

*Elizabeth Goss, Rostered Mental Health Counseling  
Under the supervision of Leora E. Black, PhD., LCMHC, LMFT  
525 Hercules Drive, Suite 1A Colchester,  
Vermont 05446  
Tele. 802-264-5333, Fax 802-264-5338*

**This document is for clients being treated by Elizabeth Goss, Rostered. Please read and sign permission to treat, decline or authorization to communication with your primary care, HIPAA form, and billing. Bring to first session completed or with questions. A copy of your insurance card(s) with co pay or deductible.**

### **Professional Disclosure**

The State of Vermont requires Clinical Mental Health Counselors to disclose information about themselves to their clients and 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.

### **Qualifications and Experience**

I am Rostered, Non-Licensed, Non-Certified Psychotherapist # 097.0134525

I hold a bachelor's of fine arts degree in fine arts from Green Mountain College, Poultney, Vermont. I am currently a graduate intern at Southern New Hampshire University's Clinical Mental Health Counseling Master's Program. I have a wide range of experience in the mental health field at multiple designated mental health agencies in Vermont. I have worked with children, teens, adults, couples and families.

### **Formal Education:**

Southern New Hampshire University Master of Clinical Mental Health Counseling	09/2017 – anticipated 5/2020 Manchester, NH
Green Mountain College Bachelors in Fine Arts	08/2010 – 05/2014 Poultney, VT

### **Practice Experience**

Title: *Counselor*

Description of Practice:

Counseling Connection Training Institute. Provide counseling and treatment planning for individuals, couples and families.

Location: Colchester, Vermont 05446

Dates of Practice: 08/12/2019 – present

Supervisor: Leora E. Black, Ph.D., weekly supervision.

Title: *Residential Counselor*  
Description of Practice: Howard Center. Provided emotional and mental health support, and life skills education to adults living in a residential group home for co-occurring mental health and substance use diagnoses.  
Location: 847 Pine Street, Burlington, VT 05401  
Dates of Practice: 07/16/2018 – present  
Supervisor: Benjamin Goodwin

Title: *Residential Case Manager*  
Description of Practice: Howard Center - Community Support Program. Provided Case Management services to adults with cooccurring diagnoses living in residential group homes. Created and oversaw financial budgets for clients. Provided emotional and mental health support, and connected clients with area community resources to assist in their finances, mental health, job support and independence in the community.  
Location: 300 Flynn Ave. Burlington, VT 05401  
Dates of Practice: 03/05/18 – 07/13/18  
Supervisor: Cathy Cashman

Title: *Family Engagement Specialist*  
Description of Practice: Easterseals partner with Vermont Department of Children and Families. Provided strengths based parent coaching, and family support services to children and their families, including foster parents. Facilitated small and large group meetings.  
Location: 426 Industrial Ave. Williston, VT 05495  
Dates of Practice: 01/01/2017 – 09/01/2018  
Supervisor: Shannon Fogg

### **Scope of Practice**

Therapeutic Orientation: Integrated approach that is Client centered, collaborative, and strengths based utilizing research based interventions and theories specific to each client’s needs. Specializing in treatment for clients with trauma history, PTSD, anxiety, depression, attachment issues, substance use/co-occurring disorders, pregnancy, post-partum support, parenting, adoption and foster care.

### **After Hours Availability**

Please direct all non-emergency calls to my office voice mail at **(802) 264-5333** ext. 107 during the week and after hours. Leave messages about cancellations, requests for services, etc. If you do not hear back from me within 1-2 days (weekends and long holiday weekends might be a longer response time) please call again as occasionally there are problems with voice mail messages or/and if you are using a cell phone the message can be garbled. Please leave your name and number twice in your message.

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) go directly to an emergency room. Or call 911 for immediate assistance.** If not imminently life threatening, you may choose to text the Vermont suicide prevention center at 741741 or call the emergency mental health services in your county.

### **Chittenden County**

**First Call for Adults, Children and Families (802) 488-7777     Domestic Abuse Hotline..... (802) 658-1996**  
**Alcohol Crisis Team..... (802) 488-6425     Dept. of Children and Families..... (802) 863 7370**

**Franklin County Crisis ..... (802) 524-6554 Addison County Crisis..... (802) 388-7641**

People living outside Chittenden, Franklin, and Addison counties should consult their local listings for emergency service numbers. When appropriate, you may inform emergency services you are engaging in mental health therapy with me, and provide my contact information, with a signed release of information form so that they can speak with me.

### 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 Marriage and Family Therapy /Mental Health Counseling is governed by the rules of the Board of Allied Mental Health Practitioners. 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/>.** You have the right to lodge a formal complaint with the Board of Allied Mental Health Practitioners in the following manner: by calling (802) 828-1505 or/and by writing: Vermont Secretary of State, Office of Professional Regulation, Board of Allied Mental Health Practitioners, 89 Main Street, 3<sup>rd</sup> Floor, , Montpelier, Vermont, 056203402.

### Office of Professional Regulation

The Office of Professional Regulation provides Vermont licensees, certifications, and registrations for over 56,000 practitioners and businesses. Forty-five professions and occupations are supported and managed by this office. A list of professions regulated 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 calling (802) 828-1505, or by writing to the Director of the Office, Secretary of State's Office, 89 Main Street, 3<sup>rd</sup> Floor, Montpelier, VT 05620-3402.

Upon receipt of a complaint, an administrative review determines if the issues raised are covered by the applicable professional conduct statute. 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.

Accountancy	Naturopaths
Acupuncture	Nursing
Architects	Nursing Home Administration
Athletic Trainers	Occupational Therapists
Auctioneers	Opticians
Audiologists	Optometry
Barbers & Cosmetologists	Osteopathic Physicians and Surgeons
Boxing	Pharmacy
Control	Physical Therapists
Chiropractic	Private Investigative & Security Services
Dental Examiners	Psychoanalyst
Dietitians	Psychology
Drug and Alcohol Counselor	Psychotherapist, Non-licensed
Electrolysis	Radiologic Technology
Professional Engineering	Real Estate Appraisers
Funeral Service	Real Estate
Hearing Aid Dispensers	Respiratory Care
Land Surveyors	Social Workers, Clinical
Landscape Architects	Tattooists
Marriage & Family Therapists	

Chapter 78: Roster of Psychotherapists Who Are Non-licensed  
§§ 4090. Disclosure of Information

The board shall adopt rules requiring persons entered on the roster to disclose to each client the psychotherapist's professional qualifications and experience, those actions that constitute unprofessional conduct, and the method for filing a complaint or making a consumer inquiry, and provisions relating to the manner in which the information shall be displayed and signed by both the Rostered psychotherapist and the client. The rules may include provisions for applying or modifying these requirements in cases involving institutionalized clients, minors and adults under the supervision of a guardian. (Added 1993, No. 222 (Adj. Sess), §§ 17; amended 1997, No. 40, §§ 69.)

**Chapter 5: SECRETARY OF STATE Sub-**  
**Chapter 3: Professional Regulation**  
3 V.S.A. § 129a. Unprofessional conduct  
§ 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.
  - (16)(A) Impeding an investigation under this chapter or unreasonably failing to reply, cooperate, or produce lawfully requested records in relation to such investigation. (B) The patient privilege set forth in 12 VSA 1612 shall not bar the licensee's obligations under this subdivision (16).
  - (17) Advertising, promoting, or recommending a therapy or treatment in a manner tending to deceive the public or to suggest a degree of reliability or efficacy unsupported by competent evidence and professional judgement.
- (18) Promotion by a treatment provider of the sale of drugs, devices, appliances, or goods provided for a patient or client in such a manner as to exploit the patient or client for the financial gain of the treatment provider, or selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes.
- (19) Willful misrepresentation in treatments or therapies.
- (20) Offering, undertaking, or agreeing to cure or treat disease or disorder by a secret method, procedure, treatment, or medicine.
- (21) Permitting one's name or license to be used by a person, group, or corporation when not actually in charge or responsible for the professional services provided.
- (22) Prescribing, selling, administering, distributing, ordering, or dispensing any drug legally classified as a controlled substance for the licensee's own use or to an immediate family member as defined by rule.
- (23) For any professional with prescribing authority, signing a blank or undated prescription form or negligently failing to secure electronic means of prescribing.
- (24) For any mental health care provider, use of conversion therapy as defined in 18 VSA 8351 on a client younger than 18 years of age. Subdivision (a)(25) effective July 1, 2019.

(25) For providers of clinical care to patients, failing to have in place a plan for responsible disposition of patient health records in the event the licensee should become incapacitated or unexpectedly discontinue practice.

(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.; 2017, No. 48 §; 2017, No. 144 (Adj. Sess.), 6, eff July 1, 2019)

#### § 4093. Unprofessional conduct

(a) Unprofessional conduct means the following conduct and conduct set forth in section 129a of Title 3:

(1) Providing fraudulent or deceptive information in an application for entry on the roster.

(2) Conviction of a crime that evinces an unfitness to practice psychotherapy.

(3) Unauthorized use of a protected title in professional activity.

(4) Conduct which evidences moral unfitness to practice psychotherapy.

(5) Engaging in any sexual conduct with a client, or with the immediate family member of a client, with whom the psychotherapist has had a professional relationship within the previous two years.

(6) Harassing, intimidating or abusing a client.

(7) Entering into an additional relationship with a client, supervisee, research participant or student that might impair the psychotherapist's objectivity or otherwise interfere with his or her professional obligations.

(8) Practicing outside or beyond a psychotherapist's area of training, experience or competence without appropriate supervision.

(b) After hearing, and upon a finding of unprofessional conduct, the board may take disciplinary action against a rostered psychotherapist or an applicant. (Added 1993, No. 222 (Adj. Sess.), § 17; amended 1997, No. 40, § 71; 1997, No. 145 (Adj. Sess.), § 61; 1999, No. 52, § 37.)

### **My Relationship with Counseling Connection Training Institute, PLC**

I am rostered by the State of Vermont and am practicing under the supervision of Leora Black, Ph.D., LCMHC, LMFT, who is d/b/a Counseling Connection, PLC. I practice as an employee of the Counseling Connection Training Institute, PLC, located at 525 Hercules Drive, Colchester, Vermont. While independent clinicians and the Counseling Connection Training Institute, PLC sometimes share office space, certain expenses, and administrative functions, I independently provide you, my client, with clinical services, and am fully responsible for those services. My professional records are maintained separately, and no member of the group other than Leora Black, Ph.D. can have access to them without your specific permission, or unless I am incapacitated or have died. Your signature at the end of this document indicates that you have read this information and agree to abide by its terms during our professional relationship.

### **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. Insurances do not cover missed appointments. 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 insurance company. 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 Leora Black, Ph.D. and/or the clinician's billing agent, Elite Billing, Mary Myers 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 hours' notice is required for cancellation of appointments. **I understand 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. If there is a natural disaster, or weather would not permit safe transportation to the appointment, this fee will be waived. If you are sick and cannot make the appointment, please contact me by 7:00am to avoid being billed for the session. Likewise, if cannot make the scheduled appointment due to inclement weather or illness, I will call the number you have provided me to cancel. If you have an outstanding balance and have refused to make payment upon request, you understand that I can invoke the right to take you to small claims court.

My initial evaluation and return visit fee are \$120. Follow up visits are 45-55 minutes. I expect payment at the time of the appointment for self-pay, deductibles, or co-payments. I am a participating provider for several insurance companies and accept their contracted rates. It is your responsibility to contact your insurance carrier to review your coverage. If I am a provider for your insurance carrier, I will bill them directly. **You are responsible for charges that are not covered by your insurance including deductibles and co-payments, therefore it is very important that YOU CHECK WITH YOUR INSURANCE COMPANY PRIOR TO OUR FIRST SESSION.** I also may charge separately for report preparation, school meetings/consultations or sessions agreed to that go beyond those approved by your insurance carrier. Such fees are due at the time of service. Telephone consultations that exceed 15 minutes may be billed to the client at the regular rate. My goal is to avoid participation in legal matters, note on my billing form that my rate for court related activities is \$150 per hour. **If your check does not process you are responsible for the cost. If you fail to give me the correct insurance, costs to rebill will be encumbered by you.**

All insurance plans and EAP benefits vary, and you are responsible for finding out the details of your plan. Some require preauthorization by your primary care provider or by the insurance company or EAP provider directly before they will pay for services. Some plans authorize a set number of sessions. You are responsible for tracking this information. Some insurance companies require that I provide verbal or written up-dates of your treatment on a periodic basis for services to be covered or continued. I will provide these updates with your written or verbal permission. Please inform me ahead of time of any changes in your insurance coverage or plan information. By signing this document, you authorize your insurance benefits to be paid directly to Counseling Connection Training Institute. If necessary, I may utilize the assistance of small claims court or a collection agency to receive payment for services provided. **Checks are payable to Counseling Connection Training Institute or CCTI.**

### **Record Retention and Unexpected Therapist Absence**

**Record Retention:** It is my practice, in conjunction with state laws and insurance requirements, to retain the record of your work with me for 7 years from the date of last session with me, at which point I will destroy it. For minors at the time of service, the 7 years starts when they turn 18. Should you require information from your record, please notify me within the 7-year period.

**Unexpected therapist absence:** In the event of my unplanned absence from practice, whether due to injury, illness, death, or any other unexpected major reason, I maintain a Professional Will with instructions for an Executor, or Secondary Executor, to inform you of my status and, if you chose, to help you transition to another therapist, including forwarding records to the selected therapist or releasing the record to you. By signing this form, you authorize the Executor to access your treatment and financial records only in accordance with the terms of my Professional Will, and only if I experience such an event. If that the Executor requires assistance to complete these tasks, they may obtain assistance from others, in a professional manner, as they deem necessary. I can provide you with the name of my Executor and Secondary Executor if you request it. By signing this form, you are authorizing my executors to conduct this business without obtaining a new consent from you.

### **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.

### **Electronic Communication and Social Media**

Email, texting and related technologies pose inevitable risks to confidentiality. They are subject to “hacking” and data stealing. If you provide me with your email address and cell phone *number, you are agreeing to assume those risks.* Please use text only for brief messages or scheduling issues, in order to protect your privacy as much as possible. Because social media networks such as Facebook, LinkedIn, etc., are an even greater risk to your confidentiality, I do not connect with clients in any way on social media.

Sometimes I text you about appointment reminders. If you do not want appointment reminders, please let me know.

**Public encounters:** In order to protect your privacy, I do not initiate contact with clients in public places. Should we encounter each other outside of the office, I will not openly greet you first, unless we have made a prior agreement. I will respond should you greet me first and take your lead on how introductions will be made if there is a need for that.

### **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 which may yield to 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 Elizabeth Goss, Rostered a statement of afterhours availability, the clinician’s relationship with Counseling Connection, PLC, 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 \_\_\_\_\_ to treat \_\_\_\_\_.  
(Elizabeth Goss, Rostered) (Client(s))

\_\_\_\_\_  
(Client or Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Practitioner’s Signature)

\_\_\_\_\_  
(Date)

Mental Health Report to Physician

**PATIENT** \_\_\_\_\_

**PHYSICIAN** \_\_\_\_\_

**DOB** \_\_\_\_\_

**LOCATION** \_\_\_\_\_

**TELEPHONE** \_\_\_\_\_

**Reason for referral:** \_\_\_\_\_

**Date(s) seen:** \_\_\_\_\_

**Assessment:** \_\_\_\_\_

**Plans:** \_\_\_\_\_

I give permission to Leora E. Black, Ph.D and Elizabeth Goss, Rostered to communicate with my Primary Care Physician. I may revoke the release in writing at any time. Further disclosure of information provided by this release may not be made without my written consent, or as otherwise restricted Federal Regulations (42 Code of Federal Regulations, Part 2, Confidentiality of Alcohol and Drug Abuse Treatment and Patient records). A photocopy of this document is as valid as the original.

Mental Health Provider Signature: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

(Client signature/Parent/Guardian)

I decline authorization for Leora Black, Ph.D. and Elizabeth Goss, Rostered to communicate with my physician.

Client: \_\_\_\_\_ Date: \_\_\_\_\_

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

Counseling Connection Training Institute, PLC  
525 Hercules Drive, Suite 1A, Colchester, VT 05446  
(802) 264-5333

## HIPAA Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (“HIPAA”), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time, in accordance with the law. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

### HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

**For Treatment.** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. I may at times find it helpful to consult with other professionals about a case. During a consultation I do not reveal the identity of my client. The consultant is also legally bound to keep the information confidential.

**For Payment.** I may use and disclose PHI so that I can receive payment for 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.

**For Health Care Operations.** I may use or disclose, as needed, your PHI in order to support business activities, for example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

**Required by Law.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Without Authorization.** 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.

**Judicial and Administrative Proceedings.** I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

**Deceased Patients.** I may disclose PHI regarding deceased patients 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 patients 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 (50) 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. I 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.

**Law Enforcement.** I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), 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.

**Specialized Government Functions.** I may review requests from 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.

**Verbal Permission.** I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**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 upon your authorization. Any other use or disclosure not described in this Notice of Privacy Practices will be made only with your written authorization.

## **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to me.

- **Right of Access to Inspect and Copy.** 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. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me 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 me. I may prepare a rebuttal to your statement and will provide you with a copy.

Please contact me if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of 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.** 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 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.
- **Right to Request Confidential Communication.** 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.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice. It is available on the website <https://counselingconnectionvt.com>, go to list of therapists, Leora Black and first session paperwork. Upon request I will provide a copy.

Complaints: If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me, or to the Office for Civil Rights U.S. Department of Health and Human Services Government Center J.F. Kennedy Federal Building - Room 1875, Boston, MA 02203, Voice phone (617)565-1340, FAX (617)565-3809, Email: [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov) <https://www.hhs.gov/hipaa/filing-a-complaint/index.html>.

***Under no circumstances will you be penalized or retaliated against for filing a complaint.***

By signing below, you are acknowledging that you have reviewed and understand this document.

Rev. June 2019

## 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 <b>(parent if client minor)</b>	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 prevented us from obtaining acknowledgement
- IV. IV. Other (Please Specify)

\_\_\_\_\_

**Billing Information**  
**Counseling Connection Training Institute, PLC**

Client's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Emergency Contact and Telephone Name and Number: \_\_\_\_\_  
Gender: M F Transgender M-F F-M Alternative Gender Identity  
Marital Status: \_\_\_\_\_ Referred by: \_\_\_\_\_  
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#: \_\_\_\_\_  
PreAuthorization #: \_\_\_\_\_ Date Auth starts/ends: \_\_\_\_\_ / \_\_\_\_\_

**\*\*\*copy of your insurance card front and back; call and get authorization from your insurance company and know what your copayments and deductibles are because payment is due at time of session. Cash and checks are accepted, if your check does not process you are responsible for the cost. If you fail to give me the correct insurance, costs to rebill will be encumbered by you. Medicaid must be current or you will be billed.**

**Secondary Insurance**

Insurance II: \_\_\_\_\_ Co-pay Amount: \_\_\_\_\_  
Insurance Mailing Address: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Certificate/ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Pre-  
Authorization #: \_\_\_\_\_ Date Auth starts/ends: \_\_\_\_\_ / \_\_\_\_\_

Clinician: Elizabeth Goss. Hourly Fee: \$120.00 Initial Session / \$120.00 Return Visit Court fee: \$150 per hour for preparation, reports, and court.related activities.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Counseling Connection Training Institute, PLC**

**525 Hercules Drive, Suite 1A, Colchester, Vermont 05446**

**Tele: 802 264 5333, fax: 802 264 5338**

**AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I hereby authorize Leora Black and Elizabeth Goss 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: \_\_\_\_\_