KEVIN CHADBOURNE DOWNS
LICENSED ADDICTION COUNSELOR, LAC/S, LAC, MAC, SAP, CSAT
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I. CLIENT INFORMATION SHEET

Date:_____ Time:_____

1. Name:_____

2. Residential Address:_____

3. Home Phone: _____ **4. Cell Phone:** _____ **5. E-mail:** _____

6. Single or Married? _____ **7. Date of Birth:** _____ 8. **SSN:** _____

9. Name of Spouse, or Significant Other:_____

10. Minor Children? _____ **11. Names and Ages of each:**_____

12. Occupation: _____

13. Employer: _____

14. Work Telephone No.: _____

15. Credit Card #:_____ **Exp. Date:**_____ **Security Code:**_____ **Zip Code:**_____

16. What brings you in today:_____

17. Referral Source: _____

18. Are you currently working with another therapist? (If so, who?) _____

19. Have you had any therapy experiences before? (If so, when?) _____

20. Are you on any medications at this time? Y/N If so, list them:_____

21. Contact in case of emergency:_____

22. Do you want to designate a Family Member, or other Individual, with whom I am authorized by you to discuss your Treatment Condition? Yes/No

23. If Yes, whom: _____

24. To bill Insurance, I will need a copy of your Insurance Card/SC Drivers License:_____

25. If you are NOT the actual Insured Policy Holder, I will need: Policy Holder's Name, SSN, Date of Birth, Address, Telephone Number: (PLEASE SEE PAGE 2)

PLEASE SIGN PAGES: 3, 5, 6, 14, 28, 34

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CONTINUATION FROM PAGE I - "CLIENT INFORMATION SHEET"

1. POLICY HOLDER'S NAME: _____

2.POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____

3.POLICY HOLDER'S DATE OF BIRTH: _____

4.POLICY HOLDER'S INSURANCE COMPANY NAME: _____

5.POLICY HOLDER'S INSURANCE ACCOUNT NUMBER: _____

6.POLICY HOLDER'S INSURANCE GROUP NUMBER: _____

7.POLICY HOLDER'S INSURANCE COMPANY CONTACT TELEPHONE: _____

8.POLICY HOLDER'S ADDRESS CONNECTED TO INSURANCE: _____

9. HOLDER'S CELLPHONE NUMBER: _____

OTHER ANCILLARY INFORMATION: _____

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II. CONSENT TO TREATMENT

I acknowledge that I have received and understand the "Information for Clients" material and/or other information about the therapy I am considering, and I have had an opportunity to have all my questions answered fully.

I do, hereby, seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this treatment process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I MUST CALL to CANCEL an appointment AT LEAST 24 HOURS – BEFORE – the TIME of the appointment. If I DO NOT CANCEL, or DO NOT SHOW UP, your Credit Card on file, will be charged THE FULL APPOINTMENT RATE, OR $150.00, for that missed appointment.

I am aware that an agent of my insurance company, or other third-party payer, may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below, acknowledges that I fully understand, accept, and agree to/with all of the TERMS of this CONSENT TO TREATMENT document.
CLIENT CREDIT CARD INFORMATION: ACCOUNT #: EXPIRATION: CVV: ZIP CODE:

_____ _____
Signature of Client **Date**

_____ _____
Printed Name of Client **Time**

I, the therapist, 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.

_____ _____ _____
Kevin Chadbourne Downs **Date** **Time B.S., Crim. Justice, M.A., Psych., J.D., Attorney, LPC, MAC, and SAP**

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III. AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I, the undersigned, request that KEVIN CHADBOURNE DOWNS, LAC/S, MAC, SAP, CSAT provide professional THERAPEUTIC COUNSELING SERVICES to me, as a client, and unless otherwise discussed, I agree to pay this Therapist's fee for these services. I understand, and agree to pay Mr. Kevin Chadbourne Downs' THERAPEUTIC FEES, as listed below:

1.	**Prospective Client Consult (90 min.)**	**$200.00**
2.	**Consultation Session**	**$200.00/HOUR**
3.	**Sixty (60) Minute/Therapeutic Session**	**$150.00***
4.	**Ninety (90) Minute/Therapeutic Session**	**$225.00***
5.	**Travel Costs**	**$25.00/HOUR**
6.	**Report Writing**	**$125.00/HOUR**
7.	**Records/Document Review**	**$100.00/HOUR**
8.	**Therapeutic Related Communication(s)**	**$100.00/HOUR**
9.	**Court Appearances/Depositions**	**$200.00/HOUR**
10.	**Copying Costs**	**$0.50 cents per page**
11.	**Therapeutic Test Instrument(s) SDMI, MAWASI)**	**$150.00 Each (PAI, SDI-4, PTSI-R, IPAST,**

(Fee Includes – License Purchase/Administration/Analysis & Interpretation)

For items marked by an asterisk, this fee differs markedly when contract rates with managed care organizations (MCO) and employee assistance program (EAP) apply. You would only be required to pay the difference between the *contract rate* and what the MCO or EAP covers. In cases where insurance is being processed, your cost may be your co-pay, or your co-insurance fee.

I have been provided with this therapist's "<u>Professional Disclosure Statement</u>" and agree to cooperate with, and abide by, all of its provisions as indicated by my signature below. If at any time, I am dissatisfied with this therapy I will fully discuss my views, reasons and plans with the therapist. If the client is a minor, I understand that while I have a right to general information on issues and progress, some information shared in this professional relationship may be held in confidence by the therapist and the minor child. I agree that this financial relationship will continue in effect with the above named professional as long as this therapist provides services, or until I inform Mr. Kevin Chadbourne Downs that I wish to end it. I agree to pay for services rendered to this patient up until the time I terminate the therapeutic relationship. I understand that I am responsible for <u>ALL CHARGES FOR THERAPEUTIC SERVICES PROVIDED</u> by this therapist to this client, although other persons or insurance companies may make payments on this client's account as appropriate.

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III. Agreement to Pay for Professional Services, continued

If, at any time, I am dissatisfied with this therapy I will fully discuss my views, reasons and plans with the therapist (and if the patient is a minor, with the patient named above).

I agree that this financial relationship will continue in effect with the above named professional as long as this therapist provides services or until I inform her, in person, by telephone or by certified mail, that I wish to end it. I agree to pay for services rendered to this patient up until the time I terminate the relationship.

I understand that I am responsible for charges for services provided by this therapist to this client, although other persons or insurance companies may make payments on this client's account.

I understand, and agree, that I will be charged $125.00 for any mutually scheduled appointments that I do not personally attend AND DO NOT PROVIDE TWENTY-FOUR (24) HOUR ADVANCE CANCELLATION NOTICE TO UNDERSIGNED THERAPIST.

Signature: _____

Printed name: _____

Relationship to the patient: ☐ **Self** ☐ **Other:** _____

Date: _____

_____
Kevin Chadbourne Downs
B.S., Crim. Justice, M.A., Psych., J.D., Attorney, LPC, MAC, and SAP Date: _____

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IV. CLIENT INSURANCE AUTHORIZATION

CLIENT Release of PERSONAL Information for Insurance Verification/Insurance Authorization

of Benefits /Insurance Claims Processing/ Insurance Fee/Insurance Payment

I authorize MR. KEVIN CHADBOURNE DOWNS and its subsidiaries, to check/verify insurance coverage and benefits. I understand and agree that PETTIGREW, INCORPORATED handles all of the electronic medical billing and insurance verification for MR. KEVIN CHADBOURNE DOWNS, and its subsidiaries, and I specifically give them permission to act on MR. DOWNS' behalf.

I authorize the release of any medical or other CLIENT related PERSONAL information to PETTIGREW, INCORPORATED that is deemed necessary to process insurance claims related to Therapeutic Services provided by Mr. KEVIN CHADBOURNE DOWNS, and I authorize payment of insurance medical benefits to MR. KEVIN CHADBOURNE DOWNS / CHARLESTON ADDICTIONS COUNSELING, LLC. / MOUNT PLEASANT ADDICTIONS COUNSELING, LLC. for Therapeutic Services provided.

I, also, understand and agree that I am financially responsible to pay for ANY CO-PAY, CO-INSURANCE, INSURANCE DEDUCTABLE, AND OTHER THERAPEUTIC SERVICES NOT COVERED BY MY MEDICAL INSURANCE.

_____

SIGNATURE OF CLIENT

_____

PRINTED NAME OF CLIENT

_____

SIGNATURE OF THERAPIST

_____ _____

DATE **TIME**

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V. CONFIDENTIALITY IN PSYCHOTHERAPY

What a client tells a therapist has always been treated as private. Our society recognizes that this confidentiality is the foundation of the trust we must have for therapy to work. However, the situation is not so simple that I can promise you that everything you tell me will *never* be revealed to anyone else. It is more complicated because there are some times when the law requires me to tell others, and there are some other limitations on our confidentiality. We need to discuss all of these so that there are no misunderstandings and no incorrect assumptions and we are as clear as we can be about the limits of confidentiality. Because you can't unsay what you tell me, you must know about these rules at the beginning so that you don't tell me something you wish you had kept secret. These are important issues, so please read these pages carefully. Then we can then discuss any questions or concerns you might have.

What you tell me, since I am a South Carolina/Licensed Addiction Counselor (LAC), a South Carolina/Licensed Addiction Counselor/Supervisor (LAC/S), a South Carolina/Licensed Professional Counselor (LPC), as well as a South Carolina/Licensed Professional Counselor/Supervisor (LPC/S) is almost always confidential. Licensed Counselors in South Carolina are afforded privileged communications, with specific exceptions, which are also outlined in the professional ethics for my profession. I have listed below a few rare exceptions to our confidentiality:

ONE: There are laws written to protect persons from harm when, in a therapist's professional judgment, there is a danger to those persons from a client. Such instances would include:

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a. If I come to believe that you are threatening serious harm to another person, I am required to try to protect the other person(s). In that case I would have to tell the intended victim (if identifiable), and the police, or perhaps seek your hospitalization. This is called a "Third-Party Duty to Warn."

b. If you threaten or act in a way which is very likely to harm yourself in a serious way, I may have to seek hospitalization for you, or to call your family members or others who can help protect you. If such a situation does come up I will fully discuss the situation with you before I do anything, unless there is a very good reason not to. I work a lot with people who self-harm, and I rarely have to require hospitalization since most of the time the injury is not (and not intended to be) life-threatening.

c. In addition, my personal philosophy is such that I believe that an HIV+ person who, knowing their HIV status, chooses to engage in sexual contact (whether engaging in 'protected' or 'non-protected' sex) *without first divulging their HIV status* falls under this paragraph as being considered to threaten the life and well-being of another person. It is also a felony in South Carolina. In such a case, I would assist you in contacting the Health Dept. to implement the Partner Notification process (which does not result in your identity being divulged to the party at risk). This is not a case where I would be directly responsible for notifying a person at risk of harm. This comes under a concept entitled "*The Partner Notification Act.*"

d. In an emergency, where your life or health is in immediate danger, I may release, to another professional, information which would protect your life, without your permission if I cannot get it. If I do so, I will discuss this with you as soon as possible afterwards.

e. If I believe or suspect that a child, an elderly person, or a disabled person is being abused (or has been abused in the past 3 yrs) by your neglect, assault,

battery and/or sexual molestation, I must file a report with the appropriate South Carolina State Agency. I do not have any authority to investigate further into the situation to find out all the facts (The South Carolina agency would investigate). This might involve the South Carolina/Dept. of Social Services/Adult Protective Services.

f. If you are in your third trimester of pregnancy (defined in SC as the beginning of your 24th week) and you are using illicit substances (illegal substances; substances for which you don't have a lawful prescription) this would trigger a mandated report according to the "*Whitner Law*." This does *not* include alcohol.

g. Possession of child pornography is a federal crime. In March of 2019 a Greer, SC man was sentenced in federal court to ten (10) years in Federal Prison after pleading guilty to possession of child pornography. Since this is considered sexual exploitation of a child/children even though the victim may not be known, and it may not involve actual physical interaction with a child, I would consider it a mandated reporting issue.

h. In the event you are a licensed helping professional, including a licensed social worker, licensed psychologist, licensed psychiatrist, licensed professional counselor, licensed addictions counselor, or licensed marriage and family counselor in any state, if you are acting against the public interest in your Code of Ethics, please know that I would consider it a duty to have to report this to the appropriate authorities (most likely Labor & Licensing Board.)

In any of the above situations, I would only reveal the least amount of information necessary to protect the other person and not relate everything you have told me. If any of these situations might be an issue for you, please let us discuss the legal aspects in detail, and do this before you tell me any information on these topics.

TWO: In general, if you get involved in court proceedings, your records

should be considered confidential; however, there are some situations where the judge may require me to testify because (s)he believes the court needs my information to make an appropriate judicial decision. If a Court Order is issued, I would be required to provide this information. This might include:

a. In child custody or adoption proceedings where your fitness as a parent is questioned or in doubt, and/or in cases where a "Guardian Ad Litem (GAL)" has been assigned. NOTE: A "GAL" has a court order to access records.

b. Where your emotional, mental or psychological condition is important information needed for a court's decision.

c. During a malpractice case, or a disciplinary board hearing against a therapist.

d. In a civil commitment hearing where you might be admitted to a psychiatric hospital.

e. If you use your mental condition as a defense in court.

f. When you are seeing me for court-ordered evaluations, or treatment. In this case we would need to discuss confidentiality fully because you don't have to tell me what you don't want the court to know.

g. If you are filing a claim for Workman's Compensation. Your records may be required to be released *without your specific release* according to SC/Section 42-15-95.

THREE: If your therapy is a *required* adjunct to treatment by a medical doctor prescribing methadone or suboxone, and you do not keep appointments as recommended, I would need to advise the medical referent of this circumstance.

FOUR: Past Crimes: There is usually no duty to report past crimes - unless the crime falls under the reporting statute (child abuse), or unless future harm is

being threatened against a third party.

FIVE: There are a few other points about your confidentiality that you must be informed about:

a. I sometimes consult with other professionals/therapists about therapy cases. In such cases I do not reveal a client's name, and the other professional is also legally bound to maintain the confidentiality of such information. Similarly, when I am out of town or unavailable, another professional therapist may respond to phone calls to my office and I may need to give him or her limited information about my clients to affect such coverage.

b. I am required to keep treatment records (medical records), which include progress notes. You are entitled to review, with me, these records (see exceptions noted by HIPAA regulations).

c. If you use your health insurance to pay a part of my fees, I have to give the insurance company some information about our therapy. Insurance companies are guided by HIPAA regulations and should only receive a Designated Record Set (DRS) which includes your name, social security number, dates of first/last sessions and number of sessions, billing code, test results (if any), a symptoms and functionality checklist, and your provisional diagnosis (along with my fees/billing). It is against the law for insurers to release any information about our office visits to anyone else without your written permission (given only by signing a Release Form). While I believe the insurance company will act ethically and legally, I cannot control who sees this information at the insurer's office or in any office where you work. Note: If progress/case notes are requested, you will be notified, as this is not normal procedure.

d. If you have been referred (sent) to me by your employer or your employer's Employee Assistance Program, they may require some additional information beyond the Designated Record Set (DRS) information described above. If this is your situation, let us fully discuss this - before we talk further.

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e. If your account with me is overdue (unpaid) and we have not arranged a payment plan, I can use legal means to get paid. The only information I would give to the court, a collection agency or a lawyer would be your name, address, the dates we met for professional services, and the amount due to me.

f. Children in treatment, who are under the age of 18, technically do not have confidentiality in SC, but they do have a "reasonable right to privacy." In SC, parents/legal guardians (whether custodial or non-custodial) have a right to review their child's records, unless there is a specific Court Order preventing this, or unless the therapist fears for the child's well-being if released.

g. If you and/or your spouse have a custody agreement, or a court custody hearing, it would be advisable for you to let me know about it.h. My rule is that you must agree that if counseling does not resolve the marital difficulties and you seek a divorce you will not request my testimony for either side. After all, the intent of couples work is to allow full disclosure between the parties to work on the relationship and not to seek or use information gleaned from the therapy process against them.

i. If you are in group therapy the other members are not therapists and do not have the same ethical and legal rules. In general, you cannot be sure that they will keep confidential what you say in the group, although the intent to keep confidentiality would be stressed at the outset.

j. Any information which you share outside of therapy, voluntarily and publicly, will not be considered protected or confidential by a court.

k. I will not record our therapy sessions on audiotape, or videotape without your written permission.

SIX: You have also received a HIPAA Notice of Privacy Practices either in written or electronic form. By signing this document, you acknowledge receipt and agreement with the terms of this document.

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SEVEN: It may become useful during the course of treatment to communicate by phone, email, text message (e.g. "SMS"), fax or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with me, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- **People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages;**
- **Your employer, if you use your work email to communicate with me; and**
- **Third parties on the internet such as server administrators and others who monitor Internet traffic.**

If there are people in your life that you don't want to access these communications, please talk with me about ways to keep these kinds of communications safe and confidential. There are ways to encrypt communications. Otherwise, by signing this document, you agree that you are knowledgeable of these limitations and agree to the risks of using this type of communication.

EIGHT: If you want me send information about our therapy to someone else, you must sign a "Release of Records (ROR)" form. I have such forms which you can review should you so desire.

As you can see, the laws and rules on confidentiality are complicated; however, you should now have enough information to enter treatment well informed. Also, while complications dealt with in this document rarely come up in my practice, please bear in mind that I am not able to give you legal advice. If you have special, or unusual concerns and need more specific advice, I strongly suggest that you talk to an attorney to protect your interests from a legal

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analysis/perspective.

The signatures here attest to the fact that we each have read, discussed, understand, and agree to abide by the points presented above.

Client's Signature _____ **Date:** _____

Therapist's Signature _____ **Time:**_____

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VI. CONFIDENTIALITY IN PSYCHOTHERAPY

I appreciate your trust and the opportunity to be of Professional Therapeutic assistance to you. This document is designed to answer some frequently asked questions about my practice and our relationship, so please read all of it before you sign it at the end - to indicate your understanding of office procedures, and your willingness to abide by these policies. As you read it, please jot down any questions that come to mind so we can discuss them at our first meeting. This document is yours to keep for future reference.

1. **MY APPROACH TO PSYCHOTHERAPY:**

You can only make the best decisions if you have enough information and understanding of how psychotherapy works. Let me discuss some aspects of psychotherapy as I see it. I embrace an eclectic approach to counseling. In other words, my style is a combination of many techniques, some of which include cognitive or rational behavior therapy, Gestalt techniques, free association, rational emotive therapy, short-term psychodynamic therapy, attachment model, family systems, and others.

Therapy can be a large commitment of time, money, and energy, so a counselor should be carefully chosen. I strongly believe you should be comfortable, encouraged, and optimistic with the counselor you choose.

You have the right to ask me about other treatments for your condition and their risks and benefits. If you could benefit from any treatments I know about that I cannot provide, I have an ethical obligation to assist you in obtaining those treatments. If at any time you wish another professional's opinion and wish to consult with another counselor, I can assist you in finding someone qualified and

provide them with any information needed, included a summary of the services you have been provided.

Psychotherapy is not like visiting a medical doctor in that it requires your very active involvement and efforts to change your thoughts, feelings and behaviors. I will ask for your feedback and views on your therapy, the efforts and progress we are making, and other aspects; and I will expect you to be open about these. Offering your views and responses when they are important to you, even if I don't ask, is one of the ways you can be an active partner in your therapy.

There are no instant, painless, or passive cures, and no "magic pills." Instead, there may be homework assignments, exercises, practice sessions, and record-keeping, and perhaps other projects. Probably you will have to work on relationships and make long-term efforts.

Change will sometimes be easy and swift, but more often it will be slow and frustrating with a need for repetition.

If treatment is not progressing, I cannot ethically just keep working with you. I may then suggest that you see another counselor or professional in addition to or instead of me. For example, I may suggest that you see a physician for evaluation or prescription of medications, or attend self-help group meetings. In that event, I would fully discuss my reasoning and recommendations with you ahead of time so that we can come to an agreement.

I see therapy as a collaborative process -- one which defines the problem areas to be worked on and where assistance is offered in making the desired changes.

Periodically, together, we can evaluate our progress and goals and, if necessary, design a treatment plan, goals, and methods.

As with any powerful treatment, there are both benefits and risks associated with psychotherapy. Risks might include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness; recalling unpleasant aspects of your history; missing work or

school; or appearing or being judged as mentally disturbed or inadequate. Difficulties with people important to you may occur; family secrets may be disclosed; and, despite our best efforts, therapy may not work out well. Some changes may lead to worsening of your problems or even losses (for example, therapy may lead to the decision to separate or divorce).

Despite this, you should know that psychotherapy has been repeatedly scientifically demonstrated to be of benefit for most people and in most situations. Benefits might include the lifting of a depression or no longer feeling afraid or angry or anxious.

You will have the opportunity to "talk things out" fully and completely until you are satisfied.

Relationships and skills may improve dramatically. You may be better able to cope with social or family relationships, and so receive more satisfaction from them. You may better understand your personal goals and values and thus grow as a person and become more mature.

I do not take on clients whom, in my professional opinion, I cannot help using the techniques I have available. I will, therefore, enter our relationship with optimism and an eagerness to work with you.

2. SESSIONS

I usually schedule ninety (90) minutes for the "Prospective Client Consult" where in both the Therapist and the Prospective Client determine if the fundamental and requisite "Therapeutic Alliance" can be formed as well as additional information sharing to insure that the Prospective Client can make a fully informed decision regarding entering into a therapeutic relationship.

Future meetings, for the first two (2) months of counseling, are usually ninety (90) minute sessions.

Then, future sessions will last approximately one (1) hour each.

We will schedule our meetings cooperatively for our mutual convenience. Addictions Therapy is complex work requiring us to meet more often over the first three or four months, and then less often over several more months. A typical schedule is as follows: once a week for the first four (4) months; then once every two weeks for the next few months; and then spaced to three or four weeks in between sessions.

An appointment is a commitment to our work and a contract between us - we each agree and promise to be here and on time. On occasion, I may not be able to start on time. For this I ask your understanding and assure you that you will receive the full time agreed to. If you are late we will probably be unable to meet for the full time scheduled - as it is likely that I have another appointment scheduled after yours.

Your session time is reserved for you. Reality does not always allow us to keep our promises, but a canceled appointment is an interruption in our work which will delay completing it.

I am rarely able to fill a canceled hour- unless I have a week's notice. I will make our meetings a first priority, and ask you to do the same to keep missed hours to a minimum.

I do not have available personnel to supervise children in the reception area while we are meeting. Therefore, I request that you do not bring children with you *that need supervision* unless you have someone who can sit with them.

3. FEES FOR PSYCHOTHERAPEUTIC SERVICES RENDERED:

In any professional relationship, payment for services is an important issue. This is even truer in therapy, where clarity of relationships and responsibilities is one goal of treatment. You are responsible for assuring that services are paid

for; this demonstrates your seriousness, sincerity, and maturity. My regular fee for a "Prospective Client Consult" is $200.00 for a ninety (90) minute Consult session; and sixty (60) minute therapy services are charged at $150.00. I charge $225.00 for ninety (90) minute Sessions. For clients who have insurance, there are specific contract rates, deductibles, co-pays and/or co-insurance amounts, and if you don't know the specifics of your policy, I can have my medical biller investigate the correct amounts to be paid. In unusual circumstances we may, before the end of our first meeting, negotiate other arrangements. In addition, I charge $125.00 per hour for report-writing, $100.00 per hour for document review/analysis, and $200.00 per hour for court appearances. For those utilizing my services as a mediator, my fee is $175.00 per hour; for those utilizing my services to oversee visitation, my fee is $100.00 per hour plus travel costs averaging $25.00 per hour. I charge $150.00 per Test Instrument I administer which includes license purchase fee, test administration, analysis and interpretation.

The abovementioned fees applicable to you are, also, outlined on your
"AGREEMENT TO PAY FOR PROFESSIONAL SERVICES" document.

I will assume that our agreed-upon financial relationship will continue in effect as long as I provide services, or until you inform me that you wish to end it. I will expect you to pay for any services rendered to you until the time our relationship is terminated.

4. BILLING, INSURANCE, AND PAYMENTS

Unless we have other arrangements, I would greatly prefer that you pay for each session (or any approved co-pay) by the end of the meeting. Please do not interpret this as any distrust of you or lack of faith in your responsibility and maturity. In my experience, I have found that this arrangement keeps our attention focused on our goals and makes it most productive. If paying by check,

I suggest that you make out your check (payable to Kevin Chadbourne Downs) before each session begins -so that our time will be used most productively.

If you have health insurance which may pay all of or a portion of my fee, if I am not already an approved provider, I will help you with your insurance claim forms or provide you an insurance form known as a "Superbill." However, please bear in mind that you are responsible and not your insurance company, for paying the Therapeutic fees we agreed upon.

If I have agreed to bill a third party for your co-pays or services, and they do not make timely payment after being appropriately invoiced, then payment will be expected from you (the client). If there is any problem with my charges, billing, your insurance, or any other point, please bring it to my attention and I will do the same with you. Such problems can interfere greatly with our work, and must be resolved openly and without delay.

5. INSURANCE COVERAGE AND REIMBURSEMENT

As a Licensed Addiction Counselor, my services for evaluation and psychotherapy are partly reimbursable to you under many health insurance plans. For some plans you may need to get a physician's referral for psychotherapy, which must be dated before we meet; so read your plan carefully. Because health insurance is written by so many companies, I may not be able to tell what your plan covers. Please read your plan's booklet under coverage for "Out-patient Psychotherapy" or "Behavioral Health coverage" and call their office to find out the information you need. You are responsible for verifying your insurance coverage's, deductibles, reimbursement rates, co-payments, and other aspects because the contract is between you and the insurance company. If I am already an approved provider for your insurance plan, that will make things a lot easier. Currently I am a provider for most of the Blue Cross plans, Aetna, Beacon, Cigna, United Healthcare and Tri-Care, as well as many Employee Assistance Programs

(EAP).

If I am not in network with your insurance company, you can apply for reimbursement by simply mailing them my Statement (called a "Superbill") and a completed copy of their Claim Form which you can get from your employer's Benefits Office, or by calling the insurance company. You can just attach the "Superbill" to the back of their Claim Form, and send it to them. Insurance companies are guided by HIPAA regulations, and if requested should only receive a Designated Record Set (DRS) which includes your name, social security number, dates of first/last sessions and number of sessions, billing code, test results (if any), a symptoms and functionality checklist, and your provisional diagnosis (along with my fees/billing). This DRS becomes part of your permanent medical record, and although my experience indicates that a negative reflection is not at all a likely result, its possible influence on your future should be discussed with me if you are concerned. Basically, my policy is to provide the minimum information necessary for you to obtain appropriate reimbursement.

If you belong to an HMO or any other managed health care programs they will have rules, limitations and procedures which we should discuss. Please bring your health insurance card with you to our first meeting so that I can have my medical biller check out the limits and specifics of your policy. By signing this statement, unless otherwise discussed, you give me permission to allow my medical biller to contact your insurance carrier in order to check on policy details, and to file medical claims for you.

6. CONTACTING THERAPIST:

Out of consideration I usually do not take calls when I am in session with a client; I will note the call and, as soon as I can, pick up any messages left. My professional Office mailing address is: Charleston Addictions Counseling, LLC., 875 Lowcountry Boulevard, Suite 207, Mount Pleasant, South Carolina 29464-3094. I cannot always be reached by phone immediately, but the office number is

(843) 469-5489. If you leave a message, calls are usually returned by the end of that business day. In the event of emergency, or if you have the need to reach me quickly, call (843) 469-5489, and state that that your call "...is an Emergency." In emergencies, however, your calls will be returned as quickly as possible. In a dire emergency, if you cannot reach me, you might: call your personal physician; go the nearest emergency room; and ask for the psychiatrist, psychiatric resident or house officer on call; or call the Emergency Response Number at 9-1-1.

Other emergency possibilities include: Mobile Crisis (a division of mental health that is available 24 hours per day to Charleston, and Dorchester County residents) at (843) 414-2350; or the HOTLINE (211 or 747-HELP) which is a 24 hour counseling and/or crisis line available throughout the state.

I am, also, a "Tele-health" provider and some insurances cover appointments held over the phone, or using HIPAA-approved software. I use "Doxy.me", which is specifically HIPAA-approved, and easy to use. You do not have to have to install any software, and it can be used with your mobile phone, laptop or other device(s).

7. CONFIDENTIALITY

I regard the information you share with me with the greatest respect so I want us to be as clear as possible about how it will be handled. In *general*, I will tell no one what you tell me. The confidentiality of our conversations, including your records, is legally protected by Federal and State law, including HIPAA, and by my Counseling profession's Ethical Principles, in all but a few rare circumstances. These are outlined in my handout on *Confidentiality and Psychotherapy* which is also being provided to you.

I retain a third-party billing Corporation, Pettigrew Medical Billing, to process insurance claims, and Pettigrew Medical Billing makes every effort to preserve

the confidentiality and anonymity of all my clients. Please be advised that Pettigrew does not see my Client clinical records. Generally we will not use your name on the telephone - so as to further protect confidentiality. I, also, ask each client to abide by the "Golden Rule" which would preclude your disclosing the identity (or names) of any other clients being seen at this office (or whom you accidentally encounter here in the office, or in the waiting room). Also, as outlined in my Confidentiality document, communication(s) through electronic communication is generally not secure. By signing this document, you consent to the use of unsecured email, and mobile phone text messaging to transmit information relating to scheduling appointments, and information on billing and payment.

8. MY THERAPEUTIC PRINCIPLES

Each counselor has been taught and has expanded upon a way of doing therapy, where we have developed rules or methods which have worked well. I will be happy to explain or clarify these if you would like more information.

I often lend books, which you may keep as long as they are of use to you; but (unless otherwise instructed) I ask you to return them, so that I may lend them to other clients. I may also give you photocopies of articles or informational handouts which are yours to keep.

I often take notes during sessions, and sometimes ask my clients to take notes, both during the session, and at home. Periodically, I will also negotiate homework assignments with you. These can be a crucial component of personal change, and if you are willing to fully participate with these tasks, you will maximize your therapy dollars.

KEVIN CHADBOURNE DOWNS
LICENSED ADDICTION COUNSELOR, LAC/S, MAC, SAP, CSAT
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KEVINCDOWNS@GMAIL.COM

9. CLIENT TREATMENT FILES

You have the right to review your medical record (see limitations in HIPAA section of Confidentiality handout) in my Office files at any time, to request additions or corrections, and to obtain copies (with your written permission) for other professionals to use. South Carolina law, also, requires that I keep your case records in a secure place for at least ten (10) years after we last meet, or have had any professional contact. (For minors, South Carolina law requires such records be maintained for at least five (5) years, and in the case where a minor is thirteen (13) years of age or less, up to five (5) years after the age of majority, or eighteen (18) years old).

10. TERMINATION OF THERAPEUTIC SERVICES

Termination of Therapeutic Services is inevitable. It should not be done casually, as it can be made a most valuable part of our work. If you would like to take a "vacation" from therapy, we should discuss this - so as to make it most productive.

11. EVALUATION OF TREATMENT SERVICES

If at any time, you feel dissatisfaction with any aspect of therapy, please discuss your views, reasons, concerns, or plans regarding whatever is troubling you with me, as soon as possible, so we can resolve the problem.

12. CLIENT DESIGNATED CONTACT PERSON

If, during our work together, there is an emergency, or I become concerned about your personal safety, or the possibility of your injuring someone else, I am

morally and legally obligated to contact the person you identified upon completion of your intake information document.

13. THERAPIST'S EDUCATIONAL / PROFESSIONAL BACKGROUND

Because we all need to know we are in good hands, I indicate my credentials below. If you wish more information on my background or training, please feel free to ask. I am a: South Carolina/ Licensed Addiction Counselor (SC/LAC); South Carolina/ Licensed Addiction Counselor/Supervisor (SC/LAC-S); a South Carolina/Licensed Professional Counselor (SC/LPC); a South Carolina/Licensed Professional Counselor/Supervisor (SC/LPC-S); a Certified Master Addiction Counselor (MAC); a Certified Substance Abuse Professional (SAP); a Certified Sex Addiction Therapist (CSAT); and a Certified Arise Interventionist-II (CAI-II).

I have a: Bachelors of Science Degree, Criminal Justice, Northeastern University, Boston, Ma; Masters of Arts in Psychology/Counseling, Webster University, North Charleston, SC; and a Juris Doctor Degree, Law, New England School of Law, Boston, Ma.

I have been continuously licensed, in good standing, to practice law for thirty-four
(34) years in the following three (3) legal jurisdictions: Commonwealth of Massachusetts Bar; District of Columbia (DC) Bar; and the Federal District of Massachusetts Bar.

I have been professionally employed in the following three (3) professions: Law Enforcement, Undercover Narcotics Agent, and Homicide Detective; International Investigative Attorney where I investigated violations of the Federal Foreign Corrupt Practices Act (FCPA) in over fifty (50) countries; and, now, my current profession as a South Carolina/Licensed Addictions Counselor, et al.

I have served seven (7) years as Vice-Chairman of the Advisory Board for Charleston County's premier Alcohol and Drug Treatment Facility, entitled "The Charleston Center."

KEVIN CHADBOURNE DOWNS
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KEVINCDOWNS@GMAIL.COM

I serve as a "Pro Bono" Addiction Counselor resource in support of the Mount Pleasant Police Department, Mount Pleasant, South Carolina.

I am an Addiction Counselor resource used by the South Carolina/Recovering Professional Program (SC/RPP) for Medical Health Care Professionals, and by the South Carolina "Lawyers Helping Lawyers Program" to assist members of the South Carolina Bar with mental health related issues.

I, also, serve as a contracted Counselor resource for several National "Employee Assistance Programs (EAP)."

14. COMPLAINT PROCEDURES

If you are dissatisfied with any aspect of my work please raise your concerns with me immediately. Dissatisfactions will make our working together slower and more difficult if not resolved. If you feel that you have been treated unfairly or even unethically, by me or any other counselor, and cannot resolve this problem with me, you can contact the South Carolina/Board of Examiners (mailing address: PO Box 11329, Columbia, SC 29211; phone number (803) 896-4658), and speak to the Chairperson of the Ethics Committee for clarification, or to lodge a complaint. There may be other options which I would be glad to expound upon if you so desire.

15. ADDITIONAL POINTS OF PROFESSIONAL REFERENCE

A. CODE OF ETHICS: Like any health care professional, I have an ethical responsibility and am also available to answer professional questions which you have the right to raise. I fully abide by the Ethical Principles of the American Mental Health Counselor Association and the South Carolina/Board of Examiners for Licensed Professional Counselors.

B. OUT-OF-OFFICE CONTACT: As a result of our special, professional relationship, one frustration of being a counselor is that I cannot now nor will I ever be your "friend."

I will not see you socially or enter into any business or other relationship besides the therapeutic one, no matter how rational or beneficial it may seem at the time.

For this reason, my licensure board mandates that we not request, or accept friend requests on social media sites like Facebook. If we meet on the street or socially, I will minimize our conversation - so as not to run any risk of breaching confidentiality in an open environment. I will never introduce you to someone I may be with as "a client". You are welcome to approach me if you wish to, but please know I will not initiate any contact in ethical respect for your privacy. Also, I will never betray your trust, nor could we ever enter into or pursue a sexual relationship, as that would be highly unethical.

C. MEMORY WORK: People often approach me to help them recover memories of past traumas. I do not employ hypnosis as part of the techniques I use.

I will be happy to work with you to sort out troublesome memories, intrusive thoughts, dreams, etc., however memory work often does not have concrete resolution. Regardless of whether we can prove that a memory or dream is based on fact, we can work with the feelings associated with same.

D. PROFESSIONAL LIMITATIONS: I am not licensed or trained to practice medicine, and/or social work and am not willing, nor capable, of giving you trustworthy advice from other professional points of view.

E. NON-DISCRIMINATION: In my professional practices, as counselor, consultant, mediator, guardian and/or teacher, I do not discriminate in accepting and treating patients, clients, students or others on any of these bases: age, gender, marital status, race, color, religious beliefs or creed, belief, ancestry, national or ethnic origin, ethnicity, location of residence, physical or mental disability or handicap, veteran status, sexual

orientation, health status, having a criminal record unrelated to present dangerousness, or in violation of federal, state or local laws or executive orders. This is both a personal commitment and is made in accordance with Federal, State and local laws and regulations. If you believe you have been discriminated against -please bring this matter to my attention immediately.

17. <u>CONTRACT AGREEMENT:</u>

I, Client, have read (or had read to me) the issues and points stated above, discussed them where I was not clear about those points, had my questions fully answered, and understood, and agree to comply with them.

As such, I, hereby, voluntarily agree to enter into psychotherapeutic counseling services with this Counselor, Mr. Kevin Chadbourne Downs, as indicated by my signature below.

_____ _____

Client **Date**

I, Mr. Kevin Chadbourne Downs, the Counselor, having interacted for a suitable period of time with the client, and find no reason to believe that client is not fully competent to give full, and voluntary consent to psychotherapeutic counseling treatment.

Furthermore, I believe the issues raised above are fully understood, and because I have personally informed the client of the above-stated issues and points, discussed them, and responded to all questions raised, I agree to enter into psychotherapeutic treatment with this client, as indicated by my signature below.

_____ _____

Counselor **Date**

I, truly, appreciate the opportunity you have given me to be of Professional Psychotherapeutic Counseling Service to you, and am happy to receive your questions, comments, suggestions, and/or concerns at any time.

KEVIN CHADBOURNE DOWNS
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VIi. HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to ensure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office, which is located at 875 Lowcountry Boulevard, Suite 207, Mount Pleasant, SC 29464-3094.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others,

however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. **For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.**
2. **For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.**
3. **To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.**
4. **Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.**

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

1. **To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.**
2. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
3. **If disclosure is mandated by the Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect or if I have a reasonable suspicion of elder abuse or dependent adult abuse.**
4. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
5. **For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.**
6. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.**
7. **If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in**

emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular

mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. **The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.**

E. **The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.**

F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

Kevin Chadbourne Downs, B.S. Crim. Justice, M.A., J.D., Attorney, LAC/S, LAC, LPC/S, LPC, MAC, SAP, CSAT
875 Lowcountry Boulevard, Suite 207, Mount Pleasant, SC 29464-3094

The signatures here attest to the fact that we each have read, discussed, understand, and agree to abide by the points presented above.

_____ _____

Client's Signature **Date**

_____ _____

Kevin Chadbourne Downs **Date**
B.S. Crim. Justice, M.A., J.D., Attorney, LAC/S, LAC, LPC/S, LPC, MAC, SAP, CSAT