicated in this OCCS Supervision and Assistance Agreement

Patient / Guardian's Name______________________________

Signature________________________________Date_________

OCCS Policy on Rights of Separated or Divorced Parents/Guardians to Consent to Mental Health Services for Minor Child

In the event of a divorce or separation, the Commonwealth of Virginian recognizes only two legal custodial rights for parents/guardians of minor children: 1) Sole Custody or 2) Joint Custody. No other physical custody arrangements are legally recognized within the State.

The right of a parent/guardian of a minor child to seek mental health services for the minor child varies by the parent/guardian's legal custodial designation as follows:

1) **SOLE LEGAL CUSTODY**:
   A parent/guardian with sole legal custody has the right to seek a mental health evaluation and/or treatment of a minor child unilaterally and without consent from the non-custodial parent.

2) **JOINT LEGAL CUSTODY**: A parent/guardian with joint legal custody will be required to produce appropriate documentation in order to determine:
   a. Whether the other parent/guardian must be notified in the event one parent seeks mental
   b. Whether both parents/guardians must agree to obtain a mental health evaluation and/or treatment for the minor child.
   c. PLEASE NOTE: In some cases, depending on the custody agreement, parents/guardians who disagree can have a judge determine whether mental health services are in the minor child's best interest.

3) **NO LEGAL CUSTODY**:
   A parent/guardian without a recognized legal custodial right:

   a. Has the right to access the minor child's medical records;
   b. Can seek emergency medical treatment, which likely will not include mental health treatment;
   AND
   c. Can petition a court for an order prohibiting the evaluation and/or treatment of the minor child because it's not in the child's interests.

In accordance with these limitations, OCCS has enacted the following policies for separated or divorced parents/guardians of minor children seeking mental health services for the minor child:

1) A parent/guardian with sole legal custody shall produce, prior to services:
   a) A letter from their attorney stating that there is nothing in the custody agreement that would prevent this individual from seeking evaluation and/or treatment of this child; OR

   b) Evidence in the form of a copy of the section of the court approved legal custody agreement verifying that parent/guardian is the sole legal custodian and has the unilateral right to make decisions with regard to the minor child's mental health.

2) A parent/guardian with joint legal custody shall produce prior to services:

   a) Evidence of the court-ordered joint legal custody agreement (see above); AND

b) Written consent from both parents to pursue mental health services for the minor child.

As the parent/guardian of _________________________, I, ________________________, acknowledge the OCCS Policy on consent for mental health services for a minor by separated or divorced parents, and agree to furnish the appropriate documents, as described herein, to prove my custodial right to seek said mental health services.

Printed Name _______________________________________

Signature ____ Date: ______________________

CONSENT TO TREAT MINOR PATIENT WITHOUT PARENT PRESENT

The State of Virginia and the Virginia Medical Board require consent before medical care can be given. During a session with a minor, they are typically seen for a portion of or the entirety of the session without the parent/legal guardian present as a component of the therapeutic process. Parents and legal guardians reserve the right to be present during the sessions, however this form allows the minor to be seen individually and does not require the parent or legal guardian to be present in the session. The parent or legal guardian is always encouraged to inform the treating clinician if they would like to take part in a session or if they would like an update regarding the minor's treatment.

I, ____ (print name here), am the parent/legal guardian of

____ (print name of minor), currently a minor, whose

date of birth is _____________________.

I authorize OCCS to provide mental health care to my minor child, including, but not limited to, diagnostic and necessary medical treatment as deemed appropriate by their clinician. I understand that, should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated. I further understand, once my child reaches the age of majority, my consent for treatment is no longer required. This consent will remain in effect until the patient reaches the age of eighteen unless revoked in writing to OCCS. By signing this, I acknowledge I have read and agree to this consent and that any questions I had prior to signing were answered by OCCS.

Parent / Guardian's Name: _____________________________

Signature: ___________________________Date____________

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon. Fees for clinical interviews may or may not be reimbursable by insurance, especially if the evaluation is court ordered, depending on the terms of the particular policy. Standard insurance policies do not reimburse for any of the other charges. Thus, reimbursement will be "self-pay." Payment in advance is required for testimony, the specifics of which will be discussed on an individual basis.

MEDIATION & ARBITRATION: All disputes arising out of, or in relation to, this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a precondition of, the initiation of arbitration. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Oasis Clinical Counseling Services can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff do NOT provide custody evaluation recommendation, medication or prescription recommendation, or legal advice, as these activities do not fall within our scope of practice.

TERMINATION: As set forth above, after the first couple of meetings, Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff will assess if we can be of benefit to you. We do not work with clients who, in our opinion, we cannot help. In such a case, if appropriate, we will give you referrals that you can contact.

If at any point during psychotherapy Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff assesses that we are not effective in helping you reach the therapeutic goals or perceived you as non-compliant or non-responsive, and if you are available and/or it is possible and appropriate to do, we will discuss with you the termination of treatment and conduct pre-termination counseling prior to termination. In such a case, if appropriate and/or necessary, we will give you a couple of referrals that may be of help to you. If you request it and authorize it in writing, OCCS will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, and if we have your written consent, we will provide her or him with the essential information needed. You have the right to terminate therapy and communication at any time.

*If you have begun services with Oasis Clinical Counseling Services and set your initial appointment but did not keep that appointment or are seen within 30 days of initiating services your case will close.

*If you miss 2 sessions(late cancelations or no show) and have not spoken with your Therapist to make other arrangements or the main office your case is subject to closing.

*If you have a remaining balance and have not paid, your case is subject to closing.

* If you have not been seen in the office in 60 days your case is subject to closing.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on OCCS equipment is encrypted, e-mails, texts and e-fax are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. OCCS equipment is equipped with a firewall, a virus protection and a password, and we back up all confidential information from the computer on a regular basis onto an encrypted hard-drive. Please notify OCCS if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted email, texts or e-fax or via phone messages, Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted. **Please do not use texts, e-mail, voice mail, or faxes for emergencies or long conversations.**

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards OCSS's profession require that we keep treatment records for at least 10 years. Unless otherwise agreed to be necessary, we retain clinical records only as long as is mandated by the Commonwealth of Virginia law. If you have concerns regarding the treatment records, please discuss them with your provider. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff assesses that releasing such information might be harmful in any way. In such a case, OCCS will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, OCCS will release information to any agency/person you specify unless it is assessed that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy we will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact your provider between sessions, please leave a message at main office number of (757) 271-9030 and your call will be returned within 24-48 hours Monday-Friday. Messages a few times during the daytime only, unless she is out of town. **If an emergency situation arises and if you need to talk to someone right away call the Police: 911, The warm line with Virginia Mental Health America: 1-866-400-6428 or the National Suicide Prevention Hotline: 1-800-273-8255. Please do not use email or faxes for emergencies.**

Social Media: While you may follow OCCS business social media please note any interaction is not private or secure. You may not receive a response via social media as a result of this.

RISK OF USING EMAIL/TEXTING: The transmission of client information by email and/or texting has a number of risks that clients should consider prior to using email/texting in therapy. These include, but are not limited to, the following risks:

a. Email/Text messages can be circulated, forwarded or stored in electronic files

b. Email/Text messages can be immediately broadcast worldwide and received by many intended and unintended recipients

c. Senders can easily misaddress email and text messages

d. Email/Text messaging is easier to forge than handwritten or signed documents

e. Backup copies may exist even after sender and/or recipient has deleted their copies

f. Email/Text messages can be intercepted, altered, forwarded or used without detection or authorization

g. Email/Text messages can be used as evidence in court

h. Email/Text messages can be lost in transmission

CONDITIONS FOR THE USE OF EMAIL/TEXTING: Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff use reasonable means to protect the security and confidentiality of emails and texts we sends and receives, however due to the above outlined risks, we cannot guarantee the security and confidentiality of information sent through email/texting. Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff are not liable for improper disclosure of confidential information that is not caused by intentional misconduct. Clients must acknowledge and consent to the following conditions:

- If clients choose to use email/texting for emergency situations, they must be aware that Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff cannot guarantee that emails/texts will be received and responded to within a particular period of time.
- When at all possible, complex or sensitive situations should to be reserved for discussion during session rather than using email/text.
- Any email or text sent or received is subject to being printed out and placed in the client's medical record.
- Oasis Clinical Counseling Services (OCCS) physicians, clinicians and staff will not forward client's identifiable emails/texts to outside parties without the client's written consent, except as authorized by law and explained in the Office Policies & Informed Consent.
- Clients should use their best judgment when considering the use of email or texts for communication of sensitive medical information. OCCS will not be responsible for the content of messages.
- OCCS is not liable for breaches of confidentiality caused by the client or any third party when using email/texting.
- The Client is responsible to follow up and/or schedule an appointment if necessary.

APPOINTMENT REMINDERS: Oasis Clinical Counseling Services has adopted an appointment reminder system through Therapy Appointment. This system is an optional and beneficial tool for clients to use to remember upcoming appointments your provider. Information sent through appointment reminders is minimal and secure.

I give permission for Oasis Clinical Counseling Services to send me appointment reminders and other office related announcements via our secure system (Therapy Appointment) via email or text (check all that apply). Therapy

Appointment will be utilized as our primary source of contact for appointments but if the system is down for some unknown reason we would contact you through the secondary sources;

- Email, If yes, my email is: ____________________________________
- Text Messages of Phone call, cell number is: ______________________

Client's Name (print): ____________________________________

Signature: _______________________________________Date: _________________

____

Therapist Name and Title

Primary Care Physician Notification Letter

This letter provides notification that the patient listed below has entered into outpatient treatment at Oasis Clinical Counseling Services. The consent below allows for you, the Primary Care Physician, to collaborate with the patient's provider at 757-271-9030 to discuss the care and treatment of our mutual patient.

Name of Patient: ____________________________

Date: ________________

Primary Care Physician: ____

Physician's Address: ____

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Phone: __________________________________ Fax: __________________________________

_____ I consent for this letter to be sent to the above Primary Care Physician.

Patient/Guardian Signature: ______________________________

Printed Name: ____

_____ I decline to have my Primary Care Physician notified/involved in my treatment while at Oasis Clinical Counseling Services.

Patient/Guardian Signature: ________________________________

Printed Name:____

Acknowledgement of Receipt of Financial, Ancillary and Notice of Privacy Practice

I, ______________________________________, have reviewed, understand and received a copy (if requested) of this Office's Financial, Ancillary and Notice of Privacy Practices.

Patient name: _____________________________

Signature: ________________________________ Date: ___________

It is your right to refuse to sign this document

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:

_________ Individual refused to sign.

_________ Communication barriers prohibited obtaining the acknowledgement.

_________ An emergency situation prevented this office from obtaining it.

_________ Others: ____