5 Warren Street, Suite 209
Phone: (518) 338-3117
Fax: (518) 831-5944

Psychotherapy is not easily described, as every client, therapist, and situation is unique. To be successful, the counseling process requires consistent effort on both the part of the client and therapist.

Psychotherapy can have benefits and risks. A potential risk includes feeling intense emotions, which can be uncomfortable. Potential benefits to therapy include improved relationships, increased ability to regulate emotions, and skills to take better care of yourself. Since every situation is different, there are no guarantees.

It is important to feel that you and your therapist are a good match. For this reason, our first few sessions will serve as a consultation. After that period, we will decide whether we are a good fit for each other. If you decide to continue with me, we will discuss your treatment plan together. You may stop services at any point.

As your therapist, you agree that my role is limited to providing treatment, and that you will not involve me in any legal dispute, including visitation or custody arrangements. If there is a court appointed evaluator, appropriate releases are signed, and a court order is provided, I will provide general information which will not include recommendations concerning visitation or custody arrangements. If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $300.00 per hour for the time spent traveling, preparing reports, testifying, being in attendance, and any other court-related costs.

Confidentiality:
Since it is important that you feel safe to explore a wide range of topics, your confidentiality will be protected to the highest degree. In most instances, I will not disclose your information without your prior written consent. Without a signed release, I will neither confirm nor deny to others that you are my client.

There are several exceptions to this confidentiality, which include the following:

- If I feel you pose a serious and imminent threat to the safety of yourself or another person.
- If there is suspicion that a child or elder is being abused, or is at risk of such abuse.
- If a valid court order is issued for my records.
- Payment or subsidy for mental health treatment by a third party is contingent upon supplying information regarding your mental health condition, treatment, and other required information to those parties.
- When I feel that consulting with other health professionals would help me to provide the best treatment.
- Whenever permission has been granted in writing by you (or your guardian, if applicable), information may be shared with the identified entity.

Office Policies and Procedures:

- Therapy sessions are approximately 53 minutes, including time for payment and scheduling. If you are late for a session, we will only meet for the remaining portion of your slot.

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- If I participate with your insurance, I will collect the associated co-pay. If I do not participate with your insurance, my rate is $65.00 per session, unless other payment arrangements have been made. Payment is due in full at the beginning of each appointment. I accept cash, personal checks, and most credit cards.
- Scheduled appointments are commitments. If you fail to provide notice of at least 24 hours when canceling or rescheduling your appointment, you will be charged a $30.00 fee, which will be due at the time of our next session. You can avoid the fee if you reschedule your missed appointment within the same week(based on availability), or if you do a telehealth session during the time of your scheduled appointment.
- If you No Show to an appointment, all future appointments will be canceled and you will be charged $40.00 which must be paid before any future appointments are scheduled.
- Appointments after 3 and Weekend appointments are considered to be Prime appointment slots. Those spots are reserved for clients who have demonstrated active engagement in therapy. We do not offer these appointments until you have come to 3 consistent appointments scheduled within our availability to demonstrate active engagement in therapy.
- Reminder Calls and Text Messages are a courtesy that we provide, however, You are responsible for knowing when your appointment is scheduled. Not receiving a reminder is not an excuse for missing your appointment. DO NOT reply to the reminder text. We do not receive messages that are sent in response to the automated text. If you reply to the text message and miss your appointment it will be counted as a No Show and you will be charged the $40.00 fee. We have 24 hour confidential voicemail which you can call at any time to leave a message if you are not able to make an appointment.
- In order to provide you with the highest level of care it is important that you are consistent with your attendance. Therefore if you cancel or no show to 2 appointments you will be referred out to another provider. If you cancel 3 consecutive appointments you will be referred out to another provider.
- In the case that your insurance company denies payment of any claim I file on your behalf, You will be responsible for the denied amount. Payment will be due at your next appointment, if payment is not received your appointment will be canceled.
- You may contact me via my office phone, and can leave a message on my email or confidential voicemail system. I will do my best to return your message during my normal business hours. In case of an emergency, call 911 or go to your nearest emergency room.

I, _____ have read and understand all of the office procedures.
(Patient or Guardian Name)

_____ _____
(Patient or Guardian Signature) (Date)

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CLIENT INFORMATION

Name: _____ Date: _____
Date of Birth: _____ Social Security Number: _____
Address: _____
Telephone Numbers: Home: _____ Cell: _____ Work: _____
May confidential messages be left on your answering machine or voicemail? Yes____ No____
Referred By: _____ Significant Other: _____

If you are filling this out for a minor please complete the following for ALL caregivers or guardians:

Parent or Guardian's Name: _____ Relationship:_____
Address: _____
Telephone Numbers: Home: _____ Cell: _____ Work: _____
May confidential messages be left on your answering machine or voicemail? Yes____ No____
Parent or Guardian's Name: _____ Relationship:_____
Address: _____
Telephone Numbers: Home: _____ Cell: _____ Work: _____
May confidential messages be left on your answering machine or voicemail? Yes____ No____

Who is responsible for Payment?

Self/Parent or Guardian

If you are not responsible for payment please complete the following:

Parent or Guardian's Name: _____ Relationship:_____
Address: _____
Telephone Numbers: Home: _____ Cell: _____ Work: _____

FEE AGREEMENT

__ Bill Insurance Company: _____ ID: _____ Copay: _____

__ Self-Pay Amount: _____

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Signing this agreement serves as your informed consent to treatment, confirms our financial arrangement, and allows me to submit your information to your insurance company. If you have any questions or concerns regarding this consent form, or about the counseling process in general, you may discuss them with me at any time.

_____	_____	_____
Client Signature/Date	Parent/Guardian Signature/Date	Printed Name of Client

EMERGENCY INFORMATION

Who should I contact in case of emergency?
Name: _____ Relationship: _____ Phone Number: _____
Address: _____

MEDICAL INFORMATION

Name of your physician: _____
Address: _____ Phone Number: _____

May I contact your physician? ___Yes ___No

By signing below, you are authorizing the exchange of information related to your diagnosis, treatment, and progress for the purpose of coordinating treatment with your physician (listed above). This authorization will be valid for one year from the date below, or until treatment is terminated. You have the right to revoke this authorization at any point, by sending written notification to me. This revocation will not be effective to the extent that I have taken action in reliance on the authorization.

_____	_____
Signature of Client/Guardian	Date

NOTICE OF PRIVACY PRACTICES:

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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The effective date of this Notice is _____ Initials:_____

I only release information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes my policies related to the use and disclosure of the client's healthcare information.

Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT: With your written consent only, I will use and disclose your protected health information (PHI) to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you. Also, sharing your PHI in consultation with clinical supervisors or other treatment team members can help to ensure you receive the best care possible.

PAYMENT: I may use and disclose PHI so that I can receive payment of the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

HEALTHCARE OPERATIONS: I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, PHI will be disclosed only with your authorization.

OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT: Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect: I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Law Enforcement: I may disclose your PHI pursuant to a subpoena, court order, administrative order, or similar document, for the purpose of identifying a suspect, material witness, or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

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Deceased Clients: I may disclose PHI regarding deceased clients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased clients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty years is not protected under HIPAA.
Medical Emergencies: I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
Family Involvement in Care: I may disclose information to close family members or friends directly involved in your treatment based on your consent, or as necessary to prevent serious harm.
Health Oversight: If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
Specialized Government Functions: I may review requests for U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
Public Health: If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
Public Safety: I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
Research: PHI may only be disclosed after a special approval process or with your authorization.
Marketing: I may use or disclose certain health information in the course of providing you with information about treatment alternatives, health-related services. For example, I may mail you a brochure about meditation classes or workshops. You may contact me to request that these materials not be sent to you.
Fundraising: I may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.
Verbal Permission: I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission, only when written permission is not a timely option to ensure your safety.

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With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that I have already made a use or disclosure based on your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

CLIENT RIGHTS:

Right to request where we may contact you. You have a right to request where we contact you, and may specify phone numbers you do not want us to call. You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.

Right to release your medical records. By providing written authorization, you have the right to request that a copy of your PHI be provided to another person. You also have the right to revoke an authorization, in writing, at any time. This revocation will not be effective to the extent that I have taken action in reliance on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Right to inspect and copy your medical billing records. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.

Right to add information or amend your medical records. If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information, although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with us. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact myself and/or administrative staff at True North at 499 Glen if you have any questions.

Right to accounting of disclosures. You have the right to request an accounting of certain of the disclosures that I make on your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to request restrictions on uses and disclosures of your healthcare information. You have the right to request 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 your request unless the request is to restrict disclosure of PHI to a

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health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
Breach Notification. If there is a breach of unsecured PHI concerning you, I am required to notify you of this breach, including what happened and what you can do to protect yourself. A breach is defined as stolen or improperly accessed PHI; sent to wrong provider; unauthorized views of PHI by employee. PHI is unsecured if it is not encrypted to government standards.
Right to a copy of this notice. You have the right to a copy of this notice, as well as receive changes in policy.
Right to complain. If you believe your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202)619-0257. **I will not retaliate against you for filing a complaint.**

I have read and understand the Privacy Practices:

_____ Date:_____
(Signature of Client or Representative)

Stay up to date with exciting things happening in our office by "Liking" Turning Leaf Counseling Svcs. On Facebook and visiting our Website at www.turningleafcounselingsvcs.com. **

**Be Advised Facebook is not a secure form of communication. Do not leave any personal information about yourself or your child on our Facebook page or through Facebook Messenger. You can always call our office and leave a message on our confidential voicemail.