Enrichment Support Services, LLC.
Lending a Helping Hand, One Person At a Time.

CONSENT FOR TREATMENT

Welcome to Enrichment Support Services, LLC (ESS)! We are delighted at the prospect of working with you toward your goals. ESS is owned and operated by a Licensed Marriage and Family Therapist, Anse Daniel. At ESS, we offer psychological services, such as therapy, personal coaching, and the like. We also offer various support services that might be relevant to your situation (e.g. career counseling, parenting classes, social skills group, and the like). Support services are incorporated into a client's treatment plan when appropriate to individualized treatment goals.

Confidentiality

In all matters having to do with psychotherapy, confidentiality will be maintained unless you have signed a release of information to a specific individual or agency. Please review the Client Rights Form for information regarding other exceptions to confidentiality. The exception to confidentiality is when we are taking action under the belief that someone might be in danger (e.g., self-harm, or harm to others)

Communication with your Clinician

Contacting your Clinician

Your primary clinician may not be immediately available by telephone. When this is the case, you may leave a confidential voicemail and we will make every effort to return your call on the same day with the exception of weekends and holidays. Please inform us in your message of time slots when you will be available, and if it is acceptable for us to leave a message with either a person or on a voicemail.

If you are unable to contact me in an emergency, go to your nearest emergency room. For psychiatric admissions and hospitalizations.

Social Media Policy

ESS has a presence on certain social media venues so that clients and potential clients can better access information regarding the valuable services we offer. None-the-less, we practice a strict policy of refraining from "friending" and/or communicating with current or previous clients through social media (e.g., Facebook, Twitter, LinkedIn, etc.). We enforce this policy in order to protect your privacy, and so that the therapeutic relationship is undiluted by boundary confusions. Similarly, we do not use social media as a means of attaining information regarding our clients. The exception to this is when we are taking action under the belief that someone might be in danger (e.g., self-harm, or harm to others). If you have questions about our social media policies, please ask your clinician or Anse Daniel, LMFT.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

I hereby acknowledge that I have received a copy of the Provider's Notice of Privacy Rights, (HIPAA).

SIGNED_____ DATE. _____

Client or Guardian

Insurance:

We are paneled with the following insurance companies:

- Aetna & Aetna EAP
- Cigna
- Cenpatico
- Sunshine State Health
- Ambetter
- Magellan Health
- CareBridge EAP
- TriCare Certified
- United Healthcare
- Concordia
- Beacon Health Options

Other Staff:

Any ESS staff member who is contracted by ESS to provide specific services for a client may or may not be paneled with insurance networks. If, with the client's consent, a staff member is contracted by ESS to provide services, the status of that staff member in regard to insurance paneling would be discussed with the client prior to services being rendered.

General:

For clients with insurance outside of where we are paneled, we will provide you with a receipt of payment that can often be submitted by you for "out of network" reimbursement. Upon request, we will also help secure preapprovals where needed. Please check with your insurance company regarding reimbursement rates and policies for out-of-network benefits.

Payment

Our services are billed at $120/hour and are payable in full at the time of service, unless other arrangements are made. For clients who are with any of the above insurance companies, payment or co-payment is due at the time of service according to your insurance plan.

We accept the following methods of payment:

- Visa/Mastercard
- Cash
- Check (There will be a $35 return check fee)
-

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE PAID DIRECTLY TO THE PROVIDER, OR THE INSURED FOR MEDICAL SERVICES RECEIVED. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR THE PROCESSING OF MEDICAL CLAIMS DIRECTLY TO THE INSURED, OR THE ABOVE PROVIDER. THIS ALSO INCLUDES ANY NECESSARY INFORMATION REQUIRED TO PROCESS CLAIMS FOR WORKER'S COMPENSATION, AUTO INJURY, OR MEDICARE BENEFITS, IF APPLICABLE.

SIGNED _____ DATE _____

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Cancellation and Late-to-Appointment Policies

At ESS, we historically have had clients who keep appointments and are prompt. None-the-less, we want our clients to be informed of our cancellation and late-to appointment policies

As noted, $30 will be charged when appointments are not cancelled within 24 hours of appointment and for clients who fail to show.

Regarding tardiness, the session can proceed for the time remaining in the scheduled hour if a delay is under 20 minutes (at full session rate).

IF PAYMENT IS NOT RECEIVED WITHIN 30 DAYS OF STATEMENT DATE, YOUR ACCOUNT WILL BE SUBJECT TO AN INTEREST CHARGE OF 1.5% PER MONTH. IF PAYMENTS ARE NOT MADE AFTER 6 MONTHS, YOUR ACCOUNT WILL BE PLACED WITH A COLLECTION AGENCY FOR THE AMOUNT DUE AS WELL AS COLLECTION FEES.

Notice of Termination

You are not obligated to any specific number of sessions. It is helpful, however, to provide ESS one session's notice if you decide to terminate so that we may end our work effectively.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You also confirm that you have been provided with written material regarding confidentiality, privacy policies, consumer rights, the risks and benefits of treatment, as well as emergency procedures. A copy of this form is as valid as the original.

I, _____, agree to all the above terms and conditions.

_____

Client signature **Date**

_____

Signature of parent or legal guardian (if client is under 18) **Date**

_____

Signature of Clinician **Date**

701 Promenade Drive • Suite 204 • Pembroke Pines • FL 33026
(O) 954.364.8842 • (F) 954.874.6188 • www.enrichmentsupportservices.com

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NEW CLIENT REGISTRATION FORM

THIS FORM MUST BE COMPLETED BEFORE TREATMENT IS PROVIDED AND IF APPLICABLE, YOUR INSURANCE CARRIER FILED ON YOUR BEHALF. PLEASE MAKE SURE TO FILL OUT BOTH SIDES COMPLETELY USING N/A WHEN THE QUESTION IS NOT APPLICABLE. PLEASE PRINT.

NAME_____

ADDRESS_____

CITY, STATE, ZIP_____

DATE OF BIRTH_____

HOME PHONE_____ CELL PHONE_____

WORK PHONE_____EMAIL_____

☐ ESS can leave a detailed voicemail at the above phone number(s).

INSURED NAME_____

PRIMARY INSURANCE_____

ADJUSTER'S NAME IF APPLICABLE_____

AUTHORIZATION #_____

PLACE OF EMPLOYMENT_____

INSURANCE ADDRESS_____

CITY, STATE, ZIP_____

POLICY OR GROUP #_____

CLAIM #_____

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SECONDARY INSURANCE

INSURED NAME_____

PLACE OF EMPLOYMENT_____

INSURANCE ADDRESS_____

CITY, STATE, ZIP_____

POLICY OR GROUP #_____

CLAIM #_____

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Request and Authorization to Release Records and Information

Client Name: _____
Date of Birth: _____

I, _____, hereby authorize the following professional person/agency, (Provider name)_____, to release copies of my records or exchange information with Enrichment Support Services, LLC.

Provider Address: _____
_____
_____

Provider Phone: _____

Provider Fax: _____

The purpose for which the information is to be used:

AUTHORIZATION:

I certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. I understand that this consent will expire on the following date: _____

I hereby release Enrichment Support Services, LLC, from any liability, which may result from furnishing the information requested as authorized by this release. Re-Disclosure of my clinical records by those receiving the above-authorized information may not be accomplished without my further written consent.

A copy of this authorization may ( ) or may not ( ) be as valid as the original.

_____ _____
Signature of client or parent/legal guardian (specify relationship) Date

_____ _____
Signature of Clinician Date

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Electronic Communication

In addition, if you are comfortable with using email as a means of communication, you may contact your clinician via email. Please note that when you contact ESS via email, you could be exposing your communication to a breach in privacy that is outside of the control of ESS. If you are comfortable with email and other forms of electronic communication, please indicate so here.

Check all the boxes that apply, fill out requested information where applicable, and sign below.

☐ ESS can contact me via email for appointment and information that pertains to treatment:

_____@_____

_____@_____

☐ ESS can enroll me in Paperless Billing at the above email address(s). Invoices concerning clinical treatments not done in an office setting, cancelled or missed appointments (as stated in our policy) and any other requested visits or treatments not covered by your insurance provider.

☐ I authorize ESS to conduct clinical treatment with me/my child via the following electronic (tele-therapy) means

_____

Client's Name **Client's or Responsible Party's Signature** **Date**

CLIENT RIGHTS SUMMARY

(To be shared at intake in verbal and written form with all clients and receipt Acknowledged by signature on the Consent for Treatment form.)

It is the policy of this practice to fully support, endorse and enforce the rights of its clients as promulgated in contract and service program standards.

Clients shall not be excluded from a program nor be denied access to services based on race, creed, national origin, color, gender, physical handicap or sexual orientation.

SERVICE PROVIDER does not restrain, secure, or provide manual restrictive measures. All efforts to manage client behaviors are verbal and de-escalating techniques and providing support for the caregivers. Staff may intervene to address management of age-appropriate but potentially dangerous behavior, for example, to protect a child who runs into the street so as to prevent harm to him/her.

SERVICE PROVIDER ensures the rights of their clients. These rights include:

- The right to services and a service plan regardless of your age, race, sex, national origin, or developmental disability (degree of retardation or mental illness).
- The right to be treated with dignity and respect.
- The right to confidentiality including all information in your record except when state law requires or allows disclosure.
- The right to be protected from corporal punishment from SERVICE PROVIDER employees.
- The right never to be abused by a SERVICE PROVIDER employee.
- The right to contact and consult with your attorney, your private doctor, or others of your choice at your own expense.

Certain Federal or State Statutes may further define the civil rights of individual clients, but for the purpose of this plan, the civil and legal rights of clients will include, but not be limited to your:

- Right to dispose of property;
- Right to execute legal documents;
- Right to buy or sell;
- Right to enter into contractual relationship;
- Right to register to vote;
- Right to marry and obtain a separation, divorce or annulment;

- Right to hold a professional, occupational or vehicle operator's license; Right to make a will.

In addition, your legal rights include the following:

- Reasonable accommodation of the client's disability condition.
- Program admission policies that restrict admission only where the restriction is
- Reasonable accommodation of the client's disability condition.
- Program admission policies that restrict admission only where the restriction is reasonably related to treatment goals.

- Maximum participation in the development or modification of a timely written treatment plan that is responsive to the client's needs and allows an opportunity for the client to make corrective comments to case records.
- Reasonable assistance to the client in applying and making full use of any public services or benefit to which the client may be entitled and assistance with the complaint process.
- Confidential management of records with legally proper disclosure procedures.
- Confidential information regarding substance abusers shall be released or disclosed in accordance with the federal regulations 42 C.F.R. Part 2, 'Confidentiality of Alcohol and Drug Abuse Patient Records'.
- Upon admission, prompt evaluation and treatment about which information has been provided and for which general consent has been obtained.
- To be treated with dignity, which includes:
    - Being called by preferred or legal name;
    - Being protected by reasonable efforts from harm, abuse, and exploitation; o Receiving a copy of the Program expectations or rules (where applicable regarding the service being provided;
    - Receipt of services in the home setting unless circumstances dictate
        - Service being provided elsewhere.

    - To be provided with general information about program services and policies in a manner easily understood.
    - To be provided with information regarding fee schedule or costs of services.
    - To be treated in the least restrictive setting consistent with your condition and availability of services.
    - To receive treatment without being the subject of experimental or investigation research unless prior informed consent is given and is appropriately documented.
    - To have access to consultation and communication in private with lawyers, legislators, clergy, licensed health care practitioners and employees of a protection and advocacy agency at your expense.

- Notification of the availability of a Regional Advocate (where available) and the access to an impartial review procedure regarding any alleged violation of your rights.

- That any incidents related to your safety in the community or with staff are handled in a matter that promotes full disclosure to the proper authorities and minimizes risk.
- Freedom from threat or fear of unwarranted suspension or expulsion from the facility.

- If you are dissatisfied with any aspect of the counseling process, please inform me so we can determine if our work together can be more effective or whether referral would be appropriate. If you think I have treated you unfairly or unethically and we cannot resolve the problem, contact the Governor's Advocacy Council for Person's with Disabilities (GACPD), the statewide agency designated under Federal and State law to protect and advocate the rights of persons with disabilities, at **1- 800-821-6922**.

CLIENT RIGHTS ACKNOWLEDGEMENT FORM

I, _____ (client's name, or parent/legal guardian), hereby acknowledge that my rights as a Client of Enrichment Support Services, LLC were explained and a copy of those rights were given to me on this date. The following information was also reviewed and/or explained to me: Agency Rules and Guidelines, Procedures for obtaining my treatment plan, fee assessment and collection practices, how to resolve problems. I have received a copy of the Client Rights and I have been given an opportunity to review it and ask questions.

_____ _____

Client signature **Date**

IF APPLICABLE:

_____ _____

Signature of Representative **Date**

A REPRESENTATIVE SHOULD DESCRIBE HERE THEIR AUTHORITY TO ACT FOR THE RECIPIENT (E.G., LEGAL GUARDIAN, PARENT OF MINOR CHILD)

Client's Name_____ **DOB**_____

To be shared at intake in verbal and written form with all recipients and receipt acknowledged by signature on the Consent for Treatment form.

My practice is concerned with any problems you may experience. You* or any members of your family have the right of grievance. To help correct the problems, I need to know about them. Therefore, I have set up a Grievance Procedure that I request you use.

If you have a problem with my practice or if, you believe that any of your rights have been violated, please report your concern by:

1. Informing me about the problem. While you can tell your complaint to me verbally, if possible, I suggest that you put your complaint in writing.
2. If you are not satisfied with my response to your complaint within five business days, you can file the complaint with the Governor's Advocacy Council or the Regional Advocate, in the state in which you reside. In most states the Regional Advocate will help you file an appeal with the local Human Rights Committee. Your SERVICE PROVIDER is responsible for reporting all complaints to the local Human Rights Committee.

*Youth or any family member

You always maintain the right to seek other remedies that may be available. The advocates listed below can be contacted for general human rights information as well as for grievances. Contact your advocate or committee via the following number:

Governor's Advocacy Council
GACPD
800-821-6922
www.gacpd.com

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CLIENT GRIEVANCE ACKNOWLEDGEMENT FORM

I, _____ (client's name, or parent/legal guardian), hereby acknowledge that I have received a copy of the Client Grievance Procedure and I have been given an opportunity to review it and ask questions.

_____ _____
Client signature Date

IF APPLICABLE:

_____ _____
Signature of Representative Date

A REPRESENTATIVE SHOULD DESCRIBE HERE THEIR AUTHORITY TO ACT FOR THE RECIPIENT (E.G., LEGAL GUARDIAN, PARENT OF MINOR CHILD)

Client's Name_____ DOB_____