Louann Toscano, LCSW, LLC
Licensed Clinical Social Worker
louann.toscano.lcsw@gmail.com | 773.466.5992

OUTPATIENT CONSENT FOR TREATMENT

The undersigned Client or responsible party (parent, legal guardian, or conservator) consents to, and authorizes Louann Toscano, LCSW, LLC to provide psychotherapy services to the Client indicated below.

The undersigned understands that:

1. The Client has the right to be informed of and participate in the selection of treatment modalities; and, the Client's provider will use her professional judgment in the best interest of the Client to ultimately determine which modality(ies) to utilize.
2. He/she has the right to receive a copy of this consent form.
3. He/she has the right to revoke this consent at any time for the future provision of services from the date of revocation.
4. There is no guarantee that the Client will benefit from treatment or that treatment will yield positive or intended results.

Further, the undersigned, on behalf of himself/herself, his/her heirs, successors, assigns, and any other persons or entity claiming through or under any of them, agrees to release, indemnify, and hold harmless Louann Toscano, LCSW, LLC and her staff, administrators, employees, agents, board members from and against any and all losses, claims, damages, causes of action, liabilities, costs, and expenses which may be asserted, of every nature whatsoever, known or unknown, which arise out of or are connected with any loss, harm, or injury, including death, resulting from the provision of services implemented during the course of treatment by Louann Toscano, LCSW, LLC and/or her staff, administrators, employees, and agents.

_____

Name of Client Date of Birth

_____

Signature of Client Date Signed

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OUTPATIENT CLIENT INFORMATION FORM

Name: _____ Date of Birth: _____/_____/_____ Age: _____

Home Address: _____

Client Email: _____ Client Cell: _____

Authorization to leave confidential message at this number: ___ Yes ___ No

Preferred method of contact for appointment reminders: _____

School: _____ Employer: _____

Social Security Number: _____

Emergency Contact Name: _____ Relation: _____

Contact Phone: _____

In case of an emergency, can I contact this person? ___ Yes ___ No

Who referred you to Louann Toscano, LCSW, LLC? _____

Presenting Treatment Issues

Please indicate if you have experienced any of the following (current or past):

Anxiety Alcohol problems Body image concerns Chronic pain Drug abuse/addiction Dizziness
Depression Death in the family Digestion problems Domestic violence Easily angered
Excessive worry Head injury Excessive fighting with partner Headaches/Migraines Job Problems
Lack of confidence Loss of appetite Low self-image Nervous breakdown Panic Attacks
Physical abuse Stroke Seizures / Epilepsy Sexual abuse Sexual dysfunction
Problems related to sexual orientation Self-harming behavior/s Suicidal thoughts /actions
Sleep problems Tremors/shakes Thoughts of hurting self /others Traumatic experience
Sexually transmitted disease Violent behavior/s

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Why are you seeking therapy at this time?

_____

_____

Therapy Goals:

_____

_____

_____

Treatment History

Providers

Previous or current outpatient therapist(s): _____

Previous or current outpatient psychiatrist(s): _____

Compliance with treatment: _____

Feelings about being in therapy: _____

Treatment Settings

Psychiatric Hospitalizations (Y/N? And when?): _____

Partial Hospitalization or Intensive Outpatient Programs (Y/N? And when?):_____

Medical

Primary Care Provider: _____ Phone #: _____

Please list all of your current and past medication/s & supplements including OTC, prescribed, etc.

Medication name and dosage: _____

Medication name and dosage: _____

Please list any chronic medical problems, allergies, and medical hospitalizations or surgeries:

_____

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Psychiatric History

Current Diagnoses: _____

History of Suicide thoughts, plans, or attempts? _____

Are you currently having any thoughts or plans of suicide? _____

Family History of Mental Illness, Suicide/Suicide attempts or Substance Use:

Maternal: _____

Paternal: _____

Social History

Client's Relationship Status: Single Engaged Married Partnered Separated Divorced Widowed

Other:_____

Who are your strongest supports?_____

Hobbies/Recreational Activities? _____

Education

Name of school (current or most recent): _____ Year or grade: _____

Employment

Job title or function (current or most recent. Leave blank if N/A): _____

Company: _____ Does your current work satisfy you? _____

Current Household:

Please list all individuals living at your same address.

Name	Age	Relationship	Comments

Client Signature: _____ Date: _____

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RELEASE OF INFORMATION: Outpatient Psychiatrist (if applicable)

This form allows us to speak with the individual/entity listed below about your treatment.

I hereby authorize: **Louann Toscano, LCSW, LLC** to use, release, disclose, receive and/or exchange mental health and medical information concerning:

_____ _____
Name of Client **Date of Birth**

This information will be disclosed and/or exchanged with:

Psychiatrist Name: _____ **Confidential Phone:** _____

Address: _____
The relation to the Client is: Psychiatrist.

The purpose for which the information may be disclosed is to facilitate, support, inform, and guide the Client's treatment with Louann Toscano. I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, sexually transmitted disease, HIV/AIDS test results or diagnoses, and Protected Health Information. The information to be used or released includes:

☐ Verbal/Written Communication – ***No Restrictions*** **OR** ☐ Verbal/Written Communication – ***Limited to Areas Checked Below***

☐ Intake Evaluation(s)	☐ Medical History	☐ Alcohol/Drug Use/Abuse	☐ Psychotherapy Notes
☐ Medication	☐ AIDS/HIV Status	☐ Treatment Summary	☐ Diagnoses
☐ Medical Records	☐ Discharge Summary	☐ Other_____	☐ Neuropsychological Evaluation

This authorization is limited to only that information requested above. The Client and/or the Parent/Legal Guardian/Personal Representative hereby releases Louann Toscano, LCSW, LLC and her agents, employees and administrators, individually and collectively, from all legal responsibilities or liability that may arise from the use or disclosure of medical or other records and other health information in reliance on this authorization.

RECITALS: **Expiration:** I/we understand that unless I revoke the authorization earlier, this authorization will automatically expire on the following date:_____, two years from the date of Client's signature**. Redisclosure:** I/we understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party, pursuant to any agreement I may have with such party. **Refusal to sign:** I/we understand that I/we may refuse to sign this authorization and the result would be that the records would not be disclosed. I understand that Louann Toscano, LCSW generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. **Revocation:** I/we have the right to stop the use or release of this information at any time if I do so in writing; although, I/we understand that I/we cannot do anything about information already used or disclosed pursuant to this authorization. **Copy Received:** I/we understand that I/we will receive a copy of this completed form. **Inspect & Copy:** I/we understand that I/we have the right to inspect and copy the information to be disclosed. **Challenge:** I/we understand that I/we have the right to challenge the accuracy of any information contained in the subject file. **Effect of Copies:** I/we intend that mailed disc, fax, copies or electronic versions of this document shall carry the same force and effect as the original. **Alcohol/Substance Abuse Files:** If any requested records contain information regarding alcohol or drug abuse treatment, these records are protected by Federal confidentiality rules. These rules prohibit further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal rules. A general authorization for the use or release of medical or other information is insufficient for this purpose. Federal rules restrict use of the information for criminal investigation or prosecution of any alcohol or drug abuse client.

Certification: The undersigned affirms that I am (check whichever applies): ☐ The Client, and the identification that I have provided is true and correct. ☐ The Client's authorized representative, and that the identification and proof of authority that I/we have provided are true and correct. My relationship to the Client is that of: (circle one) Parent, Guardian, Other _____. ☐ *I authorize the transmission of this information via facsimile, electronic or disc sent via USPS mail to the party indicated above, and understand the limits of confidentiality as a result of such transmission.*

_____ _____
Date **Client Signature**

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RELEASE OF INFORMATION: Parent(s)/Significant Other (if applicable)

This form allows us to speak with the individual/entity listed below about your treatment.

I hereby authorize: **Louann Toscano, LCSW, LLC** to use, release, disclose, receive and/or exchange mental health and medical information concerning:

_____ _____

Name of Client **Date of Birth**

This information will be disclosed and/or exchanged with:

Name(s): _____ **Confidential Phone:** _____

Address:

_____

The relation to the Client is: _____

The purpose for which the information may be disclosed is to facilitate, support, inform, and guide the Client's treatment with Louann Toscano. I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, sexually transmitted disease, HIV/AIDS test results or diagnoses, and Protected Health Information. The information to be used or released includes:

☐ Verbal/Written Communication – ***No Restrictions*** **OR** ☐ Verbal/Written Communication – ***Limited to Areas Checked Below***

☐ Intake Evaluation(s)	☐ Medical History	☐ Alcohol/Drug Use/Abuse	☐ Psychotherapy Notes
☐ Medication	☐ AIDS/HIV Status	☐ Treatment Summary	☐ Diagnoses
☐ Medical Records	☐ Discharge Summary	☐ Other_____	☐ Neuropsychological Evaluation

This authorization is limited to only that information requested above. The Client and/or the Parent/Legal Guardian/Personal Representative hereby releases Louann Toscano, LCSW, LLC and her agents, employees and administrators, individually and collectively, from all legal responsibilities or liability that may arise from the use or disclosure of medical or other records and other health information in reliance on this authorization.

RECITALS: **Expiration:** I/we understand that unless I revoke the authorization earlier, this authorization will automatically expire on the following date:_____, two years from the date of Client's signature**. Redisclosure:** I/we understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or redisclosed by the receiving party, pursuant to any agreement I may have with such party. **Refusal to sign:** I/we understand that I/we may refuse to sign this authorization and the result would be that the records would not be disclosed. I understand that Louann Toscano, LCSW generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. **Revocation:** I/we have the right to stop the use or release of this information at any time if I do so in writing; although, I/we understand that I/we cannot do anything about information already used or disclosed pursuant to this authorization. **Copy Received:** I/we understand that I/we will receive a copy of this completed form. **Inspect & Copy:** I/we understand that I/we have the right to inspect and copy the information to be disclosed. **Challenge:** I/we understand that I/we have the right to challenge the accuracy of any information contained in the subject file. **Effect of Copies:** I/we intend that mailed disc, fax, copies or electronic versions of this document shall carry the same force and effect as the original. **Alcohol/Substance Abuse Files:** If any requested records contain information regarding alcohol or drug abuse treatment, these records are protected by Federal confidentiality rules. These rules prohibit further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal rules. A general authorization for the use or release of medical or other information is insufficient for this purpose. Federal rules restrict use of the information for criminal investigation or prosecution of any alcohol or drug abuse client.

Certification: The undersigned affirms that I am (check whichever applies): ☐ The Client, and the identification that I have provided is true and correct. ☐ The Client's authorized representative, and that the identification and proof of authority that I/we have provided are true and correct. My relationship to the Client is that of: (circle one) Parent, Guardian, Other _____. ☐ *I authorize the transmission of this information via facsimile, electronic or disc sent via USPS mail to the party indicated above, and understand the limits of confidentiality as a result of such transmission.*

_____ _____

Date **Client Signature**

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OUTPATIENT FINANCIAL POLICY AGREEMENT

Louann Toscano, LCSW, LLC is committed to providing her clients with the best possible care. Your understanding of her financial policy is important to your professional relationship. Please be advised of the following:

Authorizations: Your insurance benefit is a contract between you and your insurance carrier; Louann Toscano, LCSW, LLC is not a party to that contract.

Outstanding Bills: Clients are required to have a credit card on file. Payment is due at time of service and will be charged to the credit card on file.

Nonpayment & Collection Measures: Unresolved accounts that could not be charged to a credit card may be referred to an outside agency for collection, reported to the local credit reporting bureau and may result in legal proceedings. Louann Toscano, LCSW, LLC reserves the right to pursue any such paid claims.

Divorce/Separation of Parents/Legal Guardians: In the case of a divorce or separation, the party responsible for the account balance is the parent authorizing treatment for the child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

These established financial policy guidelines will be followed in resolving your balance:
Form of payment (initial next to selected form of payment):

_____ **BCBS PPO - Illinois** _____**Private/Self-Pay** [credit card, cash, or check]

ID number: _____ Group number: _____

Policy Holder name: _____ Policy Holder DOB: _____

I, the Client or his/her parent, legal guardian, authorized representative, and/or guarantor, agree to make suitable arrangements, including payment at time of service and resolution of the account, with payment in full, as per LOUANN TOSCANO, LCSW, LLC's policy. In signing, I am allowing Louann Toscano, LCSW, LLC to bill my insurance (if I elect to utilize it). **I understand that my insurance provider may not reimburse for teletherapy sessions, and it is my responsibility to reach out to my insurance company to identify my benefits. I also understand that I will be personally responsible for any unpaid balances, such as co-pays, deductibles, and non-covered services.** Lastly, in signing this, I agree to inform Louann Toscano, LCSW, LLC if my insurance policy changes, or if I possess or add-on secondary insurance. I am aware that any changes to my insurance policy will not be retroactively back-billed and will only be effective as of when I inform Louann Toscano, LCSW, LLC otherwise.

My signature below acknowledges that I have read and understand Louann Toscano, LCSW, LLC's financial policy and my financial responsibilities hereunder. By signing below I agree to the terms and conditions set forth herein and have received a copy of this form for my records.

Client Name: _____

Client Signature:_____ **Date:**_____

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ACKNOWLEDGEMENT OF OUT-OF-NETWORK STATUS

I, the undersigned, acknowledge that I have been informed that Louann Toscano, LCSW, LLC is in network with BlueCross BlueShield PPO of Illinois for her outpatient practice. In signing, I acknowledge that I either:

a) do not have insurance coverage,

b) have insurance coverage, but am choosing not to use it, or

c) have insurance coverage, but understand that Louann Toscano, LCSW LLC's services are not covered by my specific plan.

I acknowledge that I am responsible for fees at time of service, that I am a self-paying client, and that I will be provided a super bill that I can submit for out-of-network benefits reimbursement (should I decide to submit my payment to my insurance company).

In signing this, I also agree to inform Louann Toscano, LCSW, LLC if my insurance policy changes, or if I possess or add-on secondary insurance. I am aware that any changes to my insurance policy will not be retroactively back-billed and will only be effective as of when I inform Louann Toscano, LCSW, LLC otherwise.

_____ _____

Print Name Date

_____ _____

Signature Date

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OUTPATIENT BILLING AND CREDIT CARD AUTHORIZATION FORM

Client's Full Name: _____ Date:_____

1. Payment is due at the time of service for services provided by Louann Toscano, LCSW, LLC as per her Outpatient Financial Policy.

2. Credit card information will be kept on file to be used for any outstanding bills. All services will be billed to the credit card on file at time of service.

3. By signing this Billing and Credit Card Authorization form, I indicate that I fully understand the above billing policy and acknowledge that I will be responsible for any unpaid balances, such as co-pays, deductibles, and non-covered services. **Missed appointments, not cancelled within 24 hours, will be charged to the credit card that is on file. The credit card on file also may be charged to fulfill any balances incurred from late arrivals to appointments.** If the credit card on file is denied, or if no credit card is provided, then outstanding balances may be referred to an outside agency for further follow up, reported to the local credit reporting bureau, and may result in legal proceedings.

Credit Card Provider (Please Circle): Mastercard Visa Amex Discover

Credit Card #:_____

EXP Date:_____ 3 digit code on back of card (4 on front, if AMEX):_____

Cardholder Name:_____

Cardholder Signature:_____

Mailing Address: _____

_____

_____

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INFORMED CONSENT AND CLINICAL PROCEDURES

This document contains important information about professional services and business policies. Although these documents are long and sometimes complex, it is very important that you read them carefully. I can discuss any questions you have. When you sign this document, it will also represent an agreement between you and LOUANN TOSCANO, LCSW, LLC. You have the right to receive a copy of this consent at any time. You may revoke this Agreement in writing at any time. That revocation will be binding on LOUANN TOSCANO, LCSW, LLC, unless LOUANN TOSCANO, LCSW, LLC, has taken action in reliance on it; if there are obligations imposed on LOUANN TOSCANO, LCSW, LLC, by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

TREATMENT CONSENT

By signing this agreement you consent to assessments and psychotherapy rendered by LOUANN TOSCANO, LCSW, LLC. The undersigned client or responsible party (parent, legal guardian or conservator) consents to, and authorizes these services.

PSYCHOLOGICAL SERVICES

Psychological treatment is not easily described in general statements. It varies depending on the personalities of the mental health professional and client, and the particular problems you are experiencing. My approach uses dialectical behavior therapy and cognitive behavioral therapy, which calls for an active effort on your part. 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. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Before beginning psychotherapy, it is important to understand that I cannot guarantee that you or your child will benefit from treatment. No therapist can make such a guarantee because each client responds differently to this experience. If you have questions about your treatment, you should discuss them whenever they arise. If doubts persist, I will be happy to help you obtain an appropriate referral to another treatment facility or mental health professional. The first number of sessions may be used as an evaluation. From the evaluation, I will be able to offer some first impressions of what your work will include and a treatment plan to follow, if you decided to continue psychotherapy. If you have any questions throughout this process, they should be discussed as they arise.

PROFESSIONAL RECORD

The law and standards of this profession require that I keep treatment records. You are entitled to receive a copy of your records or I can prepare a summary of your records. Because of the professional nature of these records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that we review them together, so any of your questions or concerns can be addressed. Clients will be charged an appropriate fee for any professional time spent in responding to requests.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and therapist. In most situations, I can only release information to others about your treatment if you sign a written authorization form.

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There are other situations that require only that you provide written, advance consent. Your signature on this current agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals, including potential referral sources, about a case. During a consultation, I make every effort to avoid revealing the identity of a client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel it is important for our work together. I will note all consultations in your Clinical Record. You should be aware that we employ administrative staff. In most cases, we need to share protected information with these individuals for administrative purposes,
- You should be aware that we employ administrative staff. In most cases, we need to share protected information with these individuals for administrative purposes, such as scheduling, billing, and communication with insurance companies. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures to collect overdue fees are discussed elsewhere in this agreement.
- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her and/or to contact family members, or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning our professional services, such information is protected by the psychologist/client privilege law. I cannot provide any information without your written authorization, or a court order.
- If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order LOUANN TOSCANO, LCSW, LLC, to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against LOUANN TOSCANO, LCSW, LLC, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

Pursuant to the APA Code of Ethics Standard 4.05, there are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment:

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Children Services (DFCS). Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon him or her, other than by accidental means, or that he or she has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once I have filed such a report, I may be required to provide additional information.

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- If I determine that a client presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and /or contacting the police, and/or seeking hospitalization for the client. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary. 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 now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

TREATMENT STRUCTURE

We will begin treatment with a comprehensive assessment. During this time, you can decide if psychotherapy is a good fit for you. If psychotherapy is begun, we will develop a specific treatment plan and treatment goals. In most instances, sessions are initially scheduled for once a week for approximately 55 minutes. Variations in frequency and duration may be made based on type and severity of symptoms, as well as treatment goals.

BETWEEN-SESSION AVAILABILITY AND EMERGENCY COVERAGE

Dialectical Behavior Therapy and Cognitive Behavioral Therapy philosophies include an expectation of growing independent practice of therapy skills. Therefore, I encourage clients to attempt practice of learned treatment strategies prior to contacting me for support. If you need to contact LOUANN TOSCANO, please call my business number (773) 466 - 5992. Please understand that I will not answer the phone when I am with other clients. Therefore, I may not be available to respond immediately. You are invited to leave a message and can expect a response within 24 hours, with the exception of weekends and holidays. If it is an emergency and you are unable to reach me, call 911 or go to your local emergency room. If I am out of town for an extended period of time, I will provide you with the name of a colleague to contact, if necessary. This will be planned out in advance. I am not available to be on-call for emergencies or provide ongoing crisis management. In the latter case, I will refer to a more appropriate level of care.

FEE POLICIES, BILLING, AND PAYMENT

LOUANN TOSCANO, LCSW, LLC, is in-network with BlueCross BlueShield PPO of Illinois. If you are enrolled in another health insurance plan, oftentimes, policies (with the exception of Medicare and Medicaid) partially or fully reimburse the services of out-of-network licensed clinical social workers. You will be provided with a statement that includes all information that insurance companies need to process claims. It is highly suggested that you verify that your benefits include coverage of out-of-network providers should you decide to submit statements for reimbursement. Fees for teletherapy sessions are based on a 55-minute time block at the rate of **$125**. Shorter or longer sessions will be prorated correspondingly at this rate. Payment is expected at the time of service. For payment, I accept cash, check, and major credit cards. By signing this document you agree to pay LOUANN TOSCANO, LCSW, LLC, professional and facility services in accordance with the regular rates and terms. You also understand that when this agreement is signed by your spouse, parent or a financial guarantor, your spouse, parent or financial guarantor shall be jointly and individually liable with LOUANN TOSCANO, LCSW, LLC, for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear

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interest at the current legal rate. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, we have the option of charging your credit card on file or legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. If such legal action is necessary, its costs will be included in the claim.

CANCELLATIONS

Appointment times are reserved especially for you. Missed appointments interfere with therapeutic momentum and can lessen the effect of therapy. It is understood that occasional circumstances may arise that necessitate a cancelled appointment. In these events, 24 hours' notice is requested so that your appointment time can be offered to another person. Except in the case of emergency, cancellations without 24 hours' notice are charged at the rate of **$100.** Strategies to minimize frequent missed appointments may be generated with your therapist. Please note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, your therapist will try to find another time to reschedule the appointment.

It is also important that you arrive on time for your virtual appointments as scheduled. If arriving later than your scheduled time, your appointment time may not be extended. If you are running late and are due to arrive more than 30 minutes after your scheduled appointment time, your appointment time slot will be cancelled and you will be charged the cancellation rate of **$100.**

FOR CLIENTS REFERRED VIA CORONAVIRUSONLINETHERAPY.ORG:

I understand that Louann Toscano, LCSW, LLC is offering me a sliding scale rate of **$50**/session for **4 online therapy sessions** in response to COVID19, as I was referred through coronavirusonlinetherapy.org. I understand this sliding scale rate is time limited, and will expire after 4 online therapy sessions. At this time, we will reevaluate together based on Louann Toscano, LCSW, LLC's sliding scale availability and my need/interest in additional sessions. I understand that Louann Toscano, LCSW, LLC's full rate is **$125**/session.

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

Client's Name: _____ Date: _____

Client's Signature: _____

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INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and

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having passwords to protect the device you use for telepsychology). The extent of confidentiality and the exceptions to confidentiality that we outlined in our Outpatient Agreement still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you name that person along with their contact information at the bottom of this forms, which will allow me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, and/or any other hotlines local resources that we will identify in our emergency plan or go to your nearest emergency room. Call me back after you have called or obtained emergency services. If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees
The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. ***If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.***

Records
The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent
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 indicates agreement with its terms and conditions.

Client Name: _____ Date: _____

Client Signature: _____

Telehealth Emergency Contact

Contact Name: _____ Phone #: _____

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CLIENT RIGHTS AND RESPONSIBILITIES

Right to request how we contact you
It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

Right to release your medical records
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact LOUANN TOSCANO, LCSW, LLC. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact LOUANN TOSCANO, LCSW, LLC. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period, please submit your request in writing to the Privacy Officer, LOUANN TOSCANO, LCSW, LLC. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to LOUANN TOSCANO, LCSW, LLC. However, we are not required to agree to such a request.

Right to file a complaint
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Dept. of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive notice of a breach
You have the right to be notified in writing following a breach of your health information that was not secured in accordance with security standards as required by law.

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HIPAA NOTICE OF PRIVACY PROCEDURES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Louann Toscano, LCSW, LLC has been and will always be totally committed to maintaining clients' confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession. This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services
Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT
We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT
Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS
We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent
There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Illinois State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Clinical records, psychotherapy notes and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information where you have paid for services out-of-pocket and in full.

If you have any questions, please contact LOUANN TOSCANO, LCSW, LLC.

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ACKNOWLEDGEMENT OF

CLIENT RIGHTS AND RESPONSIBILITIES
&
HIPAA NOTICE OF PRIVACY PROCEDURES

(SIGNATURE PAGE)

I, the undersigned, acknowledge that I have received, read, understand and, and agree to all the terms, stipulations, conditions, rules, regulations, and expectations in the "*Client Rights and Responsibilities*" and "*HIPAA Notice of Privacy Procedures*" from Louann Toscano, LCSW, LCSW.

_____
Client Name

_____ _____
Signature of Client Date