Peace of Time Wellness
4748 Liberty Ave
Pittsburgh, PA 15224
412-578-9700

Disclosure Form and Office Policies

Welcome to Peace of Time Wellness (POTW). In order to establish a relationship with our clients and to have an understanding of what to expect while in our care, we provide this disclosure form of office policies. Below outlines the policies of POTW which include all services provided at our site. These policies are in place for clients to know their rights and responsibilities as well as those of the service provider. These policies are given to and filled out by all new clients. Please read all the information carefully and initial each section to acknowledge that you have read, understood and agree to adhere to our office policies below.

Purpose of Services: Services at POTW are provided through a professional relationship. The intent is for individuals seeking services to find relief through therapeutic processes. The goal of POTW is to provide you with evidence-based treatment and services for you to meet your goals of finding peace. Our expectation is that you are open and honest with your provider as well as yourself in order to best have your needs met. Our biggest obligation is safety. The providers at POTW are committed to providing appropriate therapies and providing a safe environment for our clients. Our providers rely on your feedback and reports to know the progress of treatment.

Patient Initials: _____

Client Rights to Services Provided: Therapy is a process, and outcomes are determined by you, the client, as well as the provider. Goals are determined at the onset of treatment and will be reviewed throughout the therapy process to determine progress. You have the right to choose your provider. Our policy is that if there is a discrepancy with your therapist, you first discuss the concern with your therapist before being referred to another provider or other services. During treatment, your provider may recommend other services. Please understand that your provider is seeking treatment that would be most beneficial to you, the client. Know that if there is noncompliance with a recommendation, progress in treatment may be minimal.

Patient Initials: _____

Service Process: The first 1-3 sessions of the service are considered the assessment process. During this time, you and your therapist will be determining your needs and best modalities for the service provided. Communication with your provider is key to gaining the most benefit from the therapeutic process. Please communicate with your therapist. If the therapist observes non-compliance with modalities and/or referrals, the therapist holds the right to terminate the therapeutic relationship for the time and offer client referrals for more appropriate care.

Patient Initials: _____

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Cancellation and Late Policy: Since therapy is a process, attending appointments is crucial to reaching treatment goals. It is expected that you will attend all appointments as scheduled. It is the responsibility of each client to know the time of their scheduled appointment. As a courtesy our system offers text or email reminders. In the event the reminder is not sent, you will still be responsible for the appointment time. Appointments canceled with less than 24-hour notice or not attended will be subject to a $40/hour cancellation fee. The fee will be owed before you schedule the next appointment. If you are more than 15 minutes late for an appointment, you will receive a phone call and be asked to reschedule your appointment. The appointment will then be considered a no-show and follow the above late cancellation policy.

Patient Initials: _____

Emotional Support Animal Letters and Evaluations: POTW DOES NOT complete ANY emotional support animal documentation or evaluation. Please refer to the online directory for a trained and certified ESA clinician.

Patient Initials: _____

Confidentiality and Patient Records: Your treatment information is protected under HIPAA and our confidentiality policies. We do not disclose any treatment information to anyone including family members, significant others, or other treatment providers unless you sign a consent for your provider to release information. POTW does not provide information for court proceedings unless a subpoena is sent to the provider at which point the provider will review the records and inform the client that records will be sent. POTW uses electronic record keeping programs. Programs are used to schedule appointments, keep notes, and client information and are compliant with HIPAA guidelines. In the event of an insurance audit, under the contract, POTW is obligated to provide insurance with documentation of services including appointment times, treatment plans, progress notes, and any other requested information. Your insurance provider may have disclosed this in your contract with your insurance provider. POTW will attempt to inform current clients in the event of an audit but will not and is not obligated to inform inactive clients when an audit is performed. Where applicable, POTW will request to submit a summary of treatment and will advocate against sending personal session information. Privacy policies can be found on our Events and Forms page on our website at https://www.peaceoftime.org/events-and-forms. You may also request a physical copy at your appointment.

I have read and understand HIPAA policies: _____

I have _____accepted / _____ declined a copy of HIPAA policies to keep for my records.

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Patient Initials: _____

Electronic Communications: As a convenience to you POTW offers HIPAA compliant electronic communication. I hereby request that Peace of Time Wellness and entities within it may communicate regarding my treatment by using **ONLY** a HIPAA compliant portal electronic communications (email or text message via client portal). I understand that this means Peace of Time Wellness and entities within it and/or my treating providers will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted, or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Peace of Time Wellness and entities involved in it shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Peace of Time Wellness and entities within it to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Peace of Time Wellness and entities within it to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Peace of Time Wellness and entities within it, I may revoke this authorization by providing written notice to Peace of Time Wellness at 4748 Liberty Avenue Pittsburgh, PA 15224 or fax at 412-578-9800

I agree that Peace of Time Wellness and entities within it may communicate with me electronically unless and until I revoke this authorization by submitting notice to Peace of Time Wellness in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand that I must execute a separate authorization for my protected health information to be disclosed to third parties.

Patient Initials: _____

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Telephone Calls, Electronic Communications and Social Media: POTW does not offer urgent or emergency services. In the event of an urgent situation POTW expects all clients to call 911, go to the nearest emergency room, or contact Resolve at 1-888-796-8226. Phone calls received by POTW are expected to be returned within 48 hours when possible. At times service providers may not be available to maintain this expectation due to scheduling conflicts. Any service provider on vacation, leave, or with a schedule that would not allow for this obligation to be met will disclose with clients verbally while providing services, or via provider's voice mail message. POTW does not use email to communicate with clients regarding appointments, scheduling, or any other treatment information due to confidentiality. Communication with clients is primarily through the use of a phone, in person, or through the EMR client portal system. The expectation of this is the use of EMR client portal to remind clients of scheduled appointments via phone, text, or email. Service providers at POTW cannot engage in a dual relationship with clients. This includes contact via social media or any other contact beyond the scope of what is necessary to maintain a therapeutic relationship. Social media will be used to inform individuals of upcoming events as well as developments of POTW. Any attempts by clients to communicate through this platform will not be responded to and will be discussed at the time of the next services.

***** TO PROTECT THE CONFIDENTIALITY OF ALL OF OUR CLIENTS, USE OF MOBILE PHONES IS PROHIBITED IN THIS OFFICE. PLEASE STEP OUTSIDE THE BUILDING FOR MOBILE PHONE USE. STAFF WILL REQUEST YOU TO RESPECT THIS POLICY IF NEEDED. *****

Patient Initials: _____

Duty to Warn: By law providers are mandated to maintain safety with "Duty to Warn". This requires any provider to disclose a client's intent to harm either themselves or someone else without regard to confidentiality. If intent to harm is disclosed to any provider, authorities must be notified under this mandate and the client's information and intent given whether or not the client provides consent.

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Records Requests: POTW policy is to send certain records directly to other providers/organizations with a release of information only within the limitation of our practice policies due to the sensitive content within the records. Clients can review records with their therapist to discuss treatment. A release of information must be completed for requests to any outside organization or third party.

Patient Initials: _____

Public Encounters: To maintain confidentiality it is our policy that providers do not approach or acknowledge clients if seen in public. It is your right to choose to address your provider or not to at all.

Patient Initials: _____

Consent for Minors: POTW only offers certain health services and events to individuals under the age of 18. Minors over the age of 14 consent to and sign for their own treatment in Pennsylvania. Treatment information relating to any individual over the age of 14 will fall under the above written confidentiality guidelines. Meaning, guardians are not privileged to information about any minor 14 years or older. In cases of divorce where custody is shared between parents, both parents must sign and consent to treatment at POTW. If consent is not obtained by both parents, treatment will not be rendered. POTW is not responsible for obtaining the consent of other guardian(s), it is expressly the responsibility of the guardian seeking services for the minor to obtain consent. Parent must remain on the premises while child is on the premises.

Patient Initials: _____

Mandated Reporting: All service providers associated with POTW are mandated reporters under Pennsylvania mandates. A mandated reporter is required by law to report to the state any suspected child abuse for any individual under the age of 18. Reports are made anonymously and anyone who reports is NOT required to disclose the report during the course of the therapeutic relationship. For more information on what we are required to report, please visit pa.gov and search for ‘mandated reporter faq’.

Patient Initials: _____

Fee for Service: POTW operates on a fee for service system. Insurance may be accepted for specific services. It is the responsibility of the client to contact the insurance company to find out

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whether services are covered. POTW will collect fees at time of service. Fees are located on the website for specific services; however, some insurance companies require clients to pay a different rate for services due to copays and deductibles. Due to our contract with the insurance company, we must collect the amount the insurance requires otherwise it is considered insurance fraud. POTW will not bill secondary insurance. It will be the responsibility of the client to file claims with any secondary insurance and any balance owed will be due at the time of service. As stated above, any balance is due at time of service. POTW accepts cash, most credit cards, and some services accept HSA. If a balance accrues on an account and remains unpaid after 90 days and efforts have been made to collect, POTW reserves the right to use a debt collection agency to collect this debt. Past due balances may affect access to services in the future.

A Good Faith Estimate will be provided to all self-pay and out-of-network clients via the client portal in compliance with the 2022 No Surprises Act. A physical copy can be sent with you upon request.

All out of pocket charges are the patient's responsibility and due at time of service. It is the patient's responsibility to check with the insurance provider for coverage of services.

****Peace of Time will only bill primary insurance. If you have secondary insurance, it will be the responsibility of the patient to collect reimbursement if available from a secondary insurance company.****

Patient Initials: _____

Billing: Peace of Time Counseling uses automatic billing for your account. Your account will automatically generate invoices for cost-sharing the day of your appointment based on the information you have provided and your insurance company has provided to us. If the invoice is not paid by midnight ET the day of service, the invoice will automatically be paid using the card on file as per the recurring credit card agreement. Please be aware any balance on the account will be collected on the date the balance accrues including late cancel/no show fees. You can review your account through your client portal. Credits may be issued as a result of determination of payment by your insurance company. Sometimes these credits are issued months after an appointment. Credits are automatically applied to future cost-share responsibility. If your status is 'inactive', any credit on the account will be refunded to the client after 90 days of inactivity on the account whether due to an appointment or insurance company activity. Credits will be refunded to the original payment method unless this option is unavailable in which a refund check will be mailed.

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Patient Initials: _____

Cancellations: If a cancellation for an appointment is under 24 hours or an appointment is no-showed, fees will automatically adjust to the $40 fee and create an invoice. If the invoice is not paid by midnight the day of the appointment, the card on file will be charged according to the recurring credit card agreement. You can make any changes via the client portal or by calling the office to make changes to the card on file.

Patient Initials: _____

Insurance: If your insurance has changed and you have not notified us, the invoice will default to a charge of $180.00 once your insurance claim is denied. The auto bill will then charge the card on file for that amount once auto-billing is activated. Please be sure to update your insurance information in the client portal as soon as an insurance change takes effect so as not to receive this charge. We do not know when your insurance changes, only when a claim is denied and the insurance does not pay for your session. At which point the system assesses the full fee to your account. It is the responsibility of the client to update Peace of Time with any changes in information. Peace of Time does not bill secondary insurance.

**** ALL demographic information MUST be completed for billing insurance including sex at birth (prefer not to say cannot be billed). Insurance companies require this information for billing. Please enter sex at birth where indicated. Gender is indicated in a separate space in the demographics.****

Patient Initials: _____

Balance: If the balance on your account is over $300, it may restrict your access to future services. Peace of Time Counseling reserves the right to pursue collections after an attempt to collect a client's balance has been made. After 90 days of nonpayment, Peace of Time may use a collection agency to collect the balance on your account.

Any balance over 90 days past due is subject to collections.

Patient Initials: _____

Charge Error: If you believe your card has been charged in error, please contact us IMMEDIATELY. You will receive a monthly statement with the services and payments emailed

to you. You can request paper statements to be mailed monthly by calling and speaking with the front desk or the financial coordinator. You are able to access your billing account any time via your client portal. Access to the client portal for mental health can be found by clicking "Request Appointment" on our mental health page on our website at https://www.peaceoftime.org/mental-health.

Patient Initials: _____

Cost-Share: Peace of Time Counseling, LLC will attempt to check into a client's cost-share (deductible/copay/coinsurance) responsibility prior to services and dates insurance companies have provided for the next determination of benefits. However, often information may not be accurate and cost-share is not fully determined until after the claims process, which is approximately 2-4 weeks following a service date. If there is an error with an insurance payment, please contact your insurance company. The amount to be collected by Peace of Time is determined by your insurance company and is due directly to Peace of Time Counseling, LLC. Cost-Share is at the discretion of your insurance company and can change based on changes to your plan or coverage. Peace of Time will not know these changes until after a claim is paid by the insurance company. It is the responsibility of the client to know their insurance coverage. We cannot change your cost-share. It is considered insurance fraud to manipulate the guidelines of your insurance plan.

Patient Initials: _____

Self-Pay Option: This can ONLY be used if we do not accept a client's insurance. It is fraudulent to not use insurance if a provider is credentialed regardless of the amount of their payment for services. All payments are due at the time of service. Any changes to a client's status for coverage or change in income must immediately be disclosed to Peace of Time. A client's status will be reassessed every 6 months.

Patient Initials: _____

Court Testimony or Forensic Reports: It is the policy of POTW that service providers do not testify in court cases nor release records for the purpose of court cases. We do not provide any type of forensic reporting. Any client in need of this will be referred to another provider. POTW

does not present information for custody cases. In the event of a subpoena, service providers will advocate that a summary of treatment be provided to the appropriate requestor. If refused, service providers will release requested information and inform clients of such occasion.

Patient Initials: _____

Other Fees: POTW charges fees for any documentation including but not limited to letters, summaries of treatment, and record printing. A schedule of fees will be kept at the service location and payment before any documents are released.

Patient Initials: _____

Weapons Policy: ***__No weapons are permitted on premises.__ *** We respect all rights of individuals and the right for each individual to feel safe in their environment. Due to the sensitive nature of the services provided on these premises, we kindly request that weapons are left outside of the building. Staff will politely remind any individual on the premises of this policy if needed. Thank you for your cooperation.

Patient Initials: _____

Intoxication Policy: It is expected that clients receiving services with POTW will respect their service time and seek to obtain maximum benefit from treatment. Clients who appear to be intoxicated will be refused service and charged a cancellation fee. In order to protect both the client's and the public's safety, staff reserves the right to contact the authorities if the client is visibly intoxicated and attempts to drive from the premises.

Any employee that appears to be intoxicated including use or overuse of prescribed medication including intoxication due to use of medical marijuana will immediately be requested to leave the premises—not to drive, and will result in immediate termination/dismissal from Peace of Time Wellness, LLC.

Patient Initials: _____

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While this written summary provides a summary of office procedures and the disclosure policy, we welcome any questions and will be glad to provide an answer. In the event any of this document is unable to be understood, please inform a staff member and he/she/they will clarify the policies of Peace of Time Wellness. We look forward to providing you with our services.
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I have read and understood the above policies outlined for Peace of Time Wellness. I have sought assistance from staff with any policies that were unclear. By signing below, I agree to follow the above policies and have discussed any difficulties with my service provider.

Patient Signature: _____ Date: _____

Printed Named: _____

Guardian or Legal Representative: _____ Date: _____

Relationship to Client: _____