JOHNSON BEHAVIORAL SERVICES PLLC

Effective Date: *12/1/2023* **Consent to Treatment and Client Agreement**

Thank you for taking an interest in my practice. This document contains important information about my professional services and business policies. It includes the obligations of the therapist and also some expectations of you as the client. It is important that you read it carefully and ask any questions you might have so we can discuss them during our next scheduled meeting. When you sign this document, our HIPAA Privacy Notice, and other related documents, it will, together, represent the agreement between you and my practice and ensures that you understand our professional relationship. You may revoke this Agreement in writing at any time. Please initial each page of the document after reading each page and keep a copy for your records.

SERVICES, PROFESSIONAL RELATIONSHIP, LIMITATIONS AND RISKS

My Qualifications:
I am licensed psychological associate who specializes in working with children and adolescents who exhibit problem behaviors. I received my Master's in Clinical Psychology with a specialization in Applied Behavior Analysis from East Carolina University in 2008. In addition to being licensed in the state of North Carolina as a Master's level psychologist, I am also a board certified behavior analyst (BCBA). My primary training and experience has been in applied behavior analysis, which is a unique method of treatment grounded in the idea that behavior is learned over time and it is maintained by consequences in the environment.

Treatment Approach:
My practice focuses primarily on promoting functional language development and minimizing problem behavior. In my therapeutic approach, I believe that behaviors are learned and focus on identifying consequences in the environment that maintain problem behavior. I develop very specific definitions of behaviors I want to increase or decrease and I will frequently ask your input as to "what the behavior looks like?" With your input, I can help you determine what is maintaining a behavior, teach you to change the environment to prevent behaviors, teach more appropriate replacement behaviors, and then develop a plan to teach those behaviors. I can also develop a plan to help you improve your skills in working with the client Some of the time I will be working with the client directly and at other times I may be training significant others.

Working with clients individually is more effective when parents and family partner with the client and therapist in the therapeutic process. I write specific goals that address your priorities communicated at the onset of and throughout services. I will also write goals that I believe are clinically necessary to address the needs of the client. If data indicates a specific intervention is not effective, I will communicate this directly to you and develop a more effective intervention. The treatment plan is a fluid document and I will explain my assessment and the results of my assessment in language you can understand.

Risks/Benefits:
As with any therapy, there are risks and benefits and it is impossible to guarantee any specific results or timeline regarding treatment results. With treatment, it is important to know the client's behaviors may sometimes worsen before behaviors improve. However, therapy has many potential benefits, including minimizing maladaptive behaviors, increasing functional communication skills and replacement behaviors, and improving your skills in interacting with your child. At any point, if you have questions about my procedures, we should discuss them whenever they arise. I will work with you to insure your family receives the best quality services possible, including helping you locate another professional for a second opinion or treatment, if so desired.

Code of Conduct:
I am governed by various laws and regulations and by the code of ethics of my profession. As a professional, I will use my knowledge and skills within my scope of practice to help you as best I can. I am required to adhere to The American Psychological Association's *(APA) Ethical Principles of Psychologists and Code of Conduct* ® and the *Guidelines for Responsible Conduct* of the Behavior Analyst Certification Board®.

Termination:
Please know that you are not obligated to seek services with me and you have the right to terminate services at any time. If it is determined that you wish to terminate services, I will provide you with a list of appropriate resources for other professionals/services. There may also be reason for me to terminate services as well. The

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reasons I may terminate a therapeutic relationship would include a failure to meet the terms of our fee agreement, a need for services outside of my scope of practice, or if I believe my consultation has become non-productive (i.e. people who interact with the client are engaging in behaviors that are counterproductive to the treatment plan) Should any of these situations arise, the reason for termination will be discussed with you and I will assist you in making alternative plans for care, including providing referral information.

CLIENT RESPONSIBILITIES

Treatment Plan:
I will develop and review the treatment plan with you and ask that you sign the plan indicating that you understand and agree to the plan. Consistency is the most crucial component of my therapy and inconsistencies may adversely affect the client's progress. If at any point in time it is determined that you or others who come into contact with the client are engaging in behaviors that are counterproductive to the treatment plan, I will discuss this with you directly. I can only work with clients who fully communicate their needs and concerns regarding treatment. I will be asking a lot of questions and will develop intervention strategies based upon information gathered from direct observation of the client and indirectly from your responses. My interventions will be data driven and I will be showing you data as part of my ongoing evaluation of treatment.

Progress Monitoring:
One of the most unique aspects of my treatment is that decisions are made based on objective data during the course of therapy. I will take baseline data to first determine the nature and extent of the target behaviors. Following direct observation and data collection, I will develop and continue to collect data to determine if it is effective. I will show you this data and will make changes in treatment based on this data. I will also request that you, family members, or other individuals who come in contact with the client collect a variety of data during the course of therapy.

Supervision Policy
For services rendered in the home, I request that you be present in the home for the duration of the session. Please note that I am not able to provide any supplements and/or medications directly to the client or transport the client.

Dual Relationships:
Under my code of ethical conduct, I have an ethical responsibility not to develop personal friendships with clients or your immediate family members during the course of therapy. Although our relationship involves very personal interactions and discussions, I need you to understand that we have a professional relationship rather than a social one. I make every effort to avoid outing you as one of my clients. Thus, if we happen to encounter each other in a social setting, I will not approach you or initiate contact unless you initiate contact first. Moreover, even if you initiate contact, I may limit any contact initiated by you. My behavior is not intended to be personal; rather, my behavior is intended to protect your confidentiality. It is not appropriate for me to communicate via social media, accept gifts or meals, or be involved with your personal activities such as birthday parties, or family outings. In addition to personal relationships, my services are intended to treat the client and provide family training, as appropriate. Although family members are often actively involved in therapy, I can only provide recommendations that are relevant to the needs of the client. I will not conduct individual therapy with any family members regarding issues that are not relevant to the client's care; however, I will make appropriate referrals and/or provide you with resources that may best meet your specific needs. If a potentially consuming, harmful or inappropriate relationship is arising or has arisen, I will take reasonable steps to resolve it with due regards for the best interest of the client and maximal compliance with my ethics code.

APPOINTMENTS, FEES AND EMERGENCIES

Missed Appointments/Cancellation
I expect that if you need to cancel or reschedule your appointment that you will call as soon as you are aware of the change. Please ensure that you give at least 24 hour- notice if your child exhibits any of the following (includes, but is not limited to, a fever at or above 100, vomiting, sinus infection or flu-like symptoms, viral infections, pink eye, lice, strep throat). Insurance carriers will not pay for missed appointments or late cancellations. You can leave a voice message. Please do not email cancellations. If I do not receive 24-hour notification of your cancellation or you fail to show for an appointment, then you will be charged a $50

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cancellation fee for the appointment. I understand that emergency situations arise, on both ends (provider and parents), and these situations will be handled on a case-by-case basis.

Fees:
The current fee for my services is $150for the intake and $ 135 per hour for family/individual therapy and ABA therapy. This includes direct therapy with the client, observations, family training, planning, writing, and preparing reports, and attending meetings. Please see the financial policy for additional information regarding fees and payment. If you are receiving services via a third party I have prior arrangements with, you will be required to pay your copay deductible, or co-insurance at the time of service. If you are private pay or insured by a plan that I do not have a prior arrangement with ("out of network"), you will be responsible for the complete charge at the time of service. I require payment be made at the time of services For payment plans previously set up, payments on invoices are expected within thirty days or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. In most collections situations, the only information I release regarding a patient is his/her name, the nature of services provided, and the amount owed.

Health Insurance:
If you are receiving services via a third party, my services may or may not reimbursable within your benefits. You will need to verify this with your insurance carrier. I will assist you by submitting claims electronically for each visit. You will be required to pay your copay, deductible, or co-insurance at the time of service. If you are insured by a plan that I do not have a prior arrangement with, I will provide you with a detailed statement that you may submit to your insurance to obtain out-of-network reimbursement. However, you, and not your health insurance carrier, are responsible for full payment of my fees (with the exception of clients with approved sessions by accepted insurance companies and in some single case agreements). You are responsible for services not covered by the insurance carrier, including, but not limited to, copayments, coinsurance, and uncovered or ineligible services, as well as all charges for services provided over the maximum allowable benefit for the calendar year. If the client's insurance company denies payment, you are responsible for payment. Clients who change insurance companies must notify the therapist immediately. There are some companies that provide specific coverage for ABA; however, they often require an authorization through specific carriers and the establishment of an agreement between the provider and the carrier. Please be aware that insurance companies require a formal diagnosis with their claims. Please know that disclosure of confidential information may be required by your carrier in order to process the claims. By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposes of treatment and payment.

PROFESSIONAL RECORDS

All complete records will remain on file for a minimum of seven years after the last contact with the client and, if the client is a minor, the records will be maintained until three years after the age of majority. You can request these records at any time. You may also be charged a fee for any preparation time which is required to comply with an information request.

INFORMED CONSENT FOR COMPUTER, TELEPHONE, ELECTRONIC, AND MAIL CONTACT

It is important to note many of the tools of modern communication may compromise confidentiality, such as computers, cell phones, email, portable phones, and faxes. I do use these forms of communication, but make every reasonable effort to protect your privacy. My computer is encrypted with a password and virus protection; however, ordinary privacy precautions such as passwords, pin codes, voice mail boxes, mail, and secured computers are not full-proof, so your confidentiality may be compromised when communicating via electronic devices or mail. Your use of such means of communication with me constitutes implied consent for reciprocal use of electronic or mail communications as well. I will make every effort to return your email within

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48 business hours; however, I cannot guarantee a response time period due to time constraints of the practice. E-mail communication should never be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. If you have an urgent matter please call me directly, or call 911 or the mental health center emergency room (704-358-2700). In addition, you should be aware that any e-mail communications may be made part of your permanent medical record. Signing this document indicates that you accept and understand the following inherent privacy risks involved:

1. Sent and received emails are stored on both my and your computers until deleted. There is no guarantee that I will save or delete such email communication. Any saved emails are kept in a password-protected account that only I have access to.
2. Whenever communicating via email, it possible for authorities and system administrators to locate and reach such emails under various circumstances. This is due to the nature in which email is transmitted using the internet and other services/networks.
3. You understand that I may use and disclose PHI to contact me via phone or email regarding appointment reminders and health related benefits (i.e. if you are not home to receive a phone call, a message may be left on your answering machine or with a person in your household.)
4. By singing this document, you understand and agree the disclosures listed above regarding communication with me via email, phone, fax, and mail.

Print Name: _____ Signature_____ Date: _____

Print your email: _____

CHANGES TO NOTICE/POLICIES:

I reserve the right to change this notice and make the new notice apply to Health Information I already have, as well as any information I receive in the future. From time to time, I may also change the business policies described in this document. I will make every attempt to inform you of relevant changes. I will post a copy of my current privacy notice at my office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe that I may have violated your individual privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint (in writing) to me. If you prefer, you may file your written complaint with the Secretary of the Department of Health and Human Services at (919) 855-4800 (See Grievance Policy for additional information.)You will not be penalized for filing a complaint.

PHOTO/VIDEOTAPE CONSENT AND RELEASE:

I grant Johnson Behavioral Services, the full right to use my child's photographs, videotaped images, and sound recordings as a part of staff/family training, educational seminars, and promotional efforts. I understand that they may be used for educational/promotional purposes.

YES ☐ NO ☐ Initials: _____

Initials: _____

JOHNSON BEHAVIORAL SERVICES PLLC

Your signature below indicates that you have the read the information is this consent to treatment document and agree to abide by its terms during our professional relationship. This document is for your records. Please sign the attached form on your behalf and on behalf of the patient, indicating you have read, understand, and have had the opportunity to ask questions regarding the information in this document.

On behalf of yourself:

_____	_____	_____
Print Name (Parent/Legal Guardian) (1)	Signature (Parent/Legal Guardian) (1)	Date
_____	_____	_____
Print Name (Parent/Legal Guardian) (2)	Signature (Parent/Legal Guardian) (2)	Date

On behalf of the patient:

_____	_____	_____
Print Name (Parent/Legal Guardian) (1)	Signature (Parent/Legal Guardian) (1)	Date
_____	_____	_____
Print Name (Parent/Legal Guardian) (2)	Signature (Parent/Legal Guardian) (2)	Date

_____	_____
Signature (Psychologist/BCBA)	Date

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