better options counseling

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Disclosure Statement and Informed Consent to Treatment

Your Rights and Responsibilities as a Better Options Counseling (BOC) Client

Therapy works best when it is a collaborative effort between the clinician, client, and client members, and when the rights and responsibilities of each person is well defined. As a client, you have certain rights and responsibilities that you should be aware of since this is your child's therapy. Our goal is the well-being of you and your child. There are certain limitations to those rights that you should be familiar with. As a clinician, I also have responsibilities to you.

My Responsibilities to You as Your Clinician

Confidentiality: I am committed to keeping complete confidentiality of your therapy with the exception of the following instances described below. I cannot and will not tell anyone about whatever you tell me in therapy, or even the fact that you are in therapy with me without your prior written consent. It will be my responsibility to always act in a way as to protect your privacy, even when you allow me to share information about you with someone else. You can allow me to share information about you with whomever you want, and you can change your mind and revoke that permission whenever you want.

The following are exceptions to your right to confidentiality. I will let you know whenever I have to act on those exceptions.

1. If I find out that you have intention of harming someone, I will try to inform that person and warn them of your intentions. I will also contact the police and ask them to protect your intended victim.
2. If I have reason to believe that you are abusing a child or a vulnerable individual, or if you let me know of anyone else that is doing so, I will inform Child Protective Services or the police within 48 hours.
3. If I believe that you intend to harm yourself or are in danger of hurting yourself, I will call the police, crisis team, or someone that can ensure your safety. I will discuss my decision with you and we will explore your options before I decide what must be done.
4. I may use and disclose your information in order to bill and collect payment for the services that you are receiving from me. I may also use your information to obtain payment from third parties that may have been identified by you as responsible for your bill.
5. Please be advised that even though we make every effort to protect your information when using electronic communication such as e-mail, computer, cell phone, or fax, I cannot guarantee that there will not be any interception of it by someone else.
6. If you are filing a complaint or are a plaintiff in a lawsuit where your health information is needed, you will already have waived your right to the confidentiality of your records in the context of the complaint or lawsuit. Even though that might be the case, I will make every effort not to release your records unless you authorize me to do so. Please be aware that I may not always be able to do so.

Your Rights as an BOC Client

1. You and your child have the right to ask questions about anything that happens in therapy. I will always be willing to discuss how and why I have decided to do what I am doing and look at different alternatives that might work better. You are welcome to let me know of an approach that you think will be helpful. Keep in mind that we are certified to practice only within our scope of training, that is, Applied Behavior Analysis. You can ask me about my training and to transfer you to someone else if you are not comfortable with me. You are free to leave therapy at any time.
2. You have the right and responsibility to let me know if you are not in agreement with my treatment plan. At any time during therapy, you are encouraged to let me know if there is anything that you don't like or feel comfortable with, and if there is something else that you would like. Your input, no matter what it is, is very important to me.

3. You have the right to confidentiality and safe treatment. You have the right to be treated with respect and dignity.

Your Responsibilities as an BOC Client

1. You are responsible for coming to therapy on time and at the time that we have scheduled for you. If you are late, we will end on time and not run over into the next person's session. If you miss a session or cancel it with less than 24 hours, you will be charged a no-show fee of $50.00. Most places charge you for the price of the whole session. We choose to charge you only $50.00 but warn you that this fee will apply even in cases of emergency. All cancelations must be made within a 24-hour period for appointments Tuesday through Saturday. Appointments on Monday must be cancelled by 5:00 PM the Friday prior. This fee will be charged to the client or parent only and not the insurance company or the bishop. Payment will be immediately charged out of your credit card when possible or by the time of your next session. Medicaid clients are not responsible for payment of services; however, they are still required to pay the no show/late cancellation fee.

2. You are responsible for supervising your children at all times while in the office until therapy starts. Please bring an adult with you to watch your children if you are going to be in a training session that is scheduled outside of the designated client session. When waiting for therapy with your children, please be aware that they should not jump up and down or run around the office since we have other therapists providing therapy and this would be disruptive to our clients in the office.

3. You are responsible for paying for your session or your child's session at the beginning of each session unless we have made other arrangements in advance. BOC fee is $50.00 per 15 min for the initial behavioral assessment, reassessment/reauthorization (every 6 months), $40.00 per 15-minute per direct care session, and $50 per 15-min for treatment procedures modification (i.e., BCBA supervision). If your account becomes past due, and collection becomes necessary, I will give your name and the amount due to a collection agency. In this case, you will be responsible for payment of an additional 33.3% collection fee and all legal collection fees, with or without suit, including attorney fees and court fees. When requested, we can assist in billing for insurance or authorized payment from your bishop or other sources. You should be aware that insurance companies require diagnostic labels and in cases where your diagnosis is not payable by your insurance, you will be responsible for the payment. Furthermore, some insurances require that you contact them for pre-authorization. It is your responsibility to obtain approval from your insurance and keep track of the number of authorized sessions. If services are provided to you without insurance approval, you will be responsible for payment.

Complaints:
If there is anything that you are not satisfied with in your therapy, I would hope that you can talk to me about it. I will take your criticism very seriously and with care and respect. If you don't feel comfortable talking to me about it, you can contact Vittawat Sriphong-Ngarm, our ABA Program Director or Roselene Dalanhese, our Clinical Director. We will be happy to assist you in finding another therapist that might be a better fit for you or addressing your concerns.

Client Consent to BOC:
I have read this statement. I had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I consent to the use of a diagnosis in billing, and to the release of that information to my insurance company if I request so. I agree to pay the amount described in this statement at the beginning of each session. I agree to have my credit card billed for any no-show fees for sessions which I have not given a 24-hour prior notice cancelation and for any outstanding unpaid balance by my insurance. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me.

I agree to undertake therapy with _____

Print Client's name:_____

Parent/Guardian Signature (if client is a minor):_____ Date: _____

Clinician Signature:_____ Date: _____