Tory Stickney, MA

Non-Licensed & Non-Certified Rostered Psychotherapist

Counseling Connection, PLC
525 Hercules Drive, Suite 1A
Colchester, Vermont 05446
Phone 802.264.5333, Fax 802.264.5338

Counseling Connection Training Institute, PLC
525 Hercules Drive, Suite 1A
Colchester, Vermont 05446
*Phone 802.264.5333**x118**, Fax 802.264.5338*

This document is for clients being treated by Tory Stickney, MA, Non-Licensed & Non-Certified Rostered Psychotherapist, under the supervision of Leora E. Black, Ph.D., LMFT, LCHMC.

Professional Disclosure

This document is to help clarify important aspects of your treatment and to represent an agreement between us. Your signature at the end of this document indicates your agreement with these policies.

Vermont law requires persons placed on the Roster of Non-licensed and Non-certified Psychotherapists to disclose to each client his or her professional qualifications and experiences, those actions that constitute unprofessional conduct, and the method for filing a complaint or making a consumer inquiry. This must be done by the third appointment.

Qualifications and Experience

Formal Education and Credentials:

Master of Arts in Clinical Mental Health Counseling, January 2014 – May 2017
Johnson State College
Johnson, VT

Bachelor of Arts in Psychology, September 2006 - May 2010
Johnson State College
Johnson, VT

Associate of Arts, September 2004 - May 2006
Community College of Vermont
Burlington, VT

Non-Licensed & Non-Certified Psychotherapist
Credential #097.0118908 exp. 11/30/2018

Experience in the Practice of Psychotherapy:

Psychotherapist – December 2017 – Present
Counseling Connection Training Institute, Colchester, VT
Part Time – Weekly Clinical Supervision

Group Therapist – July 2017 – Present
Inpatient Psych Units, University of Vermont Medical Center, Burlington, VT
Per Diem

MAT Clinician – March 2017 – July 2017
Central Vermont Substance Abuse Services – Clara Martin Center, Berlin, VT
Full Time – Weekly Clinical Supervision

Psychotherapist – Internship, November 2016 – April 2017
Counseling Connection Training Institute, Colchester, VT
Part Time – Weekly Clinical Supervision

Drug & Alcohol Clinician – Internship, June 2016 – November 2016
Maple Leaf Treatment Center, Underhill, VT
Full Time – Weekly Clinical Supervision

Scope of Practice

Therapeutic Orientation: Client-Centered, Somatic, Existential, Cognitive-Behavioral.

Areas of Interest: Anxiety, Depression, Substance Abuse, Trauma, Physical, Sexual and Emotional Abuse, Body Image Issues, Disordered Eating, Women's Issues, Life Transitions, Sexuality, Gender Identity, Grief/Loss, Relationship Issues, Spiritual Concerns.

Treatment Methods: Cognitive-Behavioral Therapy, Sensorimotor Psychotherapy, Motivational Interviewing, Dialectical Behavior Therapy, Mindfulness, Buddhist Psychology, Strength-Based. Adults, Adolescents, Couples, Groups.

Formal Training

Sensorimotor Psychotherapy Institute

Level I: Training in Affect Dysregulation, Survival Defenses, and Traumatic Memory
Janina Fisher, Ph.D. & Amy Gladstone, LCSW, Ph.D.; New York City, NY 10018

Module 1: Introduction to Sensorimotor Psychotherapy, January 29-30, 2016
Module 2: Core Sensorimotor Skills, March 11-12, 2016
Module 4: Orienting and Defensive Responses, May 6-7, 2016
Module 5: Memory Processing: Sensorimotor Sequencing, June 10-11, 2016

Level I: Training in Affect Dysregulation, Survival Defenses, and Traumatic Memory
Lana Epstein, M., Ed., LICSW; Watertown, MA 02472

Module 3: Developing Resources, March 10 – 11, 2017
Module 6: Integration, June 16 – 17, 2017

After Hours Availability

Please direct all non-emergency calls to my office voice mail at **(802) 264-5333 x118** during the week and after hours. Leave messages about cancellations, requests for services, etc.
If you EVER (during work or after hours) have a **clinical emergency (i.e., extreme behavioral situations, risk of suicide or bodily harm to you or another person)**, call your local crisis team. If you have a life-threatening situation, call **911. You may leave a message for me in my voicemail at any time, at extension 118.**

Chittenden County:	**First Call for Children and Families.....**	**(802) 488-7777**
	Adult Crisis.....	**(802) 488-6400**
	Alcohol Crisis Team.....	**(802) 488-6425**
	Domestic Abuse Hotline.....	**(802) 658-1996**
	Dept. of Children and Families.....	**(802) 863 7370**
Franklin County Crisis.....		**(802) 524-6554**
Addison County Crisis.....		**(802) 388-7641 or 1-800- 489-7273**
National Crisis:	**Veterans Crisis Line .....**	**1-800-273-8255**
	Crisis Text Line.....	**741741**

People living outside Chittenden, Franklin, and Addison counties should consult their local listings for emergency service numbers.

Disputes or Complaints

My practice is also governed by the Rules of the Board of Allied Mental Health Practitioners. It is unprofessional conduct to violate those rules. A copy of the rules may be obtained from the Board or online at http://vtprofessionals.org. If you wish to file a complaint with, or make a consumer inquiry to the Allied Mental Health Board, please call the Office of Professional Regulation at (802) 878-2390 or visit the aforementioned website and click on the "File a Complaint Tab".

Office of Professional Regulation Statutes

Title 3: Executive
Chapter 5: Secretary of State
Sub-Chapter 3: Professional Regulation

3 V.S.A. § 129a
Unprofessional conduct

(a) In addition to any other provision of law, the following conduct by a licensee constitutes unprofessional conduct. When that conduct is by an applicant or person who later becomes an applicant, it may constitute grounds for denial of a license or other disciplinary action. Any one of the following items, or any combination of items, whether or not the conduct at issue was committed within or outside the State, shall constitute unprofessional conduct:

(1) Fraudulent or deceptive procurement or use of a license.

(2) Advertising that is intended or has a tendency to deceive.

(3) Failing to comply with provisions of federal or State statutes or rules governing the practice of the profession.

(4) Failing to comply with an order of the board or violating any term or condition of a license restricted by the board.

(5) Practicing the profession when medically or psychologically unfit to do so.

(6) Delegating professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, education, or licensing credentials to perform them, or knowingly providing professional supervision or serving as a preceptor to a person who has not been licensed or registered as required by the laws of that person's profession.

(7) Willfully making or filing false reports or records in the practice of the profession; willfully impeding or obstructing the proper making or filing of reports or records or willfully failing to file the proper reports or records.

(8) Failing to make available promptly to a person using professional health care services, that person's representative, or succeeding health care professionals or institutions, upon written request and direction of the person using professional health care services, copies of that person's records in the possession or under the control of the licensed practitioner, or failing to notify patients or clients how to obtain their records when a practice closes.

(9) Failing to retain client records for a period of seven years, unless laws specific to the profession allow for a shorter retention period. When other laws or agency rules require retention for a longer period of time, the longer retention period shall apply.

(10) Conviction of a crime related to the practice of the profession or conviction of a felony, whether or not related to the practice of the profession.

(11) Failing to report to the Office a conviction of any felony or any offense related to the practice of the profession in a Vermont District Court, a Vermont Superior Court, a federal court, or a court outside Vermont within 30 days.

(12) Exercising undue influence on or taking improper advantage of a person using professional services, or promoting the sale of services or goods in a manner which exploits a person for the financial gain of the practitioner or a third party.

(13) Performing treatments or providing services which the licensee is not qualified to perform or which are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice.

(14) Failing to report to the Office within 30 days a change of name or address.

(15) Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

(b) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes:

(1) performance of unsafe or unacceptable patient or client care; or

(2) failure to conform to the essential standards of acceptable and prevailing practice.

(c) The burden of proof in a disciplinary action shall be on the State to show by a preponderance of the evidence that the person has engaged in unprofessional conduct.

(d) After hearing, and upon a finding of unprofessional conduct, a board or an administrative law officer may take disciplinary action against a licensee or applicant, including imposing an administrative penalty not to exceed $1,000.00 for each unprofessional conduct violation. Any money received under this subsection shall be deposited in the Professional Regulatory Fee Fund established in section 124 of this title for the purpose of providing education and training for board members and advisor appointees. The Director shall detail in the annual report receipts and expenses from money received under this subsection.

(e) In the case where a standard of unprofessional conduct as set forth in this section conflicts with a standard set forth in a specific board's statute or rule, the standard that is most protective of the public shall govern. (Added 1997, No. 40, § 5; amended 2001, No. 151 (Adj. Sess.), § 2, eff. June 27, 2002; 2003, No. 60, § 2; 2005, No. 27, § 5; 2005, No. 148 (Adj. Sess.), § 4; 2009, No. 35, § 2; 2011, No. 66, § 3, eff. June 1, 2011; 2011, No. 116 (Adj. Sess.), § 5.)

26 V.S.A. § 4093
Unprofessional conduct of Rostered Non-Licensed Non-Certified Psychotherapists

(a) Unprofessional conduct means the following conduct and conduct set forth in 3 V.S.A. § 129a:

(1) Providing fraudulent or deceptive information in an application for entry on the roster.

(2) Conviction of a crime that evinces an unfitness to practice psychotherapy.

(3) Unauthorized use of a protected title in professional activity.

(4) Conduct which evidences moral unfitness to practice psychotherapy.

(5) Engaging in any sexual conduct with a client, or with the immediate family member of a client, with whom the psychotherapist has had a professional relationship within the previous two years.

(6) Harassing, intimidating, or abusing a client.

(7) Entering into an additional relationship with a client, supervisee, research participant, or student that might impair the psychotherapist's objectivity or otherwise interfere with his or her professional obligations.

(8) Practicing outside or beyond a psychotherapist's area of training, experience, or competence without appropriate supervision.

(b) After hearing, and upon a finding of unprofessional conduct, the board may take disciplinary action against a rostered psychotherapist or an applicant. (Added 1993, No. 222 (Adj. Sess.), § 17; amended 1997, No. 40, § 71; 1997, No. 145 (Adj. Sess.), § 61; 1999, No. 52, § 37.)

Informed Consent

Confidentiality

Your psychotherapy services and records are confidential, however, limits to this confidentiality do exist and include: minors or other persons with a legal guardian (information may be released to the legal guardian), imminent danger to self (e.g. suicide risk), danger to others, suspicion of abuse or neglect toward a child or vulnerable adult, or/and under court order. All mental health professionals are required by law to report such concerns. If you have signed a release with an insurer, the insurer may request such information as diagnosis, treatment plan, and general course of treatment. However, it is important to note that some insurers may request release of more detailed or sensitive information. Please discuss with me any concerns you may have about such disclosure. I may occasionally find it helpful to consult with other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential.

Treatment

I understand that my participation in therapy is completely voluntary, and that I may terminate treatment at any time. The goals of my treatment have been agreed upon with my provider. I understand that I may negotiate changes in these goals at any time. There are possible advantages and disadvantages of participating in psychotherapy and a positive outcome is not guaranteed. During the process of therapy you could face and work through difficult emotions, fears, or experiences. Therapy might also have unanticipated relationship consequences. For instance, some persons undergoing individual therapy may find their growth through the therapeutic process, sometimes to the point of yielding a relationship break-up.

Agreements of Financial Responsibility for Clients

I, client/guardian, agree to contact my insurance carrier to review available coverage and to be fully responsible for all charges that are not covered by my insurance. I understand such charges would include deductibles, co-payments, as well as fees for telephone consultation, report preparation, school meetings/consultations, late cancellations or missed sessions, and/or sessions contracted for beyond those certified by my managed care system. I understand that my managed care company or insurance company may require a review of clinical information, or other information to verify benefits and assist in claims in order to pay for services, and I give permission to Tory Stickney, MA, Non-Licensed & Non-Certified Rostered Psychotherapist, under the supervision of Leora Black, Ph.D. and/or the clinician's billing agent to provide such information. I hereby authorize my insurance benefits to be paid directly to Counseling Connection Training Institute, and acknowledge that I am financially responsible for any unpaid balance. I understand that a full 24 hour notice is required for cancellation of appointments and that a fee of $50.00 will be charged directly to me for missed appointments for which I have not given a full 24-hour notification. A collection agency will be used if outstanding balances are not paid within 30 days of being issued. I understand that this fee must be paid by me and that my insurance will not cover it. Clients with primary or secondary Medicaid insurance cannot be charged this fee. If you are ill, there is a natural disaster, or weather would not permit safe transportation to the appointment, this fee will be waived.

Client Disclosure and Consent Confirmation

My signature acknowledges that I have been given a copy of the Professional Qualifications and Experience of Tory Stickney, MA, Non-Licensed & Non-Certified Rostered Psychotherapist, under the supervision of Leora E. Black, Ph.D., LCMHC, LMFT, a statement of after-hours availability, the psychotherapist's relationship with Counseling Connection, PLC, as well as a listing of actions that constitute unprofessional conduct according to Vermont statutes. I have also been informed of the methods for making a consumer inquiry for filing a complaint with the Office of Professional Regulation. In addition, I have reviewed copies of an informed consent statement, HIPAA, and permission to release information to the client's primary care physician.

ALL CLIENTS OVER 18 need to sign after reading disclosure.

I hereby give permission for Tory Stickney, MA, Non-Licensed & Non-Certified Rostered Psychotherapist, under the supervision of Leora Black, Ph.D. to treat

_____.
Minor(s)

_____ _____
Client (or Parent/Guardian Signature) Date

_____ _____
Client (or Parent/Guardian Signature) Date

_____ _____
Tory Stickney, MA Date
Non-Licensed & Non-Certified Rostered Psychotherapist

Counseling Connection, PLC and ***Counseling Connection Training Institute, PLC***
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(802)264-5333 (tel) (802)264-5338 (fax)

Mental Health Report to Primary Care Physician

Part A to be completed by client. Part B to be completed by psychotherapist.

Part A:

PATIENT_____**PHYSICIAN**_____
DOB_____**LOCATION** _____
TELEPHONE_____

Part B:

Reason for referral: _____

_____

Date(s) seen: _____

Assessment: _____

_____

_____

Plans:_____

_____

_____

I give permission to Tory Stickney, MA, Non-Licensed & Non-Certified Rostered Psychotherapist, under the supervision of Leora E. Black, Ph.D. to communicate with my Primary Care Physician.

_____ _____
Client Print/Parent/Guardian Date

_____ _____
Client Signature/Parent/Guardian Date

_____ _____
Tory Stickney, MA Date
Non-Licensed & Non-Certified Rostered Psychotherapist

Date sent: _____

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Counseling Connection, PLC
An Affiliation of Private Practitioners
And
Counseling Connection Training Institute, PLC

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VERMONT HIPAA NOTICE

Notice of Mental Health Counselor's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.

- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within my independent practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

- "*Disclosure*" applies to activities outside of my independent practice such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy*

notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has been abused or neglected, I am required by law to report such information within 24 hours to the Commissioner of Social and Rehabilitation Services or its designee.

- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an elderly or disabled adult has been abused, neglected, or exploited, I am required by law to report this information to the Commissioner of Aging and Disabilities.

- **Health Oversight:** If I receive a subpoena for records from the Vermont Board of Allied Mental Health Practitioners in relation to a disciplinary action, I must submit such records to the Board.

- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If I know that you pose a serious risk of danger to an identifiable victim, I am required by law to exercise reasonable care to protect such victim. This may include disclosing your relevant confidential information to those people necessary to address the problem. Also, I may disclose your confidential information if I judge disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person.

IV. Patient's Rights and Mental Health Counselor's Duties

Patient's Rights:

- *Right to Request Restrictions* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Mental Health Counselor's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will have a copy posted on my bulletin board in my waiting room for you to look at.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me: Tory Stickney, MA, Non-Licensed & Non-Certified Rostered Psychotherapist, under the supervision of Dr. Leora E. Black, Ph.D., LMFT, LCMHC (802)-264-5333 ext. 101.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to Dr. Leora E. Black, Ph.D., Counseling Connection, 525 Hercules Drive, Suite 1A, Colchester, VT 05446.

You may also send a written complaint to the Vermont Secretary of State, Office of Professional Regulation. The Office of Professional Regulation provides Vermont licenses, certifications, and registrations for over 56,000 practitioners and businesses. Each profession is governed by laws defining professional conduct. Consumers who have inquiries or wish to obtain a form to register a complaint may do so by calling (802) 828-1505, or by writing to the Director of the Office, Secretary of State's Office, 89 Main Street, 3rd floor, Montpelier, VT 05620-3402. You can also find complaint forms online at www.vtprofessionals.org/conduct/complaintform.pdf. In addition, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

SEE NEXT PAGE FOR SIGNATURE AGREEMENT.

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And
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this mental health practitioner's Notice of Privacy Practices.

_____	_____	_____
Please Print Name	Signature	Date
_____	_____	_____
Please Print Name	Signature	Date
_____	_____	_____
Please Print Name	Signature	Date
_____	_____	_____
Please Print Name	Signature	Date

FOR OFFICE USE ONLY:

I. Individual refused to sign
II. Communication barriers prohibited obtaining the acknowledgement
III. An emergency situation prevented us from obtaining acknowledgement
IV. Other (Please Specify)

_____
_____
_____

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Billing Information

Client's Last Name: _____ First Name:_____

Mailing Address: _____
Street Address: _____
City: _____ State: _____ Zip: _____

Home #: _____Work #: _____ Date of Birth: _____
Emergency Contact and Telephone Number: _____
Gender: _____ Marital Status: _____ Referred by: _____

Name of Responsible Party (if other than self): _____
Address: _____ City: _____ Zip: _____
Phone: _____ Relationship: _____

Insurance Information

Insurance I: _____ Co-pay Amount: _____
Insurance Mailing Address: _____
Subscriber Name: _____ Relationship: _____
Certificate/ID#: _____ Group#: _____
Pre-Authorization #: _____ Date Auth starts/ends: _____ / _____
*****copy of your insurance card front and back; call and get authorization from your insurance company**

Secondary Insurance

Insurance II: _____ Co-pay Amount: _____
Insurance Mailing Address: _____
Subscriber Name: _____ Relationship: _____
Certificate/ID#: _____ Group#: _____
Pre-Authorization #: _____ Date Auth starts/ends: _____ / _____

Clinician: Tory Stickney, MA, Non-Licensed & Non-Certified Rostered Psychotherapist.
. Hourly Fee: $150.00 Initial Session / $150.00 Return Visit
Court fee: $250 per hour for preparation, reports, and court. .

Is condition related to employment? _____ Auto Accident? _____ Other Accident? _____

Diagnosis: _____

I, _____, authorize the release of any medical/mental health information or personal information on this form to process this claim. I understand if I refuse to pay the outstanding balance that Counseling Connection Training Institute, PLC. has the right to take me to small claims court to recover the balance due.

Signature: _____ Date: _____