Kristin C. Sopronyi, MS
KCS Psychology, PLLC

525 Hercules Drive, Suite 1A
Colchester, VT 05446
802-264-5333 ext. 104
kristin@kcspsychology.com

This document is for clients being treated by Kristin C. Sopronyi, MS.

Professional Disclosure of Information

The State of Vermont requires Psychologists to disclose information about themselves to their clients and to notify them about ways to deal with disputes and complaints. Also, 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.

Professional qualifications and experience:

Education:

Master of Science in Clinical Psychology (2007)
College of St. Joseph in Vermont
Rutland, Vermont

Bachelor of Arts in Psychology and English (2004)
The Pennsylvania State University
University Park, Pennsylvania

Qualifications:

Licensed Psychologist - Master
Credential # : 047.0091776

Professional Affiliations:

Vermont Psychological Association
American Psychological Association

Experience:

Work: I began working as an independent Clinical Psychologist part-time in 2015, and I moved to full-time in May of 2016. From 2007-2016, I worked full-time as a school-based clinician at an alternative school, providing individual and group therapy to adolescents, with additional support provided to families and associated collaterals. Prior to this, I worked as the Personal Growth Counselor at the College of St. Joseph in Rutland, VT as a part-time clinical internship (2006-2007) working with college students, faculty, and staff around therapeutic services, mentoring, and mental health screenings. Additionally, I completed a part-time clinical practicum in Rutland City Public Schools (2005-2006), conducting assessments and evaluations.

Training: While completing my graduate program at the College of St. Joseph in Rutland, VT (8/2004-5/2007), I received specific education and advanced training in the following areas:

Ethical Practice in Psychology

Diagnosis & Treatment of Psychopathology using the DSM
Counseling Techniques
Group Counseling
Intellectual & Personality Assessment Methods
Substance Abuse Assessment & Treatment
Developmental Psychology
Psychopharmacology
Forensic Psychology
Research Methods

Additionally, I have been trained in DBT (Dialectical Behavior Therapy), EMDR (Eye Movement Desensitization and Reprocessing), ARC (Attachment, Self-Regulation, and Competency), and LSCI (Life Space Crisis Intervention).

Scope of Practice:

Therapeutic Orientation:	Humanistic/Person-Centered, Cognitive
Area of Specialization:	Work with adolescents and adults around anxiety, depression, school-related issues, oppositional-defiant behaviors, trauma, relationships, self-esteem, anger management, health and wellness, co-occurring substance use/mental health concerns, and assessment. Additional experience with clients with Attention-Deficit/ Hyperactivity Disorder, developmental disabilities, and borderline personality traits.
Treatment Methods:	Approaches include talk therapy, body-based interventions such as yoga and breathing, EMDR, EFT, mindfulness, and expressive arts.

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. The practice of psychology is governed by the rules of the Board of Psychological Examiners. 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.

Office of Professional Regulation Notice

The Office of Professional Regulation provides Vermont licensees, certification, and registrations for over 58,000 practitioners and businesses. Forty-six professions and occupations are managed by this office. A list of relevant professions is found below. Each profession or occupation 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 going to https://www.sec.state.vt.us/professional-regulation/file-a-complaint.aspx, calling (802) 828-2875, or by writing to the Vermont Secretary of State, Office of Professional Regulation, Attn: Carla Preston, 89 Main Street, 3rd Floor, Montpelier, Vermont 05620-3402. Upon receipt of a complaint, an administrative review determines if the issues raised are

covered by the applicable professional conduct statue. If so, a committee is assigned to investigate, collect information, and recommend action or closure to the appropriate governing body. All complaint investigations are confidential. Should the investigation conclude with a decision for disciplinary action against a professional's license and ability to practice, the name of the license holder will then be made public. Complaint investigations focus on licensure and fitness of the licensee to practice. Disciplinary action, when warranted, ranges from warning to revocation of license, based on the circumstances. You should not expect a return of fees paid or additional unpaid services as part of the results of this process. If you seek restitution of this nature, consider consulting with the Consumer Protection Division of the Office of the Attorney General, retaining an attorney, or filing a case in Small Claims Court.

Relevant Professions:
Alcohol and Drug Abuse Counselor
Clinical Social Worker
Marriage and Family Therapist
Mental Health Counselors
Psychoanalyst
Psychologist
Psychotherapist

Statutory Definitions of Unprofessional Conduct (Psychologists)
Title 26, Chapter 55

Unprofessional conduct means the conduct listed in this section and in 3 V.S.A. § 129a:
(1) Failing to make available, upon written request of a person using psychological services to succeeding health care professionals or institutions, copies of that person's records in the possession or under the control of the licensee. (2) Failing to use a complete title in professional activity. (3) Conduct which evidences moral unfitness to practice psychology. (4) Engaging in any sexual conduct with a client, or with the immediate family member of a client, with whom the licensee has had a professional relationship within the previous two years. (5) Harassing, intimidating, or abusing a client or patient. (6) Entering into an additional relationship with a client, supervisee, research participant, or student that might impair the psychologist's objectivity or otherwise interfere with the psychologist's professional obligations. (7) Practicing outside or beyond a psychologist's area of training or competence without appropriate supervision. (8) In the course of practice, failure to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent psychologist engaged in similar practice under the same or similar conditions, whether or not actual injury to a client or patient has occurred. (9) Conduct which violates the "Ethical Principles of Psychologists and Code of Conduct" of the American Psychological Association, effective December 1, 1992, or its successor principles and code. (10) Conduct which violates the "ASPPB Code of Conduct-1990" of the Association of State and Provincial Psychology Boards, or its successor code. (11) Use of conversion therapy as defined in 18 V.S.A. § 8351 on a client younger than 18 years of age. (Added 1975, No. 228 (Adj. Sess.), § 2; amended 1981, No. 241 (Adj. Sess.), § 1; 1993, No. 98, § 7; 1993, No. 222 (Adj. Sess.), § 3; 1997, No. 145 (Adj. Sess.), § 50; 1999, No. 52, § 26; 1999, No. 133 (Adj. Sess.), § 24; 2013, No. 27, § 34; 2015, No. 138 (Adj. Sess.), § 5.)

Unprofessional Conduct Standards
Title 3,Chapter 5
Subchapter 003 : 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.)

Additional Policies and Information

My Relationship with Counseling Connection, PLC

I work with a group of independent mental health professionals, under the name of Counseling Connection, PLC. This group is an association of independently practicing professionals. While the members of Counseling Connection, PLC and Counseling Connection Training Institute sometimes share a office space, certain expenses, and administrative functions, if you are my client under my care, I am completely independent in providing you with clinical services, and I alone am fully responsible for those services. My professional records are maintained separately and no member of the group can have access to them without your specific permission. The sole exception to this is if I become incapacitated and am unable to attend appointments or contact you about my condition. In that situation, another member of Counseling Connection, PLC may be given access to my current client list and their contact information to notify clients.

I, client/guardian, understand that signing this disclosure provides temporary consent to release appointment and demographic information to another member of Counseling Connection, PLC in the event of a situation where Kristin C. Sopronyi, MS is incapacitated. This temporary consent applies only in that situation and extends only to information necessary to keep me updated on treatment availability.

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, and/or under court order. If you have signed a release with an insurer, the insurer may request information such 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.

After Hours Availability

Please direct all non-emergency calls to my office voicemail at **(802) 264-5333 ext. 104**. Leave messages about cancellations, requests for services, etc. You can also email me at kristin@kcspsychology.com.

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)** and I am not immediately available to respond to an emergency, call the community services in your area.

Addison County Crisis .....1-(800) 489 7273 or (802) 388-7641
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
Lamoille County Crisis ……..(802) 888-5026 Mon-Fri, 8-4:30
(802) 888-8888 Nights & Weekends

Crisis Text Line™ provides free, round-the-clock support, seven days a week by providing access via text messaging to trained Crisis Counselors at the moment help and support are needed. It can be accessed via cell phone by **texting VT to 741-741.**

People living outside Chittenden, Franklin, Lamoille, and Addison counties should consult their local listings for emergency service numbers. If you have a life-threatening situation, **call 911.**

Email/Text Policy

KCS Psychology, PLLC utilizes technology to communicate with clients and other service providers. Correspondence containing protected health information (PHI) will be sent with encryption. Emails being sent to KCS Psychology, PLLC are not considered secure. Therefore, if you choose to use email to connect, schedule, or share information, please take precautions to reasonably protect your privacy, such as limiting the amount or type of information disclosed. If you would like to communicate via text, you may be asked to download an app to ensure end-to-end encryption and HIPAA compliance.

I, client/guardian, understand that email and text communication is NOT a method to seek support from KCS Psychology, PLLC in a crisis situation. Also, I understand that email and text are used as a means to communicate basic information, but not as a means to provide treatment.

Community/Social Media Policy

In order to maintain your confidentiality as a client, if I encounter you in the community, I will not initiate contact. You are welcome to approach me, and I will engage if you do so. Additionally, I will not accept any social media friend/contact requests. However, KCS Psychology, PLLC maintains a Facebook page, and you may follow or like it to see posts and occasional updates if you are comfortable doing so. Please note that anything on Facebook is NOT HIPAA compliant, and Facebook messages are not a viable means of communicating with KCS Psychology, PLLC.

Treatment

I, client/guardian, understand that 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. Therapy may occur in an outdoor setting as appropriate. I also understand that the provider may terminate therapy at any time due to ethical concerns, changes in treatment needs, or therapy-interfering behaviors. If therapy is to be terminated, the provider will make every effort to provide appropriate referrals and will engage in termination processing as appropriate.

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 and 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 Kristin C. Sopronyi, MS and/or the clinician's billing agent to provide such information. I hereby authorize my insurance benefits to be paid to Kristin C. Sopronyi, and acknowledge that I am financially responsible for any unpaid balance. **I understand that a full 24 hours 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.** 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. Exceptions to this fee are illness, natural disaster, or weather causing unsafe travel conditions. If I have an outstanding balance and have refused to make payment upon request, I understand that Kristin C. Sopronyi can invoke the right to enlist the services of a collections agency or take me to small claims court.

Client Disclosure and Consent Confirmation

My signature acknowledges that I have been given a copy of the Professional Qualifications and Experience of Kristin C. Sopronyi, MS, 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 or 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. This information was given to me no later than my third office visit.

EVERYONE NEEDS TO COMPLETE THIS REQUEST FOR SIGNATURE

I hereby give permission for Kristin C. Sopronyi, MS (Practitioner) to treat

_____.
(Client(s))

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

_____ _____
(Practitioner's Signature) (Date)

Kristin C. Sopronyi, MS
KCS Psychology, PLLC

Demographic and Billing Information

Client Demographic Information

Client's Last Name: _____ Client's First Name:_____

Date of Birth: _____ Social Security #: _____

Mailing Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: _____Work #: _____ Cell #:_____

Email Address: _____

I prefer to be contacted via (please check all that apply):

☐Home # ☐Work # ☐Cell # ☐Email ☐Text

Is it okay to leave a voicemail? (please check one): ☐Yes ☐No

Gender: _____ Pronouns: _____

Referred by: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Telephone Number: _____

Parent/Guardian Information (if client is under 18)

Name(s): _____ Relationship:_____

Does a custody arrangement exist? (please check one) ☐Yes ☐No

If **YES**, please provide a copy of relevant documents.

Kristin C. Sopronyi, MS
KCS Psychology, PLLC

Billing Information

Name of Responsible Party (if other than self): _____

Address: _____ City: _____ Zip: _____

Phone: _____ Relationship: _____ Date of Birth: _____

Insurance Information

Insurance I: _____ Co-pay Amount: _____

Insurance Mailing Address: _____

Subscriber Name: _____Relationship: _____

Subscriber Date of Birth: _____

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: _____

Subscriber Date of Birth: _____

Certificate/ID#: _____ Group#: _____

Pre-Authorization #: _____ Date Auth starts/ends: _____ / _____

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

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 Kristin C Sopronyi, MS. has the right to take me to small claims court or use a collection agency to recover balance due.

Signature: _____ Date: _____

Kristin C. Sopronyi, MS
KCS Psychology, PLLC

525 Hercules Drive, Suite 1A
Colchester, VT 05446
802-264-5333 ext. 104
kristin@kcspsychology.com

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 at

(802)-264-5333 ext.104

You may also send a written complaint to the Vermont Secretary of State, Office of Professional Regulation, 89 Main St., Montpelier, VT 05620-3402 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 08/02/2014

Kristin C. Sopronyi, MS
KCS Psychology, PLLC

525 Hercules Drive, Suite 1A
Colchester, VT 05446
802-264-5333 ext. 104
kristin@kcspsychology.com

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

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)

_____

_____

_____

Kristin C. Sopronyi, MS
KCS Psychology, PLLC

525 Hercules Drive, Suite 1A
Colchester, VT 05446
802-264-5333 ext. 104
kristin@kcspsychology.com

Mental Health Report to Physician

Patient: _____ **Patient DOB:** _____

Physician:_____

Physician Location: _____

Physician Phone: _____ **Physician Fax:** _____

Reason for referral:_____

_____

Date(s) seen:_____

Assessment:_____

_____

_____

Plans:_____

_____

_____

I give permission to Kristin C. Sopronyi, MS to communicate with my Primary Care Physician.

Mental Health Provider Signature:_____ Date: _____

Client/Parent/Guardian Signature: _____Date:_____

I decline authorization for Kristin C. Sopronyi, MS to communicate with my physician.

Client:_____ Date: _____

Kristin C. Sopronyi, MS
KCS Psychology, PLLC

FIT Release

A growing body of research suggests that ***routine and frequent use of outcome questionnaires*** *is associated with* ***better treatment outcomes****.* Information from the questionnaires help the clinician and client monitor improvement and make adjustments in the treatment plan as necessary. Your therapist participates in an outcomes measurement service (The Center for Clinical Informatics) that provides automated scoring and interpretation of clinically researched outcome questionnaires. The service is HIPAA compliant and will help you and your therapist monitor your improvement.

If you agree to participate, you will be asked to complete a brief electronic questionnaire at the beginning and end of each session as part of your treatment. Please respond as honestly as possible because this will help your therapist evaluate if the treatment is effective for you.

Please be assured that your personal information is kept strictly confidential from your insurer. **The questionnaires remain anonymous**, identified only by an ID number that is assigned by your therapist. The only information which is disclosed is an ID number, the questionnaire, your age, gender, diagnosis, general health status, and whether you have received mental health treatment previously. The outcomes measurement service center and qualified academic researchers may use the data to investigate ways to improve treatment outcomes. These research professionals do not have access to any information that could be used to personally identify you as an individual receiving treatment, nor do they have any access to your confidential medical records.

You are free to decline to complete the questionnaires, even if you have authorized their use on this release. Refusal to complete the questionnaires will not affect your treatment or insurance coverage in any way.

☐ I accept use of outcome questionnaires. ☐ I decline use of outcome questionnaires.

_____
Client Name (print)

_____ _____
Client Signature Date