SYNERGY COUNSELING SERVICES, LLC

Marlo L. Floyd, MA, LPC

WHO IS MARLO FLOYD AND WHAT IS SYNERGY COUNSELING SERVICES?

Marlo Floyd is a highly qualified and passionate therapist that has worked in the field for over 15 years. I have experience with all populations with specialties in the treatment modalities of Anger Management, Dialectical Behavior Therapy, Cognitive Behavioral Therapy, Motivational Interviewing, and Trauma Focused Cognitive Behavioral Therapy. I received a Master's Degree in Counseling from the University of Arkansas in Little Rock and license to practice counseling in the state of Arkansas in 2008. My private practice is referred to as a "sole proprietorship," and is Located on 4700 West Commercial in North Little Rock Arkansas in the Old World North Building, Suite B1. I am one of many therapist that practice with Pogue and Associates.

What is Psychotherapy and how does Synergy Counseling Services offer those services?

I specialize in working with individuals that have been affected with mood disorders, anger problems, trauma, low self-esteem, and substance abuse. I counsel from a Christian perspective, as well as respectfully work with a client's source of inspiration. Allow me to join you on your journey of enlightenment and healing. I provide individual, group, and family therapy sessions. Determination of which type session will be a collaborative effort between the therapist and the client.

Initial: _____

BENEFITS AND RISK OF PSYCHOTHERAPY?

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

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APPOINTMENTS AND ATTENDANCE EXPECTATIONS

I normally conduct an evaluation that will be the initial session. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. A treatment plan will be collaborative established between the therapist and the client. When psychotherapy begin, I will usually schedule one 50-minute session (an appointment hour is considered 50 minutes duration) at a time we both agree, although some sessions may be longer or more frequent. Session frequency will be decided and agreed upon by the client and therapist with the treatment plan goals. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. Please communicate with me as soon as you know that you will not be able to attend appointment, to free that session time up for another client. Make up sessions can be scheduled on Fridays with prior notice. A fee of $25 is charged for late cancellations or "no show" appointments. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** If it is possible, I will try to find another time to reschedule the appointment.

Initial: _____

PROFESSIONAL FEES

My hourly fee is $150.00. I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, preparation of records or treatment summaries, and the time spent performing, any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time. Because of the difficulties and complexities of legal involvement, I charge $175 per hour for preparation and attendance at any legal proceeding.

Initial: _____

SELF-PAY OPTION
If you do not have health insurance, or you choose not to utilize your insurance, you will be expected to pay the original fee charge that follows:

- Psycho-social Assessment – 90 minutes - $200.00

- Individual Session – 30 minutes - $75.00
- Individual Session - 60 minutes - $150.00

- Family Therapy Session with Client – 60 minutes - $175.00

- Anger Management Assessment - 90 minutes - $200.00
- Anger Management Individual Session - 30 minutes - $75.00
- Anger Management Individual Session - 60 minutes - $150.00
- Anger Management Group – 60 minutes - $50.00

No payment arrangements will be made, and all payment for services need to be made immediately following session. All co-pay fees for services billed to a third party payer are due at time of services. All fees are comparable to ABCBS fee schedule.

Initial: _____

SOCIAL MEDIA AND ELECTRONIC COMMUNICATION
I limit the forms of communication through electronic avenues and social media. Clinicians are discouraged to communicate outside therapy session through email, text, Twitter, Facebook, Instagram, etc., unless communication is for administrative purposes. I will only communicate as it pertains to scheduling appointments through calls, text and email. These communication interactions will be documented in the client file. I do not accept friend requests from current or former clients on social networking site, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise your privacy and confidentiality. For the same reason, I am requesting that clients do not communicate with me via any interactive or social networking web sites. It is important that client's be aware that text, phone, and email are not secured avenues of communications and there are some risk of breach of confidentiality with these avenues.

I give consent for Marlo L. Floyd, LPC to communicate with me through phone, text, and/or email as it pertains to administrative purpose, i.e. scheduling appointments, etc.

Initial: _____

EMERGENCY CONTACT PROCEDURES
Solo practitioners like myself typically do not have the same resources to respond to emergency situations 24 hours per day, 7 days per week, 52 weeks per year, that larger group or community agencies can offer. If such emergencies are anticipated, some consideration should be given to seeking services from such an agency. Nevertheless, I do provide a means for contact in emergency situations, as outlined below.

In an emergency (some form of loss of control that may imperil the health or safety of yourself or another), you can call my office number (501) 350-5677 at any time. Calls will automatically be forwarded to me or my voice mail. I will respond to your voice mail, unless an emergency is communicated, by the end of the business day. However, this is not a fool-proof system. If you do not receive a prompt response from me to an emergency call, there are 3 alternative sources for emergency intervention to utilize.

Initial: _____

IN THE EVENT I AM NOT IMMEDIATELY AVAILABLE FOR AN EMERGENCY
If there is an immediate risk of harm, you should dial 911 for help. If there is an urgent need to talk with a mental health professional, you should contact the crisis hotline of your area community mental health centers. In Pulaski County/Little Rock, the number is 501-686-9300, Pulaski County/North Little Rock 501-221-1843. You can also contact the National Emergency Suicide Hotline at 1-800-273-8255. If there is an urgent need for medical attention or hospitalization, you should call 911 or go to your nearest hospital emergency room.

Initial: _____

VACATION COVERAGE
When I'm on vacation, I typically have a colleague available to intervene if any of my clients have an emergency. A name and number will be made available on my office answering machine for this purpose.

Initial: _____

LIMITS ON CONFIDENTIALITY
The law protects the privacy of all communications between a patient and a psychologist.
In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- ***Information most commonly released:***

Your intake form has a place for you to sign an authorization which allows me to release some clinical information to your insurance company in order for them to determine if your treatment is "medically necessary," and thus a payable benefit under your plan. This information typically includes: A) diagnoses, B) risk assessment, C) symptom checklists, D) functional impact assessment, E) categories of stressors, F) substance abuse/addiction status, G) medications used, H) other providers contacted, I) treatment goals and progress toward treatment goals.

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI").

- If a patient threatens to harm himself/herself or someone else, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection

There are some situations where I am permitted or required to disclose information without either your consent or Authorization.

- If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you and/or the records thereof, such information is protected by the therapist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself. There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment.

  - If I have reason to suspect that a child has been abused or neglected, the law requires that I file a report with State Police Child Maltreatment Hotline. Once such a report is filed, I may be required to provide additional information

  - If I suspect or have a good faith reason to believe that any incapacitated adult has been subjected to abuse, neglect, self-neglect, or exploitation, or is living in hazardous conditions, the law requires that I file a report with the appropriate governmental agency, usually the Department of Health and Human Services. Once such a report is filed, I may be required to provide additional information

  - If a patient communicates a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or a serious threat of substantial damage to real property, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or

seeking involuntary hospitalization for the patient. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Initial: _____

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your clinical records, minus the progress notes, if you request it in writing. In most circumstances, I am allowed to charge a copying fee of $15.00 for the first 30 pages or 50 cents per page, whichever is greater.

Initial: _____

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical
Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

To ensure clear communication and regular attendance to appointments, I will give reminder calls, text, and/or emails please specify the best way you can and are giving permission to be contacted

☐ Text/Phone Number: _____

☐ Call/Phone Number: _____

☐ Email/Email Address: _____

☐ Mail/Address: _____

Initial: _____

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise. If the treatment is for drug dependency, parents may examine the records of children under age 12. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at

scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

You must also give consent for your minor children to receive treatment at Synergy Counseling Services. Please do so by initialing and checking the consent statement below.

☐ I/we consent that _____ may be treated as a client by Marlo L. Floyd of Synergy Counseling Services.

Initial: _____

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. 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 the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Initial: _____

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer, though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

By signing this Agreement, you agree that I can provide requested information to your carrier.
Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

Initial: _____

COMPLAINT/DISSATISFACTION POLICY
The nature of mental health care is part science, part art, and seldom exact. For a variety if reasons, some clients may incur frustrations, dissatisfactions, or a complaint regarding their experience. Under these circumstances, I strongly encourage you to express this to me directly and early, either verbally or in writing, so that I can hopefully respond in a corrective manner. It may be as simple as a misunderstanding or misperception.

My professional practice is guided by the American Counseling Association's code of ethics. I also participate regularly in peer consultation to ensure that my practice behavior is consistent with current standards. Further, I am governed by the Arkansas Board of Examiners in Counseling. If a concern or conflict cannot be satisfactorily addressed directly with me, a client has a right to make a complaint to the board. This option should be considered as ***a last resort, not a first choice***. One reason for this is that such disputes are a formal process, which when pursued, requires clients to consent to my release of their entire treatment record for review by an investigative committee member. I sincerely hope that your experience will never reach this point. It is a shared responsibility between therapist and client to communicate clearly and directly enough to prevent conflicts from ever reaching this stage of grievance.

Initial: _____

HIPAA
HIPAA stands for the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time.

Initial: _____

COORDINATION OF TREATMENT
As your primary therapist, I am requesting permission to coordinate services either with your Primary Care Physician and/or a Psychiatrist/Medical Professional if it is deemed needed in the future. There may be medical issues that are affecting the progress of your treatment that need to be addressed and are outside of my scope of practice. Please check if either of the spaces below to verify if you are giving my permission to refer and coordinate your care with a medical provider.

☐ Yes, I **do** give permission to Marlo Floyd, of Synergy Counseling services to contact and coordinate my care either with my Primary Care Physician and/or refer me for services with another medical provider.

Name of Provider: _____ Telephone #:_____

☐ No, I **do not** give permission to Marlo Floyd of Synergy Counseling Services to contact my Primary Care Physician and/or coordinate my care with another medical provider.

Initial: _____

Your signature below indicates that you have read the information in the Informed Consent document and agree to abide by its terms during our professional relationship.

Client's name: _____

Client's Signature: _____ Date: _____

Therapist Signature: _____ Date: _____