UNTETHERED THERAPY GROUP
570 Lincoln Avenue • Bellevue, PA 15202 • 412 - 213 - 8028

OFFICE POLICIES AND COUNSELING SERVICES AGREEMENT

Please read and sign two copies. Keep one for your own records.

The following are policies and procedures of Untethered Therapy Group. This information is provided to assist you in making the most informed decision about your treatment. In addition, this document ("Agreement") constitutes an agreement between MentWell Inc., a Pennsylvania Nonprofit Corporation doing business as Untethered Therapy Group ("us," "we," or "Untethered Therapy Group") and you ("Client" or "Responsible Party"). Your signature at the bottom indicates your understanding and agreement to these terms.

1. **Consent to Treatment.** Untethered Therapy Group is a professional group where therapists engage in the practice of mental and behavioral health services delivery ("counseling"). Some therapists are independently licensed and others require clinical supervision by a credential supervisor. Those who require supervision work under the direction and supervision of a fully credentialed practitioner. Additionally, in limited circumstances your therapist may be assist by a co-therapist. By signing below, you are giving your consent (or, where applicable, consent as the party responsible for payment) to treatment by Untethered Therapy Group in any of the forms contemplated by this Agreement.

2. **Confidentiality.** Along with this Agreement, you will receive Untethered Therapy Group's HIPAA Notice of Privacy Practices ("Notice") as in effect at the time you begin services. That Notice describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. By signing below you acknowledge receipt of the Notice and agree to its terms.

3. **Emergencies.** In a crisis situation, including an immediate life threatening emergency, call 9-1-1 or go immediately to your local emergency room. You may also contact ReSolve Crisis Network at 1-888-7-YOU-CAN (1-888-796-8226), which provides 24-hour-a-day, 365-days-a-year telephone, mobile crisis, walk-in and crisis overnight residential services that are available to any Allegheny County resident no matter age, ability to pay, or whether they have used behavioral health services in the past. While Untethered Therapy Group and your therapist will do their best to assist you outside of a therapy session, we are not a crisis center. The best phone number for you to call is the direct phone number of your therapist. If your call goes to voice mail, please leave a message for your counselor. Your counselor may be on the phone, in therapy with someone else, or out of the office.

4. **Appointments.** All office visits are by appointment with your therapist directly. Psychotherapy sessions will be 50 minutes in length. Increased session length may be negotiated and will be charged accordingly. Please arrive on time as the session end time will not change and you will have a shortened session. You agree to be responsible for the full fee even if you arrive late to your session.

5. **Late Cancellation & No-Shows.** Appointments cancelled less than 24 hours before the appointment time and no-show appointments will be billed for the full amount and are charged to the

credit card on file. Insurance companies may not pay for no-show charges or late cancellation charges. If your appointment is cancelled or missed, contact your therapist for a new appointment time. After 3 late cancellations or no shows, you will not be able to schedule another appointment and will be referred to another provider. If you have arranged with your therapist to have standing appointments, then after the first no show, all appointments will be removed from the schedule and will have to arrange appointments weekly.

6. **Fees, Payment and Financial Responsibility.** *Payment in full is required at the time of the session* unless alternative arrangements have been agreed upon with us. Clients and parents/guardians of minor clients are responsible for payment (and insurance claims) on their accounts. By signing this Agreement, you acknowledge responsibility for payment per hour for any demand on the therapist's time that occurs under your direction and/or on your behalf. This includes time demands that result from involvement in any legal proceeding. Clients will periodically receive a statement reflecting any balance due on their account, either in paper copy or via email (when we are granted permission to do so). The Responsible Party will disclose any change in insurance or his/her financial situation.

    A. *Rates*. All services are charged at a rate of $100.00 with the exception of the first initial interview which is charged at a rate of $130.00.

    B. *Telephone consultation fees*. Phone calls over five (5) minutes will be billed in 15-minute increments, at $25 per 15 minutes. Insurance companies may not pay for telephone consultations. Unless agreed otherwise in advance, Untethered Therapy Group will not process telephone consultations for payment by insurance and will instead directly bill the client.

    C. *Written report fee*. Written reports will be provided upon request and with a signed consent to the release of information. The fee for this service is based on length of time to prepare the report and will be billed in 15-minute increments at $25 per 15 minutes.

    D. *Returned (NSF) Check fee*. A charge of $35.00 will be assessed on all returned checks.

    E. *Delinquent Accounts*. Accounts become delinquent after thirty (30) days. *Delinquent accounts may be turned over for collection at the responsible party's expense.* **You agree that in the event of non-payment, you will bear the cost of collection (including but not limited to court costs and reasonable legal fees should this be required).**

7. **Insurance Responsibility.** You understand your insurance coverage is a relationship between you and your insurance company. By signing below, you agree to accept financial responsibility for payment of all charges incurred irrespective of insurance coverage. Our office will provide an "insurance ready" receipt upon request. As a service to our clients who have their insurance with programs in which their therapist is a participating provider, at your request we will bill your insurance company directly and accept payment from them for counseling services in your behalf. Clients should contact their insurance companies regarding any co-payment (including co-insurance or other similar obligations) they are responsible to pay because they are due at the time of service. Furthermore, Untethered Therapy Group cannot accept responsibility for collecting client's insurance claims or for negotiating settlements of disputed claims; you remain obligated for any payment for services rendered. If your policy requires preauthorization to receive services, this is your responsibility and needs to be handled prior to your first visit. If required preauthorization is not on file, your credit card will be charged for your session.

8. **Assignment of Insurance Rights.** If you chose to have us bill your insurance directly, you hereby assign Untethered Therapy Group all Insurance benefits due to you to the full extent of your financial obligation to Untethered Therapy Group.

CLIENT/RESPONSIBLE PARTY ACKNOWLEDGEMENT AND ACCEPTANCE OF TERMS

I have read, understand, and agree to the above policies, procedures, terms and fees of this Agreement. I hereby agree to be fully responsibility for all expenses incurred by me or on account of this client. Furthermore, I have discussed these policies with my therapist if desired and I have been offered a copy of this Agreement.

Client Signature	**Date**
Client Signature	**Date**
Responsible Party Signature (*if different from Client*)	**Date**

Consent to Treat Minor (if applicable). You authorize Untethered Therapy Group to provide services to _____ (the "Minor Client"), who is a minor. You represent that you are the parent, guardian, or representative of the Minor Client and that you have legal authority to consent to treatment on behalf of the Minor Client. You further agree that the Minor Client and you will be bound by the terms of this Agreement. Finally, you also agree to follow up with phone conversations regarding Minor Client's progress and to participate in therapy as recommended.

Parent/Guardian Signature	**Date**
Parent/Guardian Name (*print*)	**Relationship to Minor Client**

GO PAPERLESS! By providing your email address and signature below, you authorize Untethered Therapy Group, LLC to issue your invoices and statements via email. You may withdraw your consent at any time by providing a request in writing. PLEASE PRINT CLEARLY!

@	
Email Address	Signature

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CREDIT CARD AUTHORIZATION AGREEMENT

This Credit Card Authorization Agreement ("Agreement") is between MentWell Inc., a Pennsylvania Nonprofit Corporation doing business as Untethered Therapy Group ("us," "we," or "Untethered Therapy Group") and you (the "Cardholder"). Your signature at the bottom indicates your understanding and agreement to these terms.

1. **Authorization to Charge Therapy Fees.** Cardholder agrees and authorizes Untethered Therapy Group to charge to the debit/credit/flex spending card listed below (the "Card") any therapy session fees (such as individual, group, workshops, couples, family or other), and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials, and/or fees), and ***fees for any scheduled appointments that are not cancelled 24 hours before the scheduled appointment time***. You understand that charges for ongoing services or materials will normally be posted to the Card within 48 hours of each session and the session fee will be charged at the start of the day on the day of your session.

2. **Authorization Survives Termination.** Cardholder agrees that this authorization is valid until canceled in writing, including where the Client terminates services with Untethered Therapy Group. Additionally, Cardholder agrees that the Card may be charged by Untethered Therapy Group in order to settle any outstanding balances accrued by the Client upon termination of therapy services including any materials (such as books, CD's, DVD's, etc.) that the Client has not returned within one week of discontinuing therapy services.

3. **Confidentiality**. If the Cardholder is assuming payment responsibility for the Client, and that Client is someone other than the Cardholder, the Cardholder understands and agrees that the Cardholder is not entitled to information pertaining to confidential services provided by Untethered Therapy Group.

4. **Disputes.** Cardholder understands and agrees that if the Cardholder has any concerns or questions regarding charges to the Card, or if the charge fails to post to the Card, the Cardholder will contact Untethered Therapy Group for assistance and/or disclosure. Cardholder understands and agrees that the Cardholder will not dispute any charges on the Card unless the Cardholder has already attempted to rectify the situation directly with Untethered Therapy Group and those attempts have failed. Cardholder further agrees that Cardholder is responsible for charge back or retrieval fees incurred by Untethered Therapy Group.

5. **Authorization to Retain, Assumption of Risk.** Cardholder authorizes Untethered Therapy Group to retain your signature and card information in a password-protected or physically secured storage system. Cardholder understands that the information on this form will be securely stored in a HIPAA compliant manner in a protected client file. Cardholder also understands that, while the Cardholder's information is protected and is unlikely to be tampered with, Untethered Therapy Group cannot ***guarantee*** that the file and credit card information cannot be breached. The Cardholder agrees to assume the risk if the file and credit card information is compromised.

By signing below, Cardholder understands and agrees to the terms stated above:

Signature _____ **Date** _____

Cardholder Name _____ **Relationship to Client** _____

Billing Address _____

Card Number: _____

Exp. Date _____ **Card Type** _____ **CVC** _____

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CLIENT INFORMATION FORM

Name: _____ ☐ Male ☐ Female

Address: _____
Street City / State ZIP

Contact Preference: The best way to contact me in the case of an emergency change to an appointment due to weather, illness, etc., is (check all that apply): ☐ Email ☐ Text message ☐ Phone message (_____)

Email: _____

Home Phone #: _____ ☐ check if ok to leave a message

Work Phone #: _____ ☐ check if ok to leave a message

Cell Phone #: _____ ☐ check if ok to leave a message

Date of Birth: _____ **Soc. Sec. #:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other _____

Marriage Date (*if applicable*): _____ **Referred By:** _____

Work Status: ☐ Student ☐ Retired ☐ Employed ☐ Not Employed

Employer / Ed. Inst.: _____ **Religion:** _____

Family Household Members:
(Name) (date of birth) (relation to you)

_____

_____

_____

Family Physician: _____ **Date of Last Physical Exam** _____

Address: _____ **Phone:** _____

Present Medical Conditions: _____

Present Medications (name, dosage)**:** _____

_____

Previous Psychological Contacts: _____

Previous Psychological Medications and reason for discontinuing: _____

_____

Brief statement why you are seeking therapy at this time: _____

_____

_____

By signing below, I attest the information is true and accurate, and I promise to promptly report any changes.

_____
Signature **Date**

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CLIENT INSURANCE FORM

INSURANCE (Primary)

Insurance Name: _____

ID #: _____ Group#: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Employer: _____

Subscriber's Relationship to Client: _____

INSURANCE (Secondary)

Insurance Name: _____

ID #: _____ Group#: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Employer: _____

Subscriber's Relationship to Client: _____

AUTHORIZATION, RELEASE AND ASSIGNMENT

I authorize the release of any information necessary to process my insurance claims and assign and request payment to MentWell Inc., a Pennsylvania Nonprofit Corporation doing business as Untethered Therapy Group.

Subscriber's Signature **Date**

Client's Signature **Date**

Client's Signature **Date**

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HIPAA NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes how MentWell Inc., a Pennsylvania Nonprofit Corporation doing business as Untethered Therapy Group ("we," "us," or "Untethered Therapy Group") may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that we maintain. The new notice will be available upon request, in our office, and on our website.

2. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the Untethered Therapy Group's practice, and any other used required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a psychiatrist to whom you have been referred to ensure that the psychiatrist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining authorization for treatment may require that your relevant protected health information be disclosed to the health plan.

Healthcare Operations: We may use or disclosed, as needed, your protected health information in order to support the business activities of Untethered Therapy Group's practice. These activities include but are not limited to quality assessment, employee review, training of Interns, and licensing. For example, we may call you by a name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of federal privacy laws.

Other Permitted and Required Uses and Disclosures will be made only with your written authorization or opportunity to object unless required by law. We never market or sell personal information.

You may revoke this authorization at any time, in writing, except to the extent that your therapist or Untethered Therapy Group's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

3. Your Rights

You have the right to inspect and receive a copy of your protected health information. Our practice will accept such requests in writing. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. Under federal law, however, you may not inspect or receive a copy of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to have your therapist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to obtain a paper copy of this notice from us. You have the right to request to receive confidential communications from us by an alternative means or at an alternative location (for example, home or office phone). We will agree to all reasonable requests.

You have the right to request a restriction on the disclosure of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree to your request, and we may decline if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree unless a law requires us to share that information. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your therapist is not required to agree to a restriction that you may request. If a therapist believes it is in your best interest to permit use and disclosure of your protected health information, your health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

4. Complaints

If you believe your privacy rights have been violated by us, you may file a written complaint with our office staff by submitting a letter briefly describing the nature of the violations you believe have occurred. You may also file a complaint with the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

5. Acknowledgement

I, _____, acknowledge receipt of this *HIPAA Notice of Privacy Practices* and have read and understand the information contained in it.

Client Signature	**Date**
Client Signature	**Date**
Parent/Guardian/Representative Signature (*indicate relationship*)	**Date**
Therapist's Signature (*if client refuses to sign; state reason for refusal, if known*)	

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GENERAL AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, have received and reviewed Untethered Therapy Group's *HIPPA Notice of Privacy Practices*. I understand that by signing this *General Authorization*, I am authorizing MentWell Inc., a Pennsylvania Nonprofit Corporation doing business as Untethered Therapy Group ("Untethered Therapy Group") to disclose my health information to the Authorized Persons and Entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to Untethered Therapy Group. In addition, I waive any right of privacy that I may have in connection with the disclosures hereby authorized. My health information includes, but is not limited to, any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational or psychological condition. Disclosure may also be made to describe my condition and progress and to discuss treatment.

I understand that I may revoke this *General Authorization* at any time by sending a written notice of revocation to the Untethered Therapy Group office where I am receiving counseling. I understand that any revocation of this *General Authorization* will not affect a disclosure that the Untethered Therapy Group has already made under this authorization. I understand that information used or disclosed under this *General Authorization* may be subject to re-disclosure by the recipient, and may no longer be protected by the Untethered Therapy Group confidentiality rules.

This authorization is only valid until _____ [*fill in date*], or until three months after my file is closed at the Untethered Therapy Group.

Client Signature	**Date**		
Client Signature	**Date**	**Witness**	**Date**
Parent/Guardian Signature (*if minor*)	**Date**	**Print Parent/Guardian Name** (*indicate relationship*)	

AUTHORIZED PERSONS and ENTITIES:		
Name	Address	(*Initial Here*)
Phone	Email	
Name	Address	(*Initial Here*)
Phone	Email	
Name	Address	(*Initial Here*)
Phone	Email	

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VIDEO TAPING CONSENT FORM

MentWell Inc., a Pennsylvania Nonprofit Corporation doing business as Untethered Therapy Group ("we," "us," or "Untethered Therapy Group") sometimes makes videotapes and audiotapes of clients and their families. These tapes can be used in different ways. For example, your therapist may use the tapes to (1) privately review the session for clearer understanding and to prepare for the next session; (2) to seek consultation or help with developing more effective treatment strategies; (3) to train other therapists in the models and techniques used here; (4) to obtain higher credentials of proficiency, such as certification, in the models and techniques used.

There are several things we would like you to be aware of concerning taping. First, the profession of marriage and family therapy has very clear and strict ethical standards concerning the confidentiality and protection of privacy. Consequently, Untethered Therapy Group has strict policies concerning the discussion of cases during individual and group consultation sessions. Your surname will not be associated with any of the recordings. Your case will not be discussed outside of the clinical settings. Only approved persons will be allowed to watch these tapes. All staff are prohibited from watching tapes of anyone they know even remotely. Second, all tapes will be stored at our offices under secure conditions. Furthermore, tape recordings will be used only for the purposes you mark below and are generally erased after four weeks unless special permission has been obtained from you. After any tape is made, I (We) can ask the therapist to see it and can ask the therapist to erase it and all copies of it. Lastly, only some parts of the tape(s) might be used.

I (WE) AGREE THAT THE TAPES MAY BE USED IN THE FOLLOWING WAYS:

- ☐ to be seen only by my therapist /doctor and his supervisor
- ☐ to seek consultation with other professionals
- ☐ to teach health care workers or other therapists in classes or professional meetings

Please list other restrictions: _____

I (WE) FURTHER AGREE AS FOLLOWS:

I (We) will not be paid for making this tape(s). I (We) release Untethered Therapy Group and the therapist from any claims of harm related to making or showing the tape(s). By signing below, I (we) acknowledge and agree that I (we) have read this whole form, have had a chance to ask questions about it, and fully understand what I am (we are) being asked to do. Furthermore, I (we) understand that I am (we are) free to refuse this request without it influencing my treatment. I (We) voluntarily consent to be videotaped.

Signature	Print Name	Date
Signature	Print Name	Date
Signature	Print Name	Date
Therapist	Print Name	Date