Anna Smith, Post-Graduate Marriage and Family Therapy Intern
under the supervision of Leora E. Black, Ph.D., LCMHC, LMFT

Counseling Connection, PLC
525 Hercules Drive, Suite 1A
Colchester, Vermont 05446
802-264-5333, Fax 802-264-5338

Counseling Connection Training Institute, PLC
525 Hercules Drive, Suite 1A
Colchester, Vermont 05446
802-264-5333, Fax 802-264-5338

This document is for clients being treated by Anna Smith, Rostered Non-Licensed, Non-Certified Psychotherapist #097.0129448; Post-Masters Intern under the supervision of Leora E. Black, Ph.D.

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.

Qualifications and Experience

Education:
Antioch University New England
2016-2018
Masters of Arts in Marriage and Family Therapy

Mount Holyoke College
2009-2013
Bachelors of Arts in English and Psychology

Clinical Experience:
Graduate Intern under the supervision of Loera Black, PhD, LCMHC, LMFT
Counseling Connections
2017- Present

Clinician under supervision
Antioch University Couples and Family Therapy Institute
2016-2017

Trainings:
Gottman Level 1
Gottman Level 2
Developmental Trauma and the ARC Model
1 Day DBT Training

Scope of Practice:
I work with individuals, couples, and families from a strengths and resiliency based approach incorporating a systemic lens. I have experience working with a variety of ages and issues including anxiety, depression, grief/loss, trauma, parenting and co-parenting issues, marital conflict, parent-child relationships, and more. I incorporate an integrative approach drawing on narrative theory, cognitive behavioral theory, solution focused theory, structural theory, and mindfulness skills through a

collaborative stance. I have experience working with adults in the mental health field in residential settings from 2013-2017 and working with children presenting with behavioral issues from 2016 to the present working at a group home for NFI Vermont. I am currently working on hours post-masters towards licensure.

After Hours Availability

Please direct all non-emergency calls to my office voice mail at **(802) 264-5333 x120** during the week and after hours. Leave messages about cancellations, requests for services, etc.

During work or after hours, if you 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 120.**

Chittenden County: **First Call …….....(802) 488-7777**
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.....1-(800) 489 7273 or (802)388-7641

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

Disputes or Complaints

Please discuss any concern you might have regarding your counseling or related issues directly with me at any time. I will make every reasonable effort to resolve disputes or conflicts in a satisfactory manner. If you would like to give my supervisor feedback, leave a message for Leora Black, PhD. at (802) 264-5333 ext. 101. The practice of Marriage and Family Therapy is governed by state law and the rules of the Board of Allied Mental Health Practitioners. It is unprofessional conduct to violate those rules. A copy of those rules may be obtained from the Board or online at http://vtprofessionals.org/. You have the right to lodge a formal complaint with the Board of Allied Mental Health Practitioners in the following manner: by calling (802) 828-2367 or/and by writing: Vermont Secretary of State, Office of Professional Regulation, Board of Allied Mental Health Practitioners, 89 Main Street,3rd floor, Montpelier, Vermont, 05609-1106.

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 Anna Smith, post- graduate intern, 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 with 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.

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. 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. I also have regularly scheduled confidential meetings with my supervisor, Leora Black, to discuss and review my cases and notes.

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.

Client Disclosure and Consent Confirmation

My signature acknowledges that I have been given a copy of the Professional Qualifications and Experience of Anna Smith, Post-Graduate Intern, under the supervision of Leora E. Black, Ph.D., LMFT, LCMHC, a statement of after-hours availability, financial agreement, 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 Anna Smith, Post-Masters Intern, under the supervision of Leora Black, Ph.D. to treat _____.
Minor(s)

_____ _____
***(Client** or Parent/Guardian Signature) (Date)

_____ _____
***(Client** or Parent/Guardian Signature) (Date)

_____ _____
(Clinician Signature) (Date)

Mental Health Report to Primary Care Physician

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

Reason for referral: _____

_____

Date(s) seen: _____

Assessment: _____

_____

_____

Plans:_____

_____

_____

I give permission to Anna Smith, Post-Graduate Intern, under the supervision of Leora E. Black, Ph.D. to communicate with my Primary Care Physician.

Mental Health Provider Signature: _____

_____Date sent: _____
(Client signature/Parent/Guardian)

I decline authorization for Anna Smith to communicate with my physician.

Client:_____ Date:_____

Counseling Connection, PLC and ***Counseling Connection Training Institute, PLC***
525 Hercules Drive, Suite 1A, Colchester, Vermont 05446
(802)264-5333 (tel)
(802) 264-5338 (fax)

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

525 Hercules Drive, Suite 1A, Colchester, VT 05446
(802) 264-5333

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: Anna Smith, Post-Graduate Intern, (802) 264-5333 ext. 120 or my supervisor 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 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, 89 Main Street, 3rd floor, Montpelier, VT 05609. And 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.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by posting such a notice on the bulletin board in my waiting room.

Rev 03/12/05

Counseling Connection, PLC
An Affiliation of Private Practitioners
And
Counseling Connection Training Institute, PLC
525 Hercules Drive, Suite 1A
Colchester, VT 05446
(802) 264-5333

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, (child's name if client)_____, have received a copy of this mental health practitioner's Notice of Privacy Practices.

_____	_____	_____
Please Print Name (parent or guardian if child is client)	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)

_____
_____
_____

Counseling Connection, PLC *and* Counseling Connection Training Institute, PLC

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: M / F; Transgender M-F / F-M; Alternative gender identity _____

Marital/Partner Status: _____ Referred by: _____

Billing Information

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: Anna Smith, Rostered, Non-Licensed, Non-Certified Psychotherapist under the supervision of Leora E. Black, Ph.D. Hourly Fee: $150.00 Initial Session / $150.00 Return Visit; Court fee: $250 per hour for preparation, reports, and court. Post-Masters Interns: Medicaid, BCBS, Cigna, or fee for service.

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 Anna Smith or Leora Black,Ph.D. has the right to take me to small claims court to recover balance due.

Signature: _____ Date: _____

Counseling Connection, PLC *and Counseling Connection Training Institute, PLC
525 Hercules Drive, Suite 1A, Colchester, VT 05446
Tel: (802) 264-5333 Fax: (802) 264-5338

AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Patient Name: _____ DOB: ___/_____/_____

I hereby authorize Anna Smith to communicate with the following person(s) to:
[ ] obtain information from
[ ] release information to:
:
Name: _____

Address:_____

Telephone and Fax: _____

Specific information to be disclosed is:
[ ] Psychiatric admission and discharge summaries including treatment plans
[ ] Psychological evaluation records
[ ] Psychiatric evaluation records
[ ] Vocational/educational records
[ ] Alcohol/drug evaluation including treatment history
[ ] Outpatient mental health treatment summaries
[ ] Medical history including problem list and medication list
[ ] Crisis intervention reports
[ ] Legal information including relevant court/agency documents
[ ] Other: _____

For the purpose of:
[ ] Facilitation of outpatient treatment and planning
[ ] Coordination of treatment among outpatient treatment providers
[ ] other: _____

With the understanding that:
1. I may revoke this release in writing at any time, except to the extent that action has already been taken.
2. Further disclosure of information provided by this release may not be made without my written consent, or as otherwise restricted by Federal Regulations (42 Code of Federal Regulations, Part 2, Confidentiality of Alcohol and Drug Abuse Treatment and Patient Records).
3. A photocopy of this document is as valid as the original.

Unless revoked sooner, this release expires:
[ ] One year from this date [ ] One month post discharge from therapy
[ ] Other: _____

_____ _____
Patient or Guardian Signature Date