

Marie Postiglione-Dupell, Rostered
Counseling Connection Training Institute, PLC
525 Hercules Drive, Suite 1A, Colchester, Vermont 05446
(802) 264-5333 x 107 ; (802) 264-5338 (fax)

*This document is for clients being treated by Marie Postiglione-Dupell, Rostered, Non-Licensed, Non-Certified
Psychotherapist #097.0134800*

Practicing under the supervision of Leora E. Black, Ph.D., LCMHC, LMFT

Please read, fill out, sign, and bring to your first session the following forms: permission to treat; authorization to communicate with your primary care physician; HIPAA; and billing. Please bring your insurance card to your first session for copying. Please bring your co-pay or deductible to every session.

Professional Disclosure

The State of Vermont requires Clinical Mental Health Counselors to disclose information about themselves to their clients, and to provide information regarding disputes and complaints. This document constitutes my Professional Disclosure. Additionally, this document clarifies important aspects of your treatment and record retention and represents an agreement between us. **Your signature at the end of this document indicates that you agree with and will abide by these policies.**

Qualifications and Experience: Marie Postiglione-Dupell

Education: Master's in Clinical Mental Health Counseling, Southern New Hampshire University (Projected Graduation, 2021); B.S. Science Springfield College (1987).

Training & Experience: I provide mental health counseling services to children, teens and adults at Counseling Connection Training Institute under the supervision of Dr. Leora Black, Ph.D., LCMHC, LMFT. Additional training and experience include: Office of Persons with Developmental Disabilities (OPWDD) Day Habilitation Provider (since-2010); Equine Specialist in Mental Health & Learning certified (2007-present). 13 years' work experience and learning regarding Animal Assisted therapy (2007-present). Extensive training with working with autistic and developmentally delayed children.

Scope of Practice

The theories and practices include: Cognitive Behavioral Therapy, Psychoeducational, and Mindfulness. My clinical focus includes depression, anxiety, bipolar, autism, adhd/add, trauma, reactive attachment disorder, school related issues, self esteem issues.

My modalities of practice include individuals of all ages and orientations, and families.

After Hours Availability

Please direct all non-emergency calls during the week and after hours to my voice mail at the Counseling Connection Training Institute **(802) 264-5333 ext. 107**. You may leave messages about cancellations, requests for services, etc. at either number. If you do not hear from me within 1-2 days of leaving your message, please call again. Occasional problems with voice mail messages can occur, and cell phone messages can lack clarity and/or be garbled. Please repeat your name and number twice in your voice message.

During work or after hours, should 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
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People living outside Chittenden, Franklin, and Addison counties should consult their local listings for emergency service numbers. When appropriate, you may inform emergency services that you are engaging in mental health counseling with me, and provide them my contact information. They will need a signed release of information form to speak with me.

Disputes or Complaints

Please discuss any concerns you may have regarding your counseling and/or related issues with me or my supervisor, Leora Black, Ph.D., at any time. I/we will make every reasonable effort to resolve disputes or conflicts in a satisfactory manner.

The practice of Clinical 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 by calling (802) 828-1505, and/or by writing: Vermont Secretary of State, Office of Professional Regulation, Board of Allied Mental Health Practitioners, 89 Main Street, 3rd Floor, Montpelier, Vermont, 05620-3402.

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, 3rd 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	Veterinary
Clinical Mental Health Counselors	
Midwives, Licensed	

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 (25) effective July 1, 2019.
- (25)(a) 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:
 - (1.1.1) 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.)

Marie Postiglione-Dupell, Rostered, 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 doing business as (dba) Counseling Connection, PLC.

While independent clinicians and the Counseling Connection Training Institute, PLC may share office space, certain expenses, and administrative functions, I provide you, my client, with independent clinical services. I am, therefore, fully responsible for the clinical services I provide. 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.,

Marie Postiglione-Dupell, Rostered, and/or the clinician's billing agent, Mary Myers of Elite Billing, to provide such information. I hereby authorize my insurance benefits to be paid directly to the Counseling Connection Training Institute, PLC, 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 Marie Postiglione-Dupell, by 7:30am to avoid being billed for the session. Likewise, if I, Marie Postiglione-Dupell, cannot make the scheduled appointment due to inclement weather or illness, I will call or text 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 is \$120.00 Follow up visits are 45-55 minutes. I expect payment at the time of the appointment for self-pay, deductibles, and/or co-payments. 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. Please note that my rate for court related activities is \$150.00 per hour and is indicated on my billing form. **If your check does not process you are responsible for the cost of counseling services provided. If you fail to provide correct insurance information, the cost to rebill will be encumbered by you.**

Please inform me in advance of any changes in your insurance coverage or plan information. By signing this document, you authorize your insurance benefits to be paid directly to the Counseling Connection Training Institute, PLC. 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 the 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 our last session, at which point I will destroy the file. 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, CCTI maintains 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 records 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 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, 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 will text you appointment reminders. If you do not want appointment reminders, please let me know.

Public Encounters

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 follow 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 therapy process, you may face and work through difficult emotions, fears, and/or experiences. Therapy may also have unanticipated relationship consequences. For instance, some persons undergoing individual therapy may find their growth through the therapeutic process leads 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 Marie Postiglione-Dupell, M.A. Candidate, a statement of afterhours availability, 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 the 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 MUST COMPLETE THIS REQUEST FOR SIGNATURE

I hereby give permission for _____ to treat _____
(Clinician) (Client(s))

(Client or Parent/Guardian Signature) (Date)

(Marie Postiglione-Dupell, Rostered 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 Black, Ph.D. and/or Marie Postiglione-Dupell, 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.

Marie Postiglione-Dupell, Rostered Signature: _____ Date: _____

(Client signature/Parent/Guardian) Date: _____

I decline authorization for Leora Black, Ph.D. and/or Marie Postiglione-Dupell, Rostered, to communicate with my physician.

Client: _____ Date: _____

Revised June 2019 Leora Black, Ph.D., LCMHC, LMFT

Counseling Connection Training Institute, PLC
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(802) 264-5333 ext 107 (tele) (802) 264-5338 (fax)

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. The 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>, under the list of therapists, Marie Postiglione-Dupell, Rostered, 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
<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

Marie Postiglione-Dupell, Rostered

****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 if client minor)** 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)
-

BILLING INFORMATION
Counseling Connection Training Institute, PLC

Client's Last Name: _____ First Name: _____
Mailing Address: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____ Cell #: _____ 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: _____ State: _____ Zip: _____
Phone: _____ Relationship: _____

Insurance Information

Insurance I: _____ Co-pay Amount: _____
Insurance Mailing Address: _____
Subscriber Name: _____ Relationship: _____
Certificate/ID#: _____ Group#: _____
Pre-Authorization #: _____ Date Authorization starts/ends: _____ / _____

***Please call for authorization from your insurance company and know what your co-payments and deductibles are, as payment is due at time of session. We will copy your insurance card, front and back.
If you fail to provide accurate or complete insurance information, you will owe the cost of re-billing.
*Cash and checks are accepted. If your check does not process, you are responsible for the cost of the services provided and any service fee incurred. Checks are payable to Counseling Connection Training Institute, or CCTI.**

Secondary Insurance

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

Clinician: Marie Postiglione-Dupell, Rostered 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 Marie Postiglione-Dupell, Rostered has the right to take me to small claims court to recover balance due.

Signature: _____ Date: _____

AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Patient Name: _____ DOB: ____/____/____

I hereby authorize **Leora Black, Ph.D., LCMHC, LMFT and/or Marie Postiglione-Dupell, Rostered**, 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:

(1.1.1.1) I may revoke this release in writing at any time, except to the extent that action has already been taken.

(1.1.1.2) 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).

(1.1.1.3) 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