Courtney Torgerson LCPC
690 Nth Meridian Suite 111
Kalispell, MT 59901
14 E Second Street Suite 10
Whitefish, MT 59937
4062706988

# SERVICES AGREEMENT

Thank you for choosing Courtney Torgerson LCPC for your mental health care. I appreciates the opportunity to provide you with professional services, including mental health evaluation, treatment planning and psychotherapy for your mental health needs. At all times it is important that you have a clear understanding of why you are receiving services, and how we are attempting to assist you in your mental health care. If you are uncertain about this, you are encouraged to ask for clarification.

This Services Agreement explains the office policies, procedures, and practices. Please read it carefully and let me know if you have any questions. At the end of this handout, you are asked to sign it, indicating that you have read, understand and accept this agreement and the other documents that I have collected from you for the intake process. Although it might seem like a lot of information, it is very important that you read this and any other handouts included so we can discuss questions you might have.

You can revoke this Services Agreement in writing at any time. Generally, I will consider your written revocation request as binding except in a few circumstances. These are (1) if I have taken action in reliance on the agreement and (2) you have not satisfied financial obligations you have incurred with Courtney Torgerson LCPC.

I as a practitioner reserves the right to change the practices described or terms of this Services Agreement at any time. If changed, you may receive the new Services Agreement by calling and asking for it or by visiting my office to pick one up. An electronic version can be sent upon request.

**Patient's Rights**

• You have the right to refuse treatment.• You have the right to change practitioners or receive referral to another practitioner.• You have the right and responsibility to choose a practitioner that best suits your needs.• You have the right to confidentiality. There are exceptions for the reporting of abuse as required by law, dangerousness to self or others, or grave disability. Please see the "Notice of Privacy Practices" ("NPP").• You

have the right to raise questions about my therapeutic approach or your progress at any time.

## MENTAL HEALTH SERVICES

Courtney Torgerson LCPC, has provided you with information about the Health Insurance Portability and Accountability Act ("HIPAA"). This is a federal law that provides you with certain rights and protections for your Protected Health Information ("PHI"). It is important for you to know how your health information can be disclosed or used for the purpose of treatment, payment, and health care operations. I have also provided you with a separate form, which tells you, more about your privacy rights. That form explains in detail what HIPAA is and how it applies to your health information.

## PAYMENT POLICIES AND FEES

Payment in full is due at the time of service unless other arrangements have been made with Courtney Torgerson LCPC or Carrie Schneider, Medical Billing Specialists, ahead of time, or, if Courtney Torgerson LCPC is contracted with your insurance company, your co-payment or co-insurance is due at the time of service as specified by your plan. If I am not contracted with your insurance company, please pay at time of service and Courtney Torgerson LCPC or her biller will give you a receipt that you may use to file a claim for reimbursement.

Carrie Schneider Medical Billing Specialist, is my billing service provider and can be contacted to answer your billing questions and concerns at kobschneider@yahoo.com. Carrie Schneider keeps regular business hours Monday through Friday and it may take up to a week for her to get back to you. Carrie Schneider contact information consulting406@gmail.com. Phone: 406-300-1952

At any time. You may contact Carrie Schneider to make payments or with Courtney Torgerson LCPC in person or over the phone. Credit card numbers can be retained on file with Courtney Torgerson LCPC, Carrie Schneider, Medical Billing Specialist, does not retain credit card information it is encrypted though square.

If you are a Core Client your billing will go through CORE health coordinator.

**The following insurance carriers are accepted as in-network:**

Please contact your insurance carrier to see if outpatient mental health benefits are covered. On your initial visit please make sure to bring your insurance card and state issued ID. All contracted insurance companies are billed directly as a courtesy. Any remaining balance for non-covered benefits and deductibles are your responsibility. By

paying with insurance, you are authorizing Courtney Torgerson to release information required to process your insurance claims and also authorizing your insurance to directly pay Courtney Torgerson. Courtney Torgerson accepts payments via check, cash, credit cards (Visa, MasterCard, Discover, Apple/Android/Samsung Pay (and other NFC mobile / contactless payments), and EMV chip cards.

**Fee Schedule**

Initial psychosocial evaluation - $210

Psychotherapy session 30 minutes-75

Psychotherapy session 45 minutes 120

Psychotherapy session 60 minute- 150

Family therapy-150.00

Co-parenting-150.00

Co-parenting session/hardship/ sliding scale- see Courtney Torgerson For details.

Collateral contact 15 min increments-140/hour

Court testifying, prep or meeting with attorneys-250/hour minimum of 3 hours

**Core Health Care Mental Health Provider**

Fee included in premium (initial meeting, therapy session determine at the beginning of treatment (15 to 30 min), no couples or family unless all parties are CORE clients and it is deemed necessary by mental health provider.

Additional services unless otherwise agreed upon by mental health provider will be billed at fee schedules listed above

There will be a $25 charge for checks returned due to non-sufficient funds (NSF), closed accounts, etc.

Telephone calls in excess of five to ten minutes will be charged on a pro-rated basis. Insurance companies do not necessarily reimburse for telephone calls.

For those not utilizing insurance, payment is due at the time of your appointment. If Courtney Torgerson LCPC is billing insurance and you are certain you have remaining benefits, only your copayment is due at the time of your appointment. Once insurance

claims have been processed, a monthly bill will be sent out that will inform you of any balance due. It can take up to 60 days for insurance claims to be processed. If your account remains delinquent for 120 days or more, Courtney Torgerson reserves the right to discontinue services until full payment is received and/or refer the account to a collection agency.

Insurance reimbursement is a contract between you and your insurance carrier. Courtney Torgerson LCPC and Carrie Schneider, medical billing specialist, cannot accept responsibility for collecting on a disputed insurance claim. **You** are ultimately responsible for full payment on your account.

**Out of Network Insurance Carrier Reimbursement**

Your insurance carrier may reimburse you for payments even though Courtney Torgerson LCPC is considered an "out of network" provider. If you wish to seek reimbursement from your insurance carrier Courtney Torgerson LCPC can provide you with a signed receipt for services, which contains what would reasonably be expected to be the information necessary for your insurance carrier to process your reimbursement. Patients are responsible for the disclosure of the information contained on such a receipt and for completing any relevant insurance claim form, submitting such claim, and directly seeking reimbursement from their insurance carrier. Courtney Torgerson LCPC is not able to bill Medicare.

## CANCELLATION POLICY

Less than 24 hours notice of a cancellation or not showing for a scheduled appointment will result in being charged a fee no more than the full rate for the time reserved. Insurance companies do not reimburse for missed appointments.

## LENGTH AND FREQUENCY OF APPOINTMENTS, LATE POLICY

It is necessary to start and end on time. I will do all that is possible to keep appointments on schedule. In the event that you are late for an appointment, please note that we may not be able to run over your scheduled time. Meetings may be once a week or less frequently depending on your individual needs. The frequency of these appointments is determined by the individual’s response to therapy and the level of symptoms. When an individual is stable and in a stable environment, we may meet every other week or on an as needed. This based on provider’s professional recommendation on a case-by-case basis.

## EMERGENCIES

Emergencies may arise from time to time. Courtney Torgerson's voicemail has instructions on how to seek help if it is a life threatening situation please call 911 or go to your closest emergency room. If this is a medical emergency call 911 immediately or go to the nearest hospital Emergency Room. In my absence, I will leave the phone number of a colleague on my voice mail.

## TREATMENT APPROACH

The first appointment is an opportunity for us to evaluate if we will continue a working relationship. Neither of us is under any obligation to do so. If I feel that we will not be able to work together effectively or if you would prefer not to continue in treatment, I will do my best to refer you to other qualified professionals.

Treatment is generally terminated when we mutually agree that sufficient progress has been made towards your goals. You are under no obligation to continue treatment if you are dissatisfied or do not feel your treatment is effective. If you feel that you would like to work with another provider for any reason, please let me know and I will be glad to refer you to another clinician who can assume care for you. If in the course of treatment, it becomes clear that another clinician would be more professionally suited to treat your specific needs, then I may discontinue treatment and give you referrals to other clinicians. If I conclude I am not able to provide the care an individual needs, I will give you the names of other mental health clinicians qualified to provide treatment for you. You have the right to refuse any recommendations or referrals I may make. I may legally find it appropriate to terminate therapy if it appears your refusal of recommendations may endanger the health of you or others. Please feel free to discuss any concerns you have about terminating treatment.

## PROFESSIONAL RECORDS

Courtney Torgerson LCPC keeps a record of the health care services provided to you. You may ask to see and copy that record. You may also ask to correct that record. The content of all therapy sessions and your medical records are confidential. Your medical record may contain information regarding HIV/AIDS, substance abuse, mental health, sexually transmitted diseases, or other sensitive information. Courtney Torgerson LCPC will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. If patient information is transferred or stored electronically, it will be encrypted to protect privacy. Patient records will be kept in a locked filing cabinet when not in use, or in an electronic health record (EHR) system. Courtney Torgerson LCPC is required by law to report any breach of PHI.

What is a Breach? The HITECH Act added a requirement to HIPAA that medical providers must give notice to patients and to the U.S. Department of Health and Human Services (HHS) if they discover that “unsecured” PHI has been breached. A “breach” is defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule. Examples of a breach include: stolen or improperly accessed PHI; PHI inadvertently sent to the wrong provider; and unauthorized viewing of PHI by an employee of Courtney Torgerson LCPC . PHI is “unsecured” if it is not encrypted to government standards. When Mental Bliss becomes aware of or suspects a breach, Courtney Torgerson will conduct a Risk Assessment. Mental Bliss will keep a written record of that Risk Assessment. Unless Courtney Torgerson determines that there is a low probability that PHI has been compromised, Mental Bliss will give notice of the breach. After any breach, particularly one that requires notice Courtney Torgerson will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

Although your health care records in our office are our physical property, the information belongs to you. You may request access to your medical record file, billing records, and other records used to make decisions about your treatment and payment for your treatment. You can read your records, and if you want a copy we can make one for you (but we may charge you for the costs of copying and mailing, if you want it mailed to you).

Under limited circumstances, Courtney Torgerson reserves the right to deny you access to a portion of your records. If you want to access your records, you provide a written record request to the Office address above. If you request copies, you may be charged for the reasonable cost of the copy. Courtney Torgerson LCPC will also charge you for postage costs, if you request that copies be mailed to you.

## INTERNET CONFIDENTIALITY

The Internet is not a totally secure medium for purposes of transmitting confidential information. Psychiatric advice will not normally be provided via the Internet, and any inquiry or contact with my office via the Internet should not be considered a substitute for telephonic, written, or in-person communication. Patient realizes and agrees that he/she may be compromising confidentiality if he/she uses such means of communication. Patients with psychiatric inquiries are requested to contact my office in person, by telephone, in writing, or secure messaging. If you are a patient, because you have chosen to communicate PHI by e-mail, you are consenting to associated e-mail risks. Again, please note that e-mail is not secure and Courtney Torgerson cannot

guarantee that information transmitted will remain confidential. Please do not send personal or confidential information over e-mails.

Courtney Torgerson offers a secure, an easy-to- use Internet service that provides you quick and secure online access to your clinic health information, scheduling, appointment reminders, and secure online messaging from anywhere at any time.

Service agreement updated and revised: March 1, 2020

## CREDENTIALS AND LICENSES

I am licensed by the State of Montana and the State of Idaho as a Licensed Clinical Professional Counselor (LCPC)). I hold a Master Degree in Art therapy from Marylhurst University in Marylhurst Oregon and have completed many hours of supervision, continuing education and training in Eye Movement Desensitization and Reprocessing.

If you have any questions or concerns about your treatment please discuss them with me so that I can

Service agreement updated and revised: March 1 2020

**Patient Name:** ________________________________ Printed name of patient

## AGREEMENT TO PARTICIPATE IN SERVICES AND CONSENT FOR CARE

Disclosure law requires Courtney Torgerson LCPC, to obtain your signature acknowledging that you were provided with this information. Your signature below indicates that you have read or listened to the information in this Services Agreement and in the accompanying handouts, that you understand it and agree to abide by its terms during your professional relationship with Courtney Torgerson LCPC. It also serves as an acknowledgment that you have received and read or listened to the Notice of Privacy Practices form and the current fee schedule. If you have any questions, please feel free to discuss them with me before signing this Services Agreement. These policies may be updated at any time.

I hereby authorize Courtney Torgerson LCPC to provide mental health services including the evaluation, treatment, or providing consultation to myself or the above-named person.

I authorize Courtney Torgerson LCPC and Carrie Schneider to release any information required to process my insurance claims. I understand that my medical record may

contain information regarding HIV/AIDS, substance abuse, mental health, sexually transmitted diseases, sickle cell anemia, or other sensitive information. I also authorize my insurance to directly pay Courtney Torgerson LCPC.     Your signature indicates you accept responsibility for payment of fees in accordance with these terms and conditions.

An electronic copy of this agreement may be substituted for and will be legally binding as the original agreement. This agreement constitutes informed consent without exception.

Patient/Parent/Guardian signature ___________________________________ Date ________________

Printed name if signed on behalf of patient______________________________Relationship _____________

Adolescent signature (if 13 years or older) ____________________________________

____________________________________ ________________ Courtney Torgerson LCPC

**This page will be retained in your medical record.**

Date ________________

## Informed Consent & Access Agreement for Electronic Communication,

**Patient Name: ________________________________ Date of Birth: _____________**

**E-mail address: ___________________________________________________________________________**

FOR ALL MEDICAL EMERGENCIES, IMMEDIATELY DIAL 911.

## Consent to the use of electronic communication through email or test messaging.

**Email: address to use:_______________________________________**

**Text messaging phone number to use:________________**

**Note to clients:** While this is a voluntary consent to communication through text messaging and email, there are inherent confidentiality risks in communicating via email or text messages. While safeguards are in place to ensure privacy. You should not use email and/or text messaging communication if you are concerned about any breaches of privacy that might inadvertently occur.

Courtney Torgerson LCPC
Wellness Resource Center
725 Sixth Ave East, Suite #8
Kalispell, MT 59901
4062706988

Carrie Schneider, Medical Billing Specialist.
Email: consulting406@gmail.com
Phone: 406-300-1952

Service agreement updated and revised: March 1 2020

## Demographic Information

Legal Name of Client ______________________________________________________________________
First Middle Last

Date of Birth__________Age:____________Sex:______Race:_____

Social Security Number:______________________

Parent or Guardian name:_____________________________________________

Mother's Name:_________________________Father's name____________________

Present Address_____________________________________________________________________________
Street City State Zip

Present Address_____________________________________________________________________________
Street City State Zip

Home Telephone:________________ Cell:________________Work:____________

Guarantor Name:_______________SS#____________________DOB:___________

Legal Guardian's Name: ________________ Relationship;__________________

School Attending: ____________________________________________

List any other school previously attended:______________________________

Who referred you for services:_________________________________

Other Services Involved:_________________________________________

**Emergency Contact:**

__________________________________________________________________________________
Name Relationship Telephone Number

__________________________________________________________________________________
Name Relationship Telephone Number

**Insurance Information**

Name of Insured:___________________Relationship of Client________________

Address:___________________________________ Zip:____________________

Phone:_(H)________________(W)______________________(C)______________

Social Security Number:_________________Employer:______________________

Insurance:___________________________________Address:_______________

Group or member no:_______________________ Phone:____________________

## Acknowledgment of Limits of Confidentiality, Mandated Reporter Status and Notice of Privacy

I, the undersigned, understand that my therapist, Courtney Torgerson, LCPC, is a mandated reporter under the Abused and Neglected Child Reporting Act. This means she is required by law to report or cause a report to be made to the Child Abuse Hotline whenever there is reasonable cause to suspect a child known to her in a professional capacity, may have been or is being abused or neglected. This pertains to any suspected abuse, past or present, to a minor under the age of 18 years.

I further understand Courtney Torgerson is also obligated to break my confidentiality in the event I threaten harm to myself or others. Under the Duty to Warn Act, I understand that the law enforcement and the alleged victim(s) will be informed if I threaten to harm another person or persons. I further understand I may be voluntarily or involuntarily hospitalized in a psychiatric facility should I threaten to harm myself or others with reasonable intent.

I understand, with the exception of the above, no information regarding my involvement in services with Courtney Torgerson shall be released to any third party without my written consent and I have the right to inspect and/or obtain copies of my file information and/or any information released on my behalf. I understand there may be a change in the event copies need to be made on my behalf of file information. I have the right to revoke any signed release with the understanding it may hinder my treatment and will not effect information which has already been disclosed prior to revoking.

Information released to insurance companies for billing purposes shall be limited to identification of the client and the insured, date of service and diagnostic criteria as specified by MT CPT diagnosis for mental health. In the event additional information is requested by an insurance company or third party, I understand I will be informed of the request and information will only be released per my written consent.

I understand my client file will be kept in confidential and/or locked location and only Courtney Torgerson shall have access to the files. I understand that files and/or client information is not transmitted electronically from Courtney Torgerson's office, with the exception of billing information to insurance companies. I further understand that upon discharge, my files will be kept for a minimum of six years and/or until minor clients turn 18.

I understand Courtney Torgerson will only contact me by the phone numbers and/or mailing address for which I provide and she will not discuss my case, including the scheduling of appointments, etc. with any other household member or other parties without my prior consent.

I understand that Courtney Torgerson uses a billing service to manage payments and billing my information will be given to my billing service provider and that billing service provider may contact me for payments or updated information.

However, regarding payment of fee, it is my understanding my right to confidentiality regarding my name, address, employment information and phone number will be waived should Courtney Torgerson need to implement an out of office collection process due to nonpayment of fees. The collection process will only be implemented should I fail to make a reasonable effort to make regular and timely payments on debts incurred. I understand Courtney Torgerson will not release any information regarding my diagnostic information or treatment to such agencies.

I affirm I have read this statement and have knowledge and understanding of the limits of the confidentiality and mandating reporting status of Courtney Torgerson. I understand if I have any concerns regarding by treatment with respect to my privacy or any other aspect of my treatment, I my address them with Courtney Torgerson or I may contact the Montana Board of Social Work Examiners and Professional Counselors , Compliance Specialist and / or American Counseling Association.

Signature of Client (12 or over):

_______________________________________________________________

Signature of Parent of Guardian:

_______________________________________________________________

Witness:

_______________________________________________________________

Date:

_______________________________________________________________

Courtney Torgerson, MA LCPC ID, LCPC MT

Authorization of Release/Obtain Information

Courtney Torgerson
690 Nth Meridian Suite 111
Kalispell, MT 59901
4062706988

Client Name:__________________________________________DOB:______________

Social Security Number:__________________________________

I hereby authorize Courtney Torgerson, LCPC, to release and obtain informant from the following by mail or telephone and or fax:

Individual:____________________________________________

Organization:__________________________________________

Address:_____________________________________________

City:____________________________ State:__________ Zip: _____________

Phone:____________________________ Fax:____________________________

For Insurance Purposes Only: Group Policy#: _____________________________

Name/ ID of Insured: ___________________

Information to released/received shall include:

Psychosocial history _____

Mental health assessment _____

Medication: _____

Medical history _____

Psychiatric evaluation. _____

Attendance records _____

Psychological evaluation _____

Discharge summary. _____

Other (specify). _______________________________________

The purpose for such disclosure is to coordinate services or otherwise facilitate the therapeutic treatment of the above-named client. These records may contain mental health, developmental disability, alcohol and other drugs abuse, sexually transmitted disease or other physical health information and academic records. Only records believed necessary for the stated purpose shall be released. I may inspect and obtain photocopies of the records disclosed.

The authorization expires on the following date: _____/_____/_____.
I understand this authorization may be revoked by me at any time except to the extent that action has been taken based on my signed release prior to the revocation request.

Client signature (12 or over):__________________________________Date:_______

Parent/ Guardian Signature:__________________________________Date:________

Witness Signature:_________________________________________Date:________

Revocation Signature:_____________________________________Date:________