GROWING ROOTS LLC
Integrative Health & Wellness
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Growing Roots LLC was established in 2009. Our expertly trained staff provide compassionate evidence-based mental and behavioral health services to adults, adolescents, and families in Central New Hampshire.

Our Services

Evaluation and treatment for:

- depression and mood disorders
- anxiety-related disorders
- obsessive compulsive disorder
- adult and adolescent eating disorders (anorexia nervosa, bulimia nervosa, ARFID & binge-eating)
- substance abuse and dependence
- anger and stress management
- life transitions (loss of loved one, divorce, change of career)
- sports psychology and performance improvement
- attention deficit and academic underachievement
- parent-child problems
- couple's issues

Growing Roots LLC **does not** treat sexual offenders, perpetrators of intimate partner violence, or children under six years old.

Client Rights & Responsibilities

Introduction to the Practice: Psychotherapy (or "therapy") is a change-oriented process. Therapy occurs in the context of a trusting relationship between a mental health professional and one or more individuals known as clients or patients. Therapy is unlike many medical treatments as it requires the client's active contribution. Thus, therapeutic change is most likely when the client is actively engaged both in face-to-face or VSee meetings ("Sessions") with the service provider and practicing relevant skills between these meetings.

Psychotherapy can have benefits and risks. By nature, therapy often involves establishing healthy means of coping with distressing matters. The client may experience uncomfortable feelings like anger, sadness, guilt, frustration, loneliness, and helplessness. Learning how to better manage these experiences in the context of a psychotherapeutic relationship can improve relationships, change behaviors and reduce distress. Unfortunately, there are no guarantees how psychotherapy will progress or its outcomes. It is the responsibility of the client to alert your clinician at any time if the process is misdirected or unmanageable.

The first few therapeutic sessions will involve an evaluation. Evaluation may include questionnaires, observations, third party documentation and/or interviews. By the end of the evaluation, the clinician will offer initial impressions and a treatment plan. It is the responsibility of the client to participate in this process honestly and openly and to consider feedback and recommendations.

The client may discontinue the service or ask for a referral to alternate services at any time. Because therapy may involve a significant commitment of time, emotion, money, and energy, you should be careful to select a therapist whom you trust.

Contacting Growing Roots LLC: The Growing Roots LLC office number is 603-238-3149. We do not take calls while in session unless anticipating an emergent call. When unavailable, your call is answered by a confidential automated answering service that is monitored frequently. We will make every effort to return calls within 24 hours. Our email address is office@growingrootsllc.com. We recommend limiting this type of communication to non-clinical matters, as we cannot guarantee confidentiality. It is our policy not to engage in social media communication with our clients. We do not search social media sites or search engines for information regarding our clients. Unless specifically agreed upon in advance, Growing Roots LLC does not provide 24/7/365 emergency coverage. In case of emergency, dial 911 or go to your local hospital emergency room. Once the emergency is stabilized and everyone is safe, call our office 603-238-3149 or email office@growingrootsllc.com to inform your clinician of the situation.

Fees, Insurance, Meeting & Billing:

Diagnostic Interview (initial assessment): $300.00
50-60 minute session: $195.00
90 minute session: $292.50
Psychiatry Intake: $500.00
Medication Management/Psychiatry Follow Up: $300.00

Phone calls over ten minutes will be considered a partial session and are not reimbursable by insurance. They will be billed at a prorated rate of our hourly fee of $1 9500
15-29 minutes: $97.50
30-44 minutes: $146.25
45-60 minutes: 195.00
Writing reports, attending meetings, or providing other services on your behalf is billed at $195.00 per hour, also not covered by insurance.

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide notice one full business day in advance, except in instances of illness, injury, or extreme weather conditions. Please note: insurance does not pay for late cancellations (less than 24 hours) or missed appointments, you will be charged a flat rate of $195.00 for missed therapy appointments. Missed appointments or late cancellations of Psychiatry appointments will be charged the full rate of the scheduled session.

We expect payment and/or co-payment fees at the time of service.
We require a credit or debit card on file.

We are In-Network providers for Aetna, Anthem BCBS, Cigna, and WellSense. We will bill directly to these companies on your behalf. Co-payment or deductible will be required at the time of service. Please be clear about the limitations of your policy; it is your responsibility. If you are covered by another insurance company, we can provide you with an invoice for you to submit for reimbursement upon request. Regardless of your insurance status, you are responsible for the balance on your account for professional services rendered. A sliding scale is a type of fee structure configured to give clients with fewer financial resources a lower fee. *Please speak with your clinician directly to discuss sliding scale fees, if applicable.*

We reserve the right to discontinue service if you have an outstanding bill or repeatedly fail to provide payment at the time of service. Outstanding balances of more than 90 days will be sent to collections at our discretion. Fees for collection will be your responsibility in addition to the amount due. In general, we will resist participating in concurrent legal processes in the belief that doing so is likely to undermine the therapeutic relationship. However, if you require that Growing Roots LLC participate in legal processes, you will be expected to pay for all professional time, including preparation and transportation costs, at an hourly fee of $250 with a two-hour minimum. In this case, all anticipated costs will be due as an advance retainer, even if we are called to testify by another party. *These services are not covered by your insurance.*

Diagnosis: Diagnosis is the formal identification of an illness corresponding to the client's constellation of social, emotional, and intellectual strengths and weaknesses. All diagnoses relevant to psychological services are cataloged in the Diagnostic and Statistical Manual and the International Classification of Diseases. Growing Roots LLC uses formal diagnoses to support third-party reimbursement.

Confidentiality and Limitations: Growing Roots LLC recognizes that confidentiality is one of the most important factors in the decision to pursue services from a mental health professional. Confidentiality means that no information is released to individuals outside the session without the client's consent. The following are exceptions to confidentiality where a clinician can legally share information:

- If the client provides written permission to disclose information from their clinical record
- Disclosure of child abuse and/or neglect
- Disclosure of abuse and/or neglect of incapacitated adults.
- Suicidal or homicidal intent
- You are (or become) involved in a legal proceeding in which your psychological condition is an issue (e.g. personal injury, worker's compensation, disability, other insurance requests).
- A court orders the release of clinical records.
- The client is a minor child. Growing Roots LLC strives to respect the child's confidentiality while also meeting the needs of the parent(s). If the client is an adolescent, we consider the session confidential unless the adolescent is a danger to themselves or others.

Couples: Treatment records of a couple's sessions contain information about both parties. Clients should be aware that either person has the right to obtain treatment records. If one requests records, it is the policy of Growing Roots LLC to notify the other person and to afford that individual an opportunity to receive a copy of the record as well.

Minors: Generally, the treatment of a minor child (under the age or 18) must be authorized by a parent or legal guardian. It is the policy of Growing Roots LLC to treat minors only with the consent of both parents, to the extent both are available. If one parent is unavailable and the clinician determines it is appropriate to proceed with the consent of only one parent, the absent parent will have the right to the child's treatment records upon request. If both are available but cannot reach agreement about treatment and access to records, it is the responsibility of the parents to resolve their differences through a court hearing prior to instituting treatment. Parents have the authority to access and release the child's confidential treatment records. In New Hampshire, all information regarding your child's therapy file is considered privileged and therefore can only be released in limited circumstances. If there is a dispute about the release of your child's records, the court must determine what is in the child's best interest. Upon turning 18, the child gains control over treatment, information, and records.

Group Therapy: Unlike individual treatment, the confidentiality of group therapy is not privileged, and therefore not protected by law. Group members must sign and abide by a written confidentiality agreement prior to participating in the group. Clients with concerns about confidentiality should discuss them prior to beginning group treatment.

Conflicts of Interest: New Hampshire is a small state. From time to time, actual or potential conflicts of interest may arise. If a clinician becomes aware of a conflict of interest, they may be required to refer the client to another clinician. Regardless of the existence of a conflict of interest, confidentiality still applies.

Professional Boundaries: Licensed clinicians are obligated to establish and maintain appropriate boundaries (relationships) with present and former clients. Clinicians should not socialize or become friends with clients and should never become sexually involved with a client.

Consultation, Professional & Ethical Issues: Clinicians are professionally and ethically required to consult with other health and mental health professionals to maintain professional skills and perspective. During a consultation, clinicians make every effort to avoid revealing identifying information about the client. The other professionals involved are also legally bound to keep the information confidential. Clinicians are professionally and ethically required to designate a colleague who will assist with record management/distribution upon their death or disability. The law encourages clinicians to remind clients that they are legally protected against sexual contact and various other "boundary violations" by clinicians—behavior that, of course, would never be tolerated by any ethical clinician regardless of what the law dictates.

Termination: Termination of psychotherapy can be an indication of the completion of the original treatment plan. If the client wishes to terminate prior to completion of the treatment plan, a final session will be scheduled to summarize progress, discuss any unresolved issues, transfer to another clinician, and to sign all releases of information for the transfer of the clinical file.

Note to Clients: In case the clinician is suddenly unable to continue to provide professional services or to maintain client records due to incapacitation or death, the clinician has designated a colleague who is a licensed mental health professional/clinician as their professional executor. If the clinician dies or becomes incapacitated, the clinician's professional executor will be given access to their client records and may contact the client directly to inform them of the clinician's death or incapacity, provide access to their records, provide psychological services if needed, and/or to facilitate continued care with another qualified professional if needed. If the client has any questions or concerns about this professional executor arrangement, your clinician will be glad to discuss them.

Mental Health Bill of Rights:

The unabridged version of this document hangs in the office for reference. New Hampshire State Law requires clients be notified they may obtain the following information from their provider:

- The licensed professional code of ethics
- The licensed degree, license and areas of expertise
- Confidentiality and its limits
- The licensed psychologist's responsibilities to communicate the threat of violence to self, person or property to the victim or victims or to notify the police department of such threat or obtain civil commitment
- Reporting requirements regarding child abuse and the abuse of incapacitated adults
- Illegality of sexual contact and other boundary violations between a current client or former client and therapist
- An individual mental health diagnosis as part of evaluation as designated in RSA 330-A: 2 VI
- Cost of services
- Nature of assessment and access to assessment results
- Recommended treatment with rationale and if no treatment recommended an explanation
- Provision for emergency coverage
- Provision for record management following death or disability of the clinician
- Provision for emergency coverage
- Provision for record management following death or disability of the clinician
- Information as to what to do if dissatisfied with treatment

Complaints and Concerns: Client concerns will most effectively and efficiently be addressed by bringing them directly to the attention of your clinician/ Growing Roots LLC. Clients have the right to bring any such concerns to the attention of the following agencies:

New Hampshire Board of Mental Health Practice 117 Pleasant Street Concord, NH 03301 603-271-6762
New Hampshire Board of Psychologists 7 Eagle Square Concord, NH 03301 email: jabarnes@dhhs.state.nh.us

Informed Consent Agreement

I have read and agreed to each of the previous sections of the agreement. I have had an opportunity to discuss any questions or concerns. By signing below, I indicate that I understand and agree to the terms of this agreement. ***Please note if the parents of an underage child (the client) are divorced, both parents need to be aware of and consent to treatment.**

Client Name_______________________ Date of Birth_______________________ Date____________

Signature Client____ Date____________

Signature (Parent)____ Date____________

Signature (Parent) ____ Date____________

CLIENT INFORMATION / INTAKE FORM

FAMILY MEMBERS or others who currently live in your household:

Name	DOB	Relationship	Occupation

LIST ANY ACTIVE OR PAST HEALTH CONCERNS:

CURRENT MEDICATIONS (Prescription, Over the Counter, Vitamins, Herbs, and/or Pain Medications)

Drug Name	Dose	Frequency

Have you previously taken any psychiatric medications not listed above? Yes/No

Name of medication: Effect:

SURGICAL HISTORY

Please list date of the operation or your age: Procedure/Operation:

Hospitalizations other than for surgery:

Please list date/age: Reason:

Have you ever received any previous mental health treatment? Yes / No
If yes, please list providers, dates of service, reason for service, and perceived effect of treatment:

Describe any concerns or problematic experiences with mental health services in the past?

Have you received any inpatient mental health services? Yes/No
If yes, please describe:

Please share any relevant information regarding developmental milestones (for your child/the client):

Please share any relevant information regarding pregnancy (regarding your child/the client):

Who Referred you to this office?

FAMILY HISTORY

Has any member of your family (including parents, siblings and children) ever had problems with the following:

Condition	**Specify who in the family**
Anxiety	
Depression	
Substance abuse or dependence	
Schizophrenia	
Suicide	
ADHD	

HOBBIES / EDUCATION:

What kind of grades do / did you earn in school?

Have you ever been retained/suspended/expelled from school? Yes / No
If yes please indicate reasons for retention/suspension/expulsion

Are there any special circumstances in your educational history (Individual Education Plan (IEP), tutoring, special education courses like Chapter 1, talented and gifted/honors programs, accommodations like extended test times or special seating) ? Yes/ No If yes, please describe

Please describe any extracurricular activities that you participate in:

Please describe your involvement with religious and spiritual beliefs:

Describe life events or changes that have occurred in the past year (e.g., job changes, death in the family, Divorce, child entering/leaving school, serious illness financial problems:

What do you expect to get out of this treatment or evaluation?

What is the most stressful thing in your life right now?

Please highlight any of the following that you feel are *currently problematic*:

Nervousness/Anxiety	Depression	Marriage	Fears
Shyness	Sexual Problems	Suicidal Thoughts	Nightmares
Drug Use	Inferiority Feelings	Unhappiness	Sexual Abuse
Anger	Alcohol Use	Money Problems	Temper
Irritability	Emotional Abuse	Self-Control	Appetite Sleep
Stress	Making Decisions	Relaxation	Children
Money	Concentration	Legal Matters	Tiredness
Headaches	Health Problems	Energy	Loneliness
Physical Abuse	Memory	Parents	
Insomnia	My thoughts	Stomach Problems	
		Education	

Other:

HEALTH RISKS

Do you wear seat belts? YES/NO

Do you use tobacco? YES/ NO

Do you drink alcoholic beverages? YES/NO

Do you drink caffeinated beverages? YES/NO How many?

Do you use drugs? YES/NO Explain:

Is there a gun in your home? YES/NO Is it locked/secured?

Have you been in a relationship where you have been physically hurt by someone? YES/NO Explain:

Do you feel afraid of your Partner? YES/NO

Insurance Form

Outpatient mental health coverage should be verified by the client or guardian prior to the first appointment. Benefits can be verified by calling the phone number on the back of the health insurance card. The insured is held responsible for any expenses not paid by the insurance provider.

Client Legal Name: ______________________________________ Date___________________

Date of Birth____

Insured's Name (if different than client) ____

Date of Birth: ______________ Relationship to the client: ______________________________

Daytime Phone Number: __________________________________ (circle)Work/Home/Cell

Evening Phone Number: __________________________________ (circle) Work/Home/Cell

Name of Insurance Company: ____

Telephone Number of Company: ____

ID or Policy #: ____

Group # (if applicable): ____

Employer's Name: ____

Max # of Visits per year: ______ Co-pay: _______ Insurance effective dates: _____________________

Payment Authorization

I authorize my insurance plan to pay benefits on my behalf to Growing Roots LLC:

Responsible party: ____ Date: ______________

I authorize Growing Roots LLC to release information about my claims to my insurance company.

Name of Adult Client or Subscriber: _____________________________________

Date______________

Informed Consent to Exchange Confidential Information

Regarding: ____________________ Date of Birth: ____________________

State and Federal law limits the exchange of healthcare and otherwise confidential information in the absence of written acknowledgement and authorization from the client and/or one or both client's legal guardian(s).

By signing below, you authorize Growing Roots, LLC, to release to and/or to receive any and all information regarding the individual identified above with the party identified below. This consent is inclusive of all matters, even in those jurisdictions which information pertaining to the use of drugs and/or alcohol and/or tobacco and in which information pertaining to sexual activity, reproductive health, HIV and AIDS status may be subject to specific conditions of confidentiality.

This consent will remain in effect for one (1) full year from the date of signature unless and until the individual named above or their legal guardian(s) rescind it in writing, or the court nullifies it.
Growing Roots LLC reserves the right to withhold any information believed, in their sole discretion, to cause harm.

Informed Consent to Exchange Confidential Information with:

Name of intended party: ____________________

Party's Mailing address: ____________________

Phone/fax/email contact: ____________________

Purpose of communication: ____________________

Signature of Client or Client's Legal Custodian

Client Name - please print: ____________________

Signature (if age 18 or older): ____________________ Date: ____________________

Parent/Guardian Signature: ____________________ Date: ____________________

Witness Signature: ____________________ Date: ____________________

Consent to communicate via electronic Media

By signing below, you acknowledge that information communicated via electronic media (e.g., e-mail) is time and cost efficient but may not be secure. You allow Growing Roots LLC to communicate with the above-named individual via electronic means:

Client Name - please print: ____________________

Signature (if age 18 or older): ____________________ Date: ____________________

Parent/Guardian Signature: ____________________ Date: ____________________

Witness Signature: ____________________ Date: ____________________

If you/the client are working with Knower Academics, may we speak with them regarding treatment planning as related to academics?

Parent/ Guardian Signature: ____________________ Date: ____________________

Agreement of Between-Session Communication

As you or your child / adolescent participate in treatment, it may be helpful at times to receive additional support by communicating outside of a scheduled treatment session by phone, text and/or email. Though not all clients may require or request this service, the following offers an outline of expectations and limitations for those who do choose to communicate outside of scheduled treatment sessions. By reviewing and signing this document, you confirm that you understand and agree with its stated conditions, and that you've discussed the details of this agreement with your treating clinician.

Clinicians within the Growing Roots office may offer to communicate by phone, text and/or email with clients and client's parents / guardian outside of program hours. This communication will be focused on problem-solving strategies, skills generalization, and the sharing of information relevant to treatment-related goals and interventions.

Clinicians and clients/ families who choose to communicate outside of program hours do so voluntarily. Please understand online communication may not be secure. This communication can be discontinued by the clinician or family at any time.

Clinicians who communicate with clients and/or families between sessions must document the duration and general content of phone and email contact in progress notes within the next business day. These communications will incur a charge if longer than 10 minutes (please see treatment cost sheet)

Clinicians communicating with clients and/or families outside of program do so according to HIPAA guidelines of privacy and confidentiality. Individuals and families who have agreed to communicate with Growing Roots clinicians by phone or email have reviewed these guidelines and have signed all related consents and authorizations at intake. Clients or parents who are unable to reach their Growing Roots clinician during times of crises, agree to contact emergency services as needed.

Clinicians concerned for the safety and well-being of an adolescent Client during or between session contact, will notify the adolescent's parents immediately. In the event the clinician is unable to reach a parent; the clinician will contact emergency services as needed.

Client/Adolescent Signature: ____

Signature of Parent/Guardian ____

Credit Card Form

Payments can be made by check or credit card.

***Please note if paying with AMEX we will add a $5.00 service fee to offset higher processing fees.**

Credit card information:

Type of Card: ____

Name on Card: ____

Card number: ____

Expiration date: ________________________

CV2 code on back of card: __________

Card billing address:

____

Signature authorizing credit card payment:

____ Date: __________________

Informed Consent for Telehealth

Growing Roots LLC offers the option of conducting sessions through a secure telehealth program. Telehealth is a convenient way to increase access to mental health services and has many benefits. These include increased flexibility for scheduling, increased confidentiality by eliminating the need to travel to a therapy office and use a public waiting room, increased comfort by allowing the ability to conduct a session in one's own home, and increased access for those whom the distance to the office is a barrier.

As with in-person therapy, telehealth does carry certain risks and requires certain responsibilities for both clients and clinicians. These risks include the need for a stable internet connection; technical issues may result in the need to use a voice-only system or to cancel and reschedule a session. Confidentiality may be breached if other people enter the client's space or can overhear a telehealth session. In addition, clinicians have reduced ability to intervene in issues regarding client safety.

Growing Roots LLC requires that prior to beginning telehealth services, clients and/or their legal representative read and agree to the following:

Responsibilities of Growing Roots Staff

To minimize risks, you can expect the following from Growing Roots LLC staff, your clinician will:

- Use a secure HIPAA compliant video telehealth program and explain how to use it
- Conduct the session from a private area free of distractions and intrusions from others
- Confirm your identity before the start of the session
- Ask you to confirm that you are in a quiet, private area, free of distractions
- Develop a back-up plan with you that includes a number where you can be reached in case of technical difficulties
- Develop a documented safety plan with you that includes an emergency contact and circumstances that would necessitate contacting your emergency contact or emergency services
- Turn off all apps and disable notifications that could appear on-screen
- Keep all confidential health information on a secure data storage device/service
- Reserve the right to make the determination that telehealth services are not appropriate and to resume sessions in-person

Responsibilities of Growing Roots LLC Clients

To assist with the delivery of professional and responsible services, clients will agree to the following:

- Ensure they are in a private quiet area with adequate internet connection
- Inform their therapist if someone else enters into their space
- Refrain from using any apps during the session and will turn off notifications
- Arrive to the telehealth session on time
- Be able to participate in a remote session and be free from the influence of any substances
- Follow a safety plan and be able to regulate emotions without engaging in destructive, aggressive, or self-harming behaviors
- Understand that the clinician will contact their emergency contact and/or emergency services if unable to manage emotions and there is a risk to personal or interpersonal safety
- Cancel or reschedule sessions with at least 24 hours' notice
- Sessions canceled without 24 hours' notice and no-shows will be charged a $195 late notice fee
- Respect professional boundaries and conduct themselves in a manner similar to an in-person session

My clinician has reviewed the above information with me. I understand and agree to follow all specified responsibilities.

Clinician Name / Signature: ____

Client Name: ____

Signature of Client/Client's Legal Representative:

____Date: ____________