Cindy Greer, MSW, LCSW
P.O. Box 2204
Sisters, OR 97759
541-420-7671
cgreer.lcsw@gmail.com
cindygreerlcsw.com

Welcome!

Thank you for reaching out to schedule an appointment with me. The forms I will be asking you to complete will describe my professional and office guidelines and practices, including a separated disclosure and practice contract for Telemental Health. I will also ask you to sign a HIPPA compliance form as well as a brief client information form.

The first form is “Professional Disclosure Statement and Acknowledgment and Consent to Treatment” which is an explanation of important information regarding practice policies, confidentiality and informed consent for treatment. Please initial and sign that you have read and understand.

Forms titled “Notice of Privacy Practices” and “Telemental Health Services Informed Consent” need to be signed and dated.

The “Intake Information” form allows me to set-up your record by collecting basic information necessary for insurance billing.

Please take time in reviewing all documentation before signing. Forms need to be forwarded by email to cgreer.lcsw@gmail.com before our first session. At our first session we will make time to discuss and answer any questions you may have regarding therapy and our professional relationship.

I look forward to meeting you,
Cindy Greer, LCSW
Licensed Clinical Social Worker

Cindy Greer, LCSW, LLC
392 E. Main Street, Sisters, OR
P.O. Box 2204, Sisters, OR
541.420.7671

PROFESSIONAL DISCLOSURE STATEMENT ACKNOWLEDGEMENT AND CONSENT TO TREATMENT

*Please **initial each** policy if you understand it:*

_____ **Payment:**

Fees for services are $185.00 for the Biopsychosocial Assessment, $150.00 for 50 minute sessions billed to insurance, $125.00 for 50 minute session if insurance is not billed. **You are responsible for all costs of services.**

Insurance: It is your responsibility to contact your insurance company prior to your first session to clarify what your policy covers and request pre-authorization if it is needed. Many insurance companies will be billed directly through my Billing Agent. If your insurance company is billed directly, **you are responsible to pay all deductibles and co-pays at each session** (unless another arrangement has been made). Be advised that billing information may be faxed to my Billing Agent. ***If your insurance company is not one that we bill directly, you will be responsible to pay for services at each session.*** I will provide you with a receipt that can be submitted to your insurance for possible reimbursement. I accept payments via check or credit card. A processing fee may be charged for credit card payments. There is a **$30.00** charge for returned checks.

Should your account become delinquent, then it will be sent to a collection agency. If your account is sent to collections, you agree to be liable for 35% above and beyond your outstanding balance in order to cover the cost of the collection agency. Should legal proceedings become necessary, you will be liable for all attorney fees and court costs.

_____ I give Cindy Greer, MSW, LCSW permission to fax and communicate to a person or agency for the purpose of billing insurance.

_____ I give Cindy Greer, MSW, LCSW permission to contact me via cell phone, unsecure text and unsecure email.

_____ **Managed Care:**

Some insurances use managed care systems. In order to access treatment, managed care companies may require written treatment plans to authorize additional sessions. Only information pertinent to the request for additional sessions is provided (please see the Confidentiality section listed below).

_____ **Cancellations/No-Shows/Lateness:**

When it is necessary to cancel an appointment, please give **24 hours** notice **(a full 24 hour notice is required)**. ***Sessions not canceled with a 24 hour notice, you will be billed $65.00 regardless of insurance reimbursement rates.*** If you are going to be 15 minutes or more late for a schedule appointment, please call. If no call is received, the appointment will not be guaranteed and you will be charged the late fee of $65.00.

_____ **Sessions:**

Sessions are 50 minutes in length unless other arrangements have been made.

______ **Telephone Message Service:**

I use a voice mail system that can take messages any time. Through the day, I check messages regularly and whenever possible try to return phone calls the same day. If I have not returned your call within forty-eight hours, please try again as your message may have been lost. I do not check office messages after 6:00 p.m. on weekdays or routinely on weekends and holidays. I do not return calls on weekends, evenings, holidays or when I am on vacation. If you have an emergency during any of these times listed, call 911 or go to an emergency room.

_____ **Emergencies:**

In the event of an emergency, please contact 911 or go directly to the nearest emergency room or hospital. ***DO NOT LEAVE A MESSAGE of a mental health crises on my voice mail, text or email. I ask that your commitment to yourself and to me (if you engage in treatment with me) is that you keep yourself safe. Therefore if you are not sage from imminent self-harm even during normal business hours please dial 911 or go to the nearest emergency room.***

_____ **Confidentiality:**

Information revealed during treatment is confidential and cannot be shared with anyone else without your written consent. However, you should be ware that there are some exceptions:

- According to State and Federal laws, if a disclosure is made regarding child or elder abuse or neglect, the therapist must report the abuse/neglect to the appropriate authorities. Also, if a client demonstrates imminent danger to her/himself or to another person, the therapist must act to avert that danger.
- In rare situations, clinical records and/or a therapist's testimony may be subpoenaed by a court (child custody dispute or an injury lawsuit).
- As part of our profession, we engage in supervision and consultation with colleagues. In accordance with ethical standards, we make every effort to maintain confidentiality by withholding identifying information.
- If you file a complaint against my office with the state licensing board.
- In addition, managed care companies may require that written treatment plans be filed for review by their employees for authorization of services.

In all cases, steps are taken to protect privacy; that is, only information relevant to the situation is disclosed. Every effort will be made to inform you if an exception occurs. Please refer to *Rights to Privacy and Exception to Privacy* for more information.

CLIENTS RIGHTS AND RESPONSIBILITIES:

You have the right to:

- Impartial access to treatment
- Considerate, respectful care
- Personal and information privacy
- Know the identity and professional status of your therapist
- Informed participation in decisions, involving your care
- Know the reasons for any transfer, referral of care
- Obtain access to your record, including information about diagnosis, treatment, and prognosis
- Request and receive an itemized bill

ASSESSMENT AND TREATMENT PLANNING:

To provide you with the best care possible, it is important that I have a clear understand about what brings you to treatment. To assist me in this process, I may ask you to complete forms, and I will ask you detailed questions about your past and current functioning, including information about past mental health problems, previous treatment and alcohol and drug use. We will plan together what we will work on and how we will approach it. I will also share with you my assessment of your concerns and we will evaluate together on an ongoing basis whether this treatment is helpful to you.

RISKS TO TREATMENT:
It is important for you to know there are risks involved in treatment. It is often difficult and embarrassing discussing very personal information and you might experience anxiety during and after such conversations. Many people experience an increase in stress, particularly during the early stages of treatment. Some problems also seem to get worse before they get better (in children this is called an extinction burst). In some cases (with couple or family) discussing long-standing, unresolved problems can seem to aggravate rather than help the problem. These are natural occurrences, but you should be aware of them. Other risks may occur as well, depending on your unique situation.

TREATMENT ALTERNATIVES:
Not all clients are well suited to my treatment approach, nor am I able to treat all problems confronting my clients. If at any time you have doubts about the appropriateness or effectiveness of your treatment please discuss these doubts with me as soon as possible.

RIGHTS TO PRIVACY AND EXCEPTIONS TO PRIVACY:
The work we do together is confidential. Occasionally information from other persons or professionals is useful in the treatment work. If that is acceptable, I will ask for your permission in writing and ask you to complete a “Release of Information” form. Similarly, I will not seek or receive information from others who know you without first receiving your permission. If there is specific information you believe would be helpful for me to know about, particularly previous mental health treatment, please bring this to my attention as soon as possible.

Some things, by law, cannot be kept private. Here are the exceptions to your right to privacy.

- If I am subpoenaed to testify in court, I may have to give information about you without your permission. If I am subpoenaed, I will make an effort to contact you. If you oppose release of information, a court may nevertheless require compliance with the subpoena.
- If I learn that abuse may have occurred (or is occurring) to a child or elderly person, I am required to report this to authorities per Alaska and Oregon law. This also defines a child witnessing domestic violence as abuse.
- If I learn of a client’s specific intent to bring harm to himself/herself or to another person or to commit an act of violence, it is my responsibility to protect you as well as others. Under these circumstances, I reserve the right to inform other family members, intended victims or authorities as appropriate. If I learn of a client’s intent to do harm to me, I also reserve the right to protect myself by informing the authorities.
- A non-custodial parent who desires information pertaining to their child’s treatment may have the right to review their child’s treatment record and to discuss their child’s care with me.

Confidentiality is also an important issue for children/adolescents or when spouses are involved in treatment. When children and adolescents are referred for treatment. It is important to respect the need for some privacy. While in treatment, if a child or adolescent (ages 14-17) discusses an issue that I

perceive as dangerous or clinically relevant to that child/adolescent, I will involve the parents or appropriate parties.

LEGAL PROCEEDINGS/COURT INVOLVEMENT:
It is not my policy to testify at any judicial proceeding on behalf of my clients who are engaged in adversarial issues. This includes legal proceeding involving marital, custody and/or visitation. My goal is to support my clients through the achievement of therapeutic gains.

In the event that you require my testimony or involvement in a non-adversarial aspect of legal and court proceedings, I will do so only with your consent. I will need to bill for time spent talking with your lawyer, commuting, waiting and court time. If I am asked to provide anything in writing I will also need to bill accordingly. I will be unable to disclose any information pertaining to other family members or parties involved in treatment without their specific consent to disclose this information. An invoice describing all fees will be sent to you and/or your attorney should testimony be required.

PHILOSOPHY AND APPROACH:
I approach treatment as a collaborative effort between myself and my clients. Treatment is tailored to clients' unique goals and needs, styles of integrating information, and preferred coping skills. I find that many people benefit from EMDR, CBT, brief/solution-focused, attachment-based and family systems methods.

FORMAL EDUCATION AND TRAINING:
I hold a Master degree in Social Work from Portland State Graduate School of Social Work. My undergraduate degree in General Social Sciences is through University of Oregon. I have training and experience in depression, anxiety, substance abuse, adjustment issues, trauma, grief and loss, disorders of children and adolescents. I provide services to individuals utilizing telemental health.

As a licensee of both the Alaska and Oregon Board of Licensed Clinical Social Workers, I will abide by its Code of Ethics. To maintain my licenses I am required to participate in annual continuing education.

Please sign below that you have read, understand and agree to the policies outlined above. In addition, that you acknowledge and consent to treatment.

Client Signature: ____ Date: _________________________

Parent/Guardian Signature: ________________________________ Date: _________________________

Cindy Greer, LCSW, LLC
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PO Box 2204 Sisters, OR 97759
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NOTICE OF PRIVACY PRACTICES

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

INTRODUCTION:

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by me in any form are kept properly confidential. This act gives you certain rights and control regarding how your health information is used.

MY COMMITMENT TO YOUR PRIVACY:

Your health record contains personal information about you and your health. Except in the specific instances mentioned below, I do not release identifying health information (called protected health information or PHI) about you without your specific written authorization.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

1. **Treatment:** If I need to communicate with others about your treatment, I will obtain your written permission to do so. In most instances, the purpose of this communication is to enable me to provide or coordinate your treatment. This can include consultation with physicians, other clinicians or consultants. There are some very circumscribed situations as explained in the "Required or Permitted by Law" section on page 2 of this form in which your written permission to communicate with specific others is not required.

2. **Payment:** I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities include determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, or reviewing services provided to you to determine medical necessity. The type of information usually requested by insurance companies pertains to your diagnosis, symptoms, current functioning, treatment plan, response to treatment, and other information of this nature. I will, at your request, discuss what information I am sharing with your insurer and, at your request, allow you to review this information before I submit it. If you request that this information not be shared with your insurer, treatment may then be arranged on a self-pay basis.

3. **Health Care Operations**: At times, I will have to contact you regarding your treatment, scheduling of appointments, billing and other matters. It is your responsibility to inform me which methods you prefer to maintain your privacy. For example, if you do not want to be contacted at work please inform me of this fact. Or, if you do not want me to leave my name on a family voicemail, let me know about your concerns. I attempt to conduct these communications with a respect for your privacy, but you will need to inform me of special concerns you have regarding such matters.

Also, I share information about my clients with professional colleagues for the purpose of facilitating your treatment, fostering my own professional development, or helping to train other colleagues. In doing so, I am careful to conceal the identity of a client. Such non-identifying disclosures are not formally considered "protected" information, but I do want to inform you about these.

Revocation of Authorization:

You may revoke authorization you have given for release of your personal health information at any time provided it is done in writing. You may not revoke authorization to the extent that (1) I have already taken actions relying on your original authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Required or Permitted by Law: Uses and disclosures of PHI from mental health records *not requiring* consent:

Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations. I may disclose protected health information when I am required or permitted to do so by law. For example, if I believe that you present an imminent, serious risk of physical injury or death to yourself, I may make disclosures I consider necessary to protect you from harm. If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear and imminent risk of physical injury being inflicted against another individual, I may make disclosures I consider necessary to protect that individual from harm. Suspected child abuse or neglect must be reported to the authorities. Other disclosures permitted or required by law include the following: disclosures for public health activities, health oversight activities and disclosures to judicial and law enforcement officials in response to a court order or other lawful process.

Your Rights Regarding Your PHI:

- Right to Access to Inspect and Copy: You may request access to your protected health information and billing records maintained by me in order to inspect and request copies of the records. Under limited circumstances, I may deny access to your records. Requests for access must be made in writing. I may charge a reasonable, cost-based fee for copies.

- Right to Amend: If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to do so.

- Right to an Accounting Disclosure: You generally have the right to receive an accounting of the disclosures of your PHI made by me after April 14, 2003.

- Right to Request Restrictions: You have the right to request, in writing, a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to a restriction you request.

- Right to Confidential Communication: You have the right to reasonable requests to receive confidential communications of protected health information from me by alternative means or at alternative locations. For example, you may wish to receive phone calls from me at home rather than at work or you may prefer to have bills sent to a particular location.

- Right to a Copy of this Notice: You have the right to a copy of this notice.

This notice is effective as of April 14, 2003 and I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of the Notice of Privacy

Practices and to make the new notice provisions effective for all protected health information that I maintain. I will provide you with a written copy in the case of a revised document.

Questions and Complaints:

If you desire further information about your privacy rights or are concerned that I have violated your rights, please speak to me.

If you believe that I have violated your privacy protections or violated the terms of this notice, you have the right to file a written complaint with me as well as with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. To file a complaint with the Secretary, contact: The U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.E., Washington, DC 20201. p.202-619-0257 or 1-877-696-6775.

Your Signature:

Your signature below indicates you have read the information in this document, understand its terms, and agree to abide its provisions.

______________________________	______________________________	__________
Signature	Printed Name	Date

Cindy Greer, LCSW

Client Information and Intake

Client's Name ____ Date ____________________

Address ____

STREET CITY STATE ZIP

Billing Address ____

Email ____________________________________

Phone (Day) ______________________________ Phone (Evening) ______________________

Phone calls and mailing to your home will be discreet, but please indicate any restrictions:

____

Referred By ____

Emergency Contact ___________________________ Phone _____________________________

Insurance ___________________________________ Phone _____________________________

Insured's Name ______________________________ DOB _______________________________

ID # ________________________________ Group # ___________________________________

Insurance Claims Billing Address (see card):

____

Insurance Phone Number __________________________________

Please list any medications that you are currently taking and name of Physician monitoring:

____

____

Please list any previous mental health services:

____

____

Please list any medical conditions:

____

____

Reason for seeking therapy at this time:

____

Telemental Health Services Informed Consent

Cindy Greer, MSW, LCSW

392 E. Main Street, Sisters OR 97759

cindygreerlcsw.com

What is Telemental Health?

“Telemental health” means, in short, “provision of mental health services with the provider and recipient of services being in separate locations, and the services being delivered over electronic media.” Services delivered via telemental health rely on a number of electronic, often Internet-based, technology tools. These tools can include videoconferencing software, email, text messaging, virtual environments, and FaceTime.

Tools used: Doxy.me (**HIPPA compliant** platform), text messaging, FaceTime and email (**not secure)**. The **link** to my telemental health platform is: **doxy.me/cindygreerlcsw**

You will need access to Internet services (Firefox, Chrome or Safari) and technology tools needed to use the above-listed tools in order to engage in telemental health work with Cindy Greer, LCSW.

You are encouraged to present any questions or concerns regarding risks, benefits and application to your therapy with regard to the above tools.

Benefits and Risks of Telemental Health

- Receive services at times or in places where the service may not otherwise be available
- Receive services in a fashion that may be more convenient and less prone to delays than in-person meetings
- Receive services when you or clinician are unable to travel

Receiving services via telemental health has the following risks:
Telemental health services can be impacted by technical failures, may introduce risks to your privacy, and may reduce the ability for Cindy Greer, LCSW to intervene in crises or emergencies. In addition, Internet connections and cloud services could cease working or become too unstable to use; Cloud-based service personnel, IT assistants, and malicious actors (“hackers”) may have the ability to access your private information that is transmitted or stored in the process of telemental health-based service delivery (e.g. email, text, FaceTime); Computer or smartphone hardware can have sudden failures or run out of power, or local power services an go out.

Interruptions may disrupt services at important moments, and Cindy Greer, LCSW may be unable to reach you quickly or using the most effective tools.

There may be additional benefits and risks to telemental health services that arise from the lack of in-person contact or presence, the distance between you and Cindy Greer, LCSW at the time of service, and the technological tools used to deliver services. Cindy Greer, LCSW will assess these potential benefits and risks, sometimes in collaboration with you, as your relationship progresses.

Assessing Telemental Health's Fit for You

Although it is well validated by research, service delivery via telemental health is not a good fit for everyone. Cindy Greer, LCSW will continuously assess if working via telemental health is appropriate for your case. If it is not appropriate, you will be provided with names of other providers in your area.

Please talk to Cindy Greer, LCSW if you find the telemental health media so difficult to use that it distracts from the services being provided, if the medium causes trouble focusing on your therapy, or if there are any other reasons why the telemental health medium seems to be causing problems in receiving therapy.

You also have a right to stop receiving therapy by telemental health at any time without prejudice. Cindy Greer, LCSW is not seeing clients in -person and is only providing telemental health services at this time.

Your Telemental Health Environment

You will be responsible for creating a safe and confidential space during our sessions. You should use a space that is free of other people. It should also be difficult or impossible for people outside the space to see or hear your interactions during the session. If you are unsure how to do this, please ask for assistance or discuss.

Our Communication Plan

At our first session, we will develop a plan for backup communications in case of technology failures and a plan for responding to emergencies and mental health crises. In addition to those plans, please know that the best manner in which to contact Cindy Greer, LCSW between session is by phone at **541-420-7671.**

Calls are not picked up or returned after 5:00pm weekdays, on the weekends, scheduled time away from the office or holidays. Leave non-emergent messages and they will be returned within 48-hours unless I am on vacation or it is a holiday weekend.

Note: There may be times messages will be responded to sooner than stated in this policy. That does not mean I will always respond that quickly. Feel free to text at the number above or email to cgreer.lcsw@gmail.com however, I am not able to guarantee that they are secure methods of communication.

If you experience a mental health emergency, do **NOT** phone the number above but call **9-1-1** or go to your nearest emergency room.

Cindy Greer, LCSW is located in the *Pacific time zone*.

Please note that all textual messages you relay with Cindy Greer, LCSW, e.g. emails and texts, will become part of your health record.

Our Safety and Emergency Plan

As a recipient of telemental health-based therapy, you will need to participate in ensuring your safety during mental health crises, medical emergencies, and sessions that you have with Cindy Greer, LCSW.

Cindy Greer, LCSW will require you to designate an emergency contact. You will need to provide permission for your provider to communicate with this person about your care during emergencies. ***Note here your emergency contact name and phone number***:

____

Cindy Greer, LCSW will also collaborate with you to develop a plan for what to do during mental health crises and emergencies, and a plan for how to keep your space safe during sessions if needed. It is important that you engage with Cindy Greer, LCSW in the creation of these plans and that you follow them when you need to.

Your Security and Privacy

Except where otherwise noted, Cindy Greer, LCSW employs software and hardware tools that adhere to security best practices and applicable legal standards for the purposes of protecting your privacy and ensuring that records of your therapy sessions are not lost or damaged.

As with all things in telemental health, however, you also have a role to play in maintaining your security. Please use reasonable security protocols to protect the privacy of your own health care information. For example: when communicating with Cindy Greer, LCSW, use devices and service accounts that are protected by unique passwords that only you know.

Recordings

Please do not record video or audio sessions without Cindy Greer, LCSW's consent. Making recording can quickly and easily compromise your privacy, and should be done so with great care. Cindy Greer, LCSW will **NOT** record video or audio therapy sessions.

Print name/Sign: ____ Date: ____________________