Libby Rooney Counseling, LLC

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Confidentiality Information

It is my policy and desire to protect the rights of my clients to confidentiality as defined in State and Federal statutes. Fax transmissions and phone calls are not HIPAA (Health Insurance Portability and Accountability Act, 1996) compliant. Notes that were taken pertaining to sessions are kept secure and released only with client permission. These notes will be kept on a tightly secure database that only I will have access to. Notes will be kept for 6 years following termination of treatment. There may be a need to fax or email diagnostic or other basic information regarding the client to a simultaneous caregiver, insurance company, or other. Please indicate below your response.

_____ I authorize the fax and email transmission of information from my records.

_____ I DO NOT authorize the fax and email transmission of information from my records.

Occasionally I may use a cell or cordless phone to return a call. Due to the potential broadcasting frequencies of some such types of phones, such calls cannot be guaranteed to be 100% secure. Please indicate below whether you wish to give permission for me to speak with you on such a phone.

_____ I authorize phone calls to me by cell and/or cordless phones.

_____ I DO NOT authorize phone calls to me by cell and/or cordless phones.

Often email messages may be used in therapy. Please indicate below whether you wish to give permission for me to use email messages or not.

_____ I authorize the use of email messages.

_____ I DO NOT authorize the use of email messages.

_____ _____

Client or Legal Custodial Parent/Guardian Signature Date

POLICY FOR USING EMAIL DURING COUNSELING

Email is often a fast and convenient way to communicate. However, there are some issues to consider when using email to communicate confidential therapy related information. Below is the therapist's policy regarding using emails during counseling. If you have any questions about this practice, please do not hesitate to discuss your concerns with your therapist during your sessions.

Clients often find that the change process does not occur solely within the context of a counseling session. As clients attempt to apply the concepts learned during sessions, they find that much of the work of counseling occurs outside the clinical setting. Occasionally, clients find it helpful to touch base with their counselor between sessions as they are doing this work. In these instances, the therapist is glad to correspond to emails as their schedule permits. **However, email exchanges should not be construed as any form of psychotherapy and does not take the place of a counseling session.**

The therapist will not attempt to install cookies on your computer, and will not attempt to collect data about you through the internet. If you decide to begin an email exchange with your therapist, she will obtain your email address. That address will not be shared with any third party unless the therapist is required by law to do so. Although the risk of a cyber “eavesdropper” accessing your emails is relatively small, you should be aware that **emails are not encrypted and could be read by anyone who intercepts them.**

The decision about whether to engage in an email exchange with your therapist from your place of employment is entirely up to you. However, you are encouraged to **be aware of your employer’s policies** regarding private use of computer and internet facilities, as well as conducting private business during your work time. Employers may assert a right to read any and all emails that pass through their system. Even taking precaution of printing all emails once received and then deleting local copies may still leave a copy on an employer’s mail server, which could be retrieved by the employer at a later date.

If you undertake an email exchange with your therapist from **shared environments** like internet cafes or libraries, you should take particular care to guard your privacy. Web browsers used to access web-based email accounts should not be left logged-in to the web-based email service, and likewise, usernames and passwords should not be stored in cookies. When in doubt, log out.

_____ _____

Client or Legal Custodial Parent/Guardian Signature Date

Consent Form

I _____ give my consent to receive or for my child to receive therapy from Libby Rooney. I understand that therapy will be $175 a session unless otherwise specified. A counseling session lasts approximately 45-50 minutes and might include the parent(s) and child, the child alone, or the parent(s) alone. In order to reserve the next week's appointment, current charges need to be paid. Superbills for insurance submission available upon request. Cash, check or credit cards are accepted at time of service. The counselor has a Square account for credit card payment.

It is understood that emergencies might arise which may hinder my commitment to keep an appointment. However, there is a $175.00 charge if an appointment is not canceled within 24 hours. This rule does not apply during inclement weather.

Parents are encouraged to remain in the waiting room while the child or adolescent is in therapy. For adolescents who drive themselves, I encourage a parent to accompany the adolescent client and wait in the waiting room.

Situations may arise between counseling sessions where a parent might need guidance. A brief phone call to the counselor at her office is appropriate. Voice mail is checked regularly. Email may be used also if the confidentiality form has been signed. I understand that the success of my counseling process depends to a large extent on my willingness to keep appointments and make necessary changes and I agree to do my part to facilitate family change.

_____ _____

Client or Legal Custodial Parent/Guardian Signature Date

MINOR CONSENT

This is to certify that I/we, _____ have legal custody or guardianship of the following children:

Name **Date of Birth**

_____ _____

_____ _____

_____ _____

_____ _____

By signing this form, consent is given for him/her/them to receive individual and/or family therapy from Libby Rooney, Licensed Professional Counselor.

_____ _____

Signature Date