**Jemel E. Johnson, LCSW-C**

**Clinical Therapeutic Services**

**Informed Consent, Rights & Responsibilities, and Notice of Privacy Practices**

Sign an Acknowledgement that you have received this packet prior to the start of treatment.

**Informed Consent**

**Philosophy of care**

I believe in providing treatment that is strengths-based and solution-focused. I believe you should be treated as a whole person. I will collaborate with others when it is indicated and authorized. This includes managed behavioral healthcare, PCPs & other healthcare providers, hospitals, and schools. Treatment is individualized to match your needs. Progress and outcomes are reviewed in treatment. And I believe in providing the most cost-effective care, in the least restrictive setting.

**Treatment Options and Process**

I offer individual therapy, family therapy, group therapy, couples therapy and group counseling services. Services start with an assessment. Your current situation and symptoms, history, social behavior will be reviewed followed by a recommendation for services. You will then develop a “treatment plan” together that outlines how services will go and what outcomes are expected.

Therapy sessions will last between 30-60 minutes depending on the type of session. They may be weekly or less than weekly. The frequency will likely decrease over time. Your clinician will talk with you about what is recommended for you.

**Risks & Benefits**

Mental health services are generally effective in treating most mental health conditions. Most people benefit from therapy services. Few people get worse from treatment. Improvements do require attending appointments and following through with recommendations. When the treatment plan is developed, I will discuss risks and benefits more.

**Minors and Custody**

My role is to help people with mental health issues make lasting life improvements. I will not testify in court about custody issues, unless we are compelled by a court.

Since children benefit from an expectation of some privacy, I try not to share details of what a child says or does in treatment. I will share progress in treatment, as well as notify parents of any risks of harm. Parents are included in treatment for the benefit of the child.

**Minor Consent**

If you are a minor signing this document, you authorize your clinician to use their best judgment to decide whether to contact your parents or not. It is also important to know that parents have a right to access a minor’s record, unless parental rights have been revoked, up until the son/daughter turns 18 years of age.

**Rights & Responsibilities**

**Rights**

Everyone has the right to:

* Be treated with dignity and respect
* Choose from available services and supports that are consistent with the treatment plan
* Participate in & assist in the development of the treatment plan
* Receive a copy of the treatment plan
* Receive services consistent with that treatment plan recommendations
* Participate in periodic review and reassessment of service and support needs
* Have all services explained, including expected outcomes and possible risks
* Confidentiality
* Receive prior notice of service conclusion or transfer, unless it poses a threat to health and safety
* Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation
* Have family involvement in service planning and delivery
* Make a declaration for mental health treatment
* File grievances, including appealing decisions resulting from the grievance

**Responsibilities**

There are also responsibilities that come with receiving treatment services. These include the following:

* Coverage: Please bring a copy of your medical card to each appointment. If you are no longer eligible for benefits, future appointments may be canceled. Other options will be discussed with you.
* Cancellations and No-Shows: We require a 12-hour advance notice for cancellations or re-schedules. Please call or text if you are not able to keep your appointment. Cancellation fees of $35, will be assessed if proper advanced notice is not given.
* Crisis & Emergencies: Call 911 or go to the nearest emergency room if you are experiencing a medical emergency.

Financial Responsibilities: As a courtesy, I will check with your health plan or EAP to verify your benefits. However, this is not a guarantee of payment. It is your responsibility to understand your coverage, including co-pays, co-insurance, and deductibles. This also includes understanding what services are covered and what are not covered. It is also your responsibility to let us know if there is a change in your insurance or coverage. Checks may be made to Jemel Johnson Bell. There is a $25 service charge for returned checks (non-sufficient funds).

**Notice of Privacy Practices**

This Notice describes how protected health information (PHI) about you (or your child) may be used and disclosed through this clinic. This Notice describes how you can access your information and your other privacy rights.

I am required by law to 1) make sure your medical information is kept private, 2) give you this Notice about legal duties and privacy practices about your health information and 3) do what we say in the Notice.

**Use & Disclosure of Protected Health Information (PHI):**

We may use or disclose information about your treatment for the following reasons:

* Written Authorization: We have a form you can complete that allows us to share PHI with someone or an organization.
* Treatment: We use and disclose your PHI to you in order to provide treatment and other services. You may be contacted to provide appointment reminders. We may talk to you about alternatives or other benefits and services that may be of interest to you.
* Payment: I may use and disclose your PHI to obtain payment for services that we provide to you from your insurance plan or payer.
* Disclosure to Relatives Close Friends and Other Caregivers: I will use or disclose your PHI to a relative, friend, or caregiver only if you are present and we can reasonably infer you do not object to the disclosure. For example, if you bring a friend or relative to a session, we may decide to use or disclose information for treatment purposes.
* Public Health Activities: I may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (3) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
* Abuse or Neglect: If I reasonably believe you are a victim of abuse, neglect or domestic violence, I will disclose your PHI to the appropriate government authority. This includes children, persons who have a mental health diagnosis, and the elderly. I may also disclose PHI if we come in contact with someone who has abused or neglected someone as defined by state laws.
* Judicial and Administrative Proceedings: I may disclose your PHI in response to a court or administrative order if you are court mandated for treatment.
* Law Enforcement Officials: I may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. This includes, but is not limited to, identifying or locating missing persons, fugitives, or suspects, or reporting crimes committed on our property.
* Decedents: I may disclose your PHI to a coroner or medical examiner as authorized by law. I may also disclose PHI as required for any investigation related to a death as allowed by law.
* Health or Safety: I will use or disclose your PHI to prevent a serious and imminent threat to someone’s health or safety.
* Workers Compensation: I may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.
* As required by law. I may use and disclose your PHI when required to do so by any other law not listed above.

**Coordination with Primary Care**

I believe in “holistic” care: the mind and body relate to one another. So, it is important for to coordinate your care with your primary care provider (PCP).

**Your Rights Regarding Your Protected Health Information**

* Right to Request Additional Restrictions: You may request restrictions on our use and disclosure of your PHI. This is for treatment, payment and health care operations. We are not required to agree to the request. To request a restriction please do so in written notice.
* Right to Request Confidential Communications: You may request, and I will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.
* Right to Revoke Your Authorization. You may request to revoke an Authorization by providing a written notice. If I have already used or disclosed information, we cannot take the information back.
* Right to Inspect and Copy Your Health Information. You may request access to your health information. To access your records, please submit a written request complete a Record request. There are limited circumstances where we may deny you access to portions of your record. If you request copies, I will charge you $10.00. Postage cost will also be charged if you request that we mail the copies to you.
* Right to Receive Paper Copy of this Notice: This is a paper copy of our Notice.
* Right to Be Notified of a Breach. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.