Bridger Psychiatric Services Counseling Services

Billie Stredwick, MA, LCPC, NCC

This document contains important information about the professional counseling services being offered, our office policies, and your rights and responsibilities as a client. Please read this document carefully and let us know if you have any questions or concerns.

Sessions: The initial visit is scheduled for 90 minutes, with each appointment after scheduled at 60-minutes. If you would like longer sessions, the price will be prorated according to the length of the appointment. If you arrive late for an appointment, please notify the office and the remaining time for your scheduled session will be available to you, once you arrive. If no notice has been given, an appointment will be considered a no-show after 15 minutes, and the counselor may no longer be available to see you.

If you need to cancel a scheduled counseling session, you must do so with at least 24-hours notice. If you do not cancel a scheduled appointment with 24-hour notice, a fee of $60.00 will be charged. If you fail to attend a scheduled session with no prior notice, you agree to pay the full fee for that session, unless it is agreed that the absence was due to uncontrollable circumstances.

Sessions that are left early will be billed for the time spent, with a minimum rate of $60.00. If submitting to insurance and unable to bill due to duration, you as the patient will be liable for this fee.

Insurance: It is your responsibility to contact your insurance company and verify your mental health benefits. We must have a copy of your current insurance card to process your claims correctly. You agree to keep our office informed of any changes to your insurance and recognize that failure to provide accurate and up-to-date information will result in financial liability for any expenses incurred.

Our counselor is in-network with Aetna, Allegiance, Cigna, Blue Cross Blue Shield, Medicare, Montana Medicaid, Mountain Health Co-Op, Pacific Source, and United HealthCare. Our office will not submit to any insurance that is considered out-of-network, though we are happy to provide you with the documents you may need to self-submit for reimbursement purposes. You are liable for all co-pays, deductibles, and other costs not covered by your insurance for any reason.

You are authorizing Bridger Psychiatric Services to contact your insurance company in reference to claims and to release any documentation required to process claims on your behalf.

Any disputes regarding payment by your insurance are solely the responsibility of the patient and are to be resolved between the patient and insurance company.

Professional Fees: Fees are listed on the Counseling Fees Document. In addition to regular sessions, it is policy to charge the counseling rate on a prorated basis for other professional services required. Other services include report writing, letter writing, telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals which have been authorized, preparation of records or treatment summaries, and time spent performing any other professional service.

Billing and Payments: You will be expected to pay co-pays, deductible balances, or session fees at each session unless other arrangements have been made. Payments may be made by cash, check, or credit card. If a check does not clear due to insufficient funds or for any other reason, you will be expected to reimburse any bank fees.

Failure to maintain a current balance may result in termination of services as well as collection activity. Our office will add a 30% fee for all accounts sent to a collection service, and you will be liable for this expense in addition to any fees accrued through the collections service.

Professional Records: Legal and ethical standards of the counseling profession require that records be retained for 7 years after time of service. You are entitled to have access to your records unless it is believed

that seeing them could be considered harmful, in which case you have the right to request they be sent to a mental health professional of your choosing for interpretation. We reserve the right to charge a $25.00 administrative fee and $0.50/page in addition to any shipping costs for any records.

Confidentiality: All communication between a client and mental health professional are protected under HIPAA and will remain private and confidential. Only information which you expressly authorize will be released to others, in which circumstance we will ask that you sign a form giving authorization to use and disclose protected health information. Such authorization may be revoked at any time. Exceptions to confidentiality exist in the following situations:

- Intent to commit suicide, homicide, or threat of imminent, serious harm to another individual
- Suspected abuse or neglect of children, elderly, or vulnerable adults
- Subpoenaed by a court of law
- Information required for a Public Health Investigation
- Requests from the FDA for product recalls
- Disclosures related to criminal investigations as mandated by law
- If you are a member of the military as required by armed forces services
- Release of information to your insurance carrier for Prior Authorizations, Pretreatment screening, and reimbursement on claims.

Other Client Rights: You agree that you understand the following:

- I have the right to request and receive confidential communication of my protected health information by alternative means or at alternative locations.
- I have the right to request that the counselor amend information in my record. I understand that I am required to make such requests in writing along with the reasons for the requested amendment. The client's request will be noted.
    - Any amendments considered must accurately reflect actual services provided and billed, to do otherwise would be considered fraudulent.
- I understand that I generally have the right to receive an accounting of any disclosures the counselor has made of protected health information, which did not require client authorization.
- I understand that my counselor may use or disclose my health information for treatment purposes including presentation of my case in consultation with other professionals or consultants who are bound by the legal framework of privacy and confidentiality for professional development and guidance purposes.
- I understand that my counselor may use or disclose my health information for the purpose of payment and health care operations including internal administration, participating in periodic file review, and normal business accounting procedures.

Contacting Billie: Billie has office hours Monday through Thursday and can be reached at the clinic between 8:00am and 5:00pm. Because she does not take calls during her sessions, she may not be immediately available by telephone. A confidential voicemail may be left in our general clinic voicemail at (406) 586-5511. Every effort will be made to return calls within 24 business hours, more promptly if possible

For emergency services call the Help Center at (406) 586-3333 or go to the local emergency room.

Telehealth: The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. By agreeing to use these telehealth/telemedicine services, I understand, agree, and expressly consent to BPS obtaining, using, storing, and disseminating information about me, to nay necessary third parties in order to provide the telehealth/telemedicine services and for billing purposes.

I understand that if I am utilizing insurance to cover telehealth/telemedicine services that the telehealth/telemedicine services may not be covered by my insurance plan, and it is my responsibility to look into my insurance coverage guidelines. I understand that I am financially liable for any outstanding balances not covered by my insurance.

I understand that when agreeing to telehealth/telemedicine services **I am required to do so within a quiet and confidential space with secure and reliable service connection**. If I am unable to do so, services

may not be completed at that time and there may be associated fees. I understand that this is to protect my privacy and to create an optimal space for effective treatment.

Changes to Services or Fees: Billie reserves the right to change the policies, practices, procedures, and fees described in this document. You will be notified within 30 days of any such change.

Conduct: Maintaining a safe environment for our clients and staff is very important to us. Please let us know immediately if you have any concerns for your safety while at our office.

You agree to conduct yourself in a kind and courteous manner and understand that if you engage in verbal, written, or physical behavior that is threatening to a counselor, the counselor's family, or any other persons affiliated with Bridger Psychiatric Services, we reserve the right to terminate or refuse services, and if actions are severe enough to make a formal report using your identifying information with the local police.

By signing this contract you are stating that you have received and read the information above and that you agree to abide by the terms set forth. You may request a copy of this document at any time.

_____	_____	_____
Client Name	Client Signature	Date
Billie Jo Stredwick, MA, LCPC, NCC	_____	_____
Counselor Name	Counselor Signature	Date