Welcome Letter
Salathe Behavioral Health, Inc.

4010 Dupont Circle, Suite 574. Louisville, KY 40207
Phone: (502) 396-6241 Fax: (502) 653-0396
Email: sms@scottsalathe.com
www.scottsalathe.com

Welcome! It is an honor for me to meet a client and invite you into the process of therapy—a process that is often comforting and effective for most people. Therapy is essentially a journey into bringing out the best in yourself. This includes finding and maximizing your strengths and also identifying and working on your limitations. The vehicle for this journey is through a professional and therapeutic relationship. I will offer you my undivided attention; I will listen, support, suggest, collaborate, coach, challenge, and laugh with you—hopefully in the right doses!

For our first session, you can expect three things. First, I will spend roughly 90 min getting to know you and your family and help you to feel comfortable with my style so that you can begin to trust me with your personal and family information.

Second, I am committed to providing you with a thorough evaluation of your mental health, starting with what is most important and urgent for you. By the end of our 90 minute evaluation, I will give you some feedback, and we will begin to form treatment goals to guide our work together.

Third, in order for us to work toward common goals, we must be in agreement on the basics of this therapeutic (and financial) relationship. Because this is fundamental, we will begin our first session with this discussion. Although no one enjoys paperwork (myself included!), I have tried to make my forms clear and user-friendly.

Brief Bio of Dr. Scott

I am a Licensed Clinical Psychologist who has provided therapy since 2003 to adolescents and adults, couples and families with a wide variety of mild, moderate, and severe mental health problems. I also teach (as a clinical/part-time faculty) at Spalding University. I graduated from Spring Hill College (BA), Spalding University (MA and PsyD), and completed an internship at Emory University Student Counseling Center. You can call me Dr. Salathe, Dr. Scott, or just Scott---whatever suits you!

Client Information Form
Salathe Behavioral Health, Inc.

First Name _____ Middle _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

Birth Date _____ E-mail Address _____

Primary Phone _____ Secondary Phone _____

Insurance Information

Insurance Company _____

Policy ID _____ Group ID _____

Insured's Name _____ Insured's Birth Date _____

Insured's Employer _____

Insurance Street Address _____

City _____ State _____ Zip _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

rev: 2017

Consent to Treatment
Salathe Behavioral Health, Inc.

Client Name:_____

I do hereby seek and consent to take part in psychological treatment by Dr. Scott Salathe (or in the case of minors, seek treatment for the above-named child). I understand that developing a treatment strategy with Dr. Salathe and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Dr. Salathe. I am aware that I may stop my treatment with Dr. Salathe at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that if payment for the services I receive here is not made, the psychologist may limit and/or stop my treatment.

HIPAA Notification

I attest, by my signature, that I have been made aware of and given the opportunity to review the ***Psychological Services Agreement-Psychotherapy***, and agree to its terms. Further, I acknowledge that I have received/or been offered and declined the practice's ***HIPAA Notice of Privacy Practices*** form, which is **located in the waiting area.**

My signature below indicates that I understand and agree with all of the above statements.

_____ _____
Signature of client or parent/guardian Date

_____ _____
Printed name of person signing Relationship to client (if necessary)

I, the psychologist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Psychologist Date

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Limits of Confidentiality

Salathe Behavioral Health, Inc.

The contents of a counseling, intake, or assessment session are strictly confidential. Neither verbal information nor written records about a client can be shared with another party without the informed written consent of the client or the client's legal guardian. Salathe Behavioral Health, Inc. considers it an ethical and legal responsibility to adhere strictly to this policy. According to Kentucky state law the exceptions are as follows:

Abuse or Neglect of Children and Vulnerable Adults

If a client states or suggests that he/she is abusing and/or neglecting a child (or vulnerable adult) or has recently abused and/or neglected a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse and/or neglect, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Minors/Guardianship & Court Orders

Parents or legal guardians of non-emancipated minors have the right to access the client's records. Health care professionals are required to release client records when a court order has been placed.

Other Provisions

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Record-keeping (both electronic and physical) is shared with Dr. Tony Sheppard who works in this office and maintains strict confidentiality and physical safety of records through password protection and secured, locked file cabinets. In the event in which the practice must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Typically, the practice will be referred to as "*Dr. Salathe's Office.*"

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Signature of Client_____**Date:**_____

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Payment Contract
Salathe Behavioral Health, Inc.

Client Name: _____

Person Responsible for Account: _____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One - Fees for Professional Services

- Initial Intake Appointment -- **$180 per assessment (**defined as 90 min.)
- Individual & Family Therapy -- **$120 per clinical unit** (defined as 50 min.)
- Group Therapy – **TBD.**
- Attendance at School Meeting (Metro Louisville only)**-- $120 per hour** (minimum of 1 hour is billed)
- Hospital Visits (Metro Louisville only)-- **$120 per hour** (billed in 15 min. units).
- Preparation of Letters/Legal Documents/Legal Testimony **-- $120 per hour** (billed in 15 min. units)
- Lengthy emails or extended phone calls--**$120 per hour** (billed in 15 min. units)

Part Two - Clients with Insurance (Deductible and Co-payment Agreement)

☐ If this box is checked, you have informed this clinic that you desire to have services rendered filed with your insurance provider. The clinic will make every effort to secure prior approval before initiating treatment. It is strongly suggested that you review your coverage by contacting your insurance company prior to your first visit. **The Person Responsible for Payment of Account shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles.** I (we) authorize Salathe Behavioral Health, Inc. to disclose billing information including but not limited to: diagnoses, dates of service, service provided, treatment updates to the third-party payer or insurance company for the purpose of receiving payment directly to Salathe Behavioral Health, Inc. and/or Dr. Scott Salathe.

- I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits.
- I (we) understand that I (we) may revoke this consent at any time by providing written notice.
- I (we) have been informed what information will be given, its purpose, and who will receive it.
- I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form if requested.

Part Three - All Clients

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date. Delinquent accounts may be referred to a collection agency. In order to remain fiscally sound, the practice employs a **Missed Appointment charge of $40 in the case of failure to provide 24 hours notice for cancellation of appointments.** This charge will be applied to appointments that are missed with failure to provide adequate notice. Questions regarding the financial policies can be answered by Dr. Salathe or authorized practice staff.

Signature of Person Responsible for Account: _____ Date: _____

Signature of Psychologist or Representative:_____Date:_____

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Email Consent
Salathe Behavioral Health, Inc.

E-mail communication offers an efficient way to communicate with Dr. Salathe. From appointment scheduling to providing updates, information and billing, e-mail allows the psychologist and the client to avoid some of the frustrations of 'phone tag', and voice mail communication that may not convey all of the necessary data. However, this medium is not without its risks.

1. RISKS OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:

- Email can be stored electronically and on paper or forwarded to unintended recipients.
- Backup copies of email may exist even after they are sent or the recipient has deleted the copy.
- Employers and on-line services have a right to inspect email transmitted through their systems.
- Email can be used to introduce viruses into computer systems.
- Emails may not be secure, and it is possible that the confidentiality may be breeched by a third party. Email can be intercepted, altered, forwarded, or used without authorization or detection.

2. GUIDELINES FOR USE OF EMAIL COMMUNICATION

Dr. Salathe cannot guarantee, but will use reasonable means, to maintain security and confidentiality of email information sent or received. Dr. Salathe will not be liable for improper disclosure of confidential information that is not caused by his intentional misconduct. Patients must consent to the following conditions:

- **Email is NOT appropriate for urgent or an emergency situation**. Instead, **please call Dr. Salathe** using his emergency contact number: 502-396-6241. Dr. Salathe cannot guarantee that any particular email will be read and responded to within any particular period-of-time.
- Email should be concise. The patient should schedule an appointment if the issue is too complex to discuss via email.
- Dr. Salathe typically checks e-mail on a regular basis, however there may be exceptions to this. In addition there can be server problems or line/connection problems. Dr. Salathe does not check e-mail when out of the office on vacation or in-training.
- Most email messages will be filed electronically in the patient record.
- Dr. Salathe will not forward patient identifiable emails to others outside his practice without the patient's prior written consent, except as authorized or required by law.
- Dr. Salathe is not liable for breach of confidentiality caused by the patient or any third party.
- Normally, there will be no charge for use of short, periodic emails. Should a message be lengthy or complex, regular session rates will apply ($100/hour, billed in 10 min. increments).
- Use caution when using your employer's computer.
- Consider placement of sensitive information in a password protected attachment file.
- Put the patient name in the body of the password protected email attachment.
- Inform provider of changes in your email address.
- Please acknowledge any email received from Dr. Salathe, with a courtesy email response.
- Dr. Salathe does not correspond with clients via Facebook, Twitter, Linked-In or other social media.

3. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand Dr. Salathe's e-mail consent form. I understand the risks associated with the use of e-mail communication with Dr. Salathe, and consent to the conditions and instructions outlined.

Dr. Salathe's e-mail: **sms@scottsalathe.com**

_____	_____	_____
Signature of Patient, Parent/Legal guardian	Print Patient Name and Date	Email address to be used

_____	_____
Signature of Witness	Date

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Consent to Release/Obtain Confidential Records/Information
Salathe Behavioral Health, Inc.

4010 Dupont Circle, Suite 574 Louisville, KY 40207
Phone: (502) 396-6241 Fax: (502) 653-0396
Email: sms@scottsalathe.com
www.scottsalathe.com

I hereby authorize **Dr. Scott Salathe** to release/obtain confidential records concerning:

Client Name:_____ **Date of Birth:**_____

This information may be released to, or obtained from:

_____
Name of Person or Agency

_____
Address of Person or Agency

_____
Phone Fax Email

The purposes of this exchange of information are:
- ☐ Further Mental Health Evaluation, Treatment, or Care
- ☐ Treatment Planning
- ☐ Other:_____

The following types of information may be shared:
- ☐ Treatment Updates/Treatment Planning
- ☐ Intake & Discharge Summaries
- ☐ Psychological Evaluation Results
- ☐ Developmental/Social History
- ☐ Progress Notes
- ☐ Other:_____

This consent has been explained to me and I fully understand this consent to release records and/or information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may withdraw this consent at any time by notifying Dr. Salathe in writing. I acknowledge that any action already taken based upon this consent cannot be rescinded. This consent expires _____.

_____ _____
Signature of Client or Parent/Guardian Date

_____ _____
Printed Name of Client Relationship to Client

_____ _____
Signature of Witness Date