

COUNSELOR-PATIENT SERVICES INFORMED CONSENT AGREEMENT

Thank you for choosing Deborah Del Vecchio-Scully, MS, LPC, NCC. Today's appointment will take approximately 50 minutes. I realize that starting counseling is a major decision and you may have questions. This document is to inform you of my policies, state and federal laws and your rights. This document (the agreement) contains important information about my professional services and business policies, and the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the treatment, payment and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. The notice, which is attached to this agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you this information by the end of the first session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at that time. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

ABOUT PSYCHOTHERAPY

People consult with Counselors for many reasons. I will make every effort to respect your individual needs and goals in treatment. The therapy process involves a working partnership between us. Our work may include a variety of activities, and for optimum outcomes to occur, your active participation is essential. I will attempt to help you achieve your goals, but I cannot guarantee that the outcome will be what you now seek. In addition, change is often accompanied by feeling states that can be distressing. You may experience moments of frustration, anxiety, self-doubt, depression, and confusion. While I am a trained, licensed and experienced counselor, I cannot guarantee change nor can I promise that all problems will be resolved.

PROFESSIONAL FEES

The fee for an initial consultation is \$275.00. During the consultation, the client and the therapist will decide together the length of future visits. Longer or shorter visits may be scheduled at times and will be charged at the hourly rate of \$175.00 for 50 minute time segments. You are responsible for payment at the time of each visit as I do not bill insurance companies for reimbursement.

I revisit my fee structure biannually and increases in our agreed upon rate may occur to reflect cost of living increases, training, and experience. You will receive a minimum of 4 week's notice should our fee agreement change and you will have the option of continuing at the new rate or receiving a referral if preferred.

Other fees:

1. Telephone consultations with you, or on your behalf, may be billed proportionate to the hourly rate billed for therapy. Written communication to you or on your behalf may be billed proportionate to the hourly rate billed for therapy.
2. The fee for returned checks is \$50.00.
3. Any court appearance or deposition, or the provision of documents for any attorney or for the court will be billed at an hourly rate of \$250 per hour, and will include preparation and travel time. You will be responsible for all such fees related to your evaluation or treatment, payable at the time any such court-related services are requested.

Payment for services by check, cash or credit card is expected at time of service.

CANCELLATION POLICY

As a counselor, I work as a service provider. My product is my time and expertise. When someone fails to appear for a scheduled appointment or cancels less than 48 hours before the appointment, I am unable to fill that time with another client. If you give me 48 hours' notice of your intention to cancel your appointment, I will not charge you for the time. If you fail to provide 48 hours notice, a no-show fee of \$100.00 will be charged. Please call me to cancel or reschedule any appointment only; email or text cancellations are unacceptable.

CONTACTING ME:

I am available by cell phone, 203.988.6769. If I do not answer the phone, please indicate in your message your name and contact phone number as I do not store client information on my cell phone; please indicate whether you need me to return your call. Please do not contact me by text message.

In the case of an emergency and if you are unable to reach me immediately, call 911, your primary care physician or go to the nearest emergency room for assistance.

If I am unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a counselor in most situations; we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of a client. The other professionals are legally bound to keep the information confidential. If you don't object, I will not inform you of these consultations unless I feel it is important to our work together. I will note all consultations in your Clinical Record.
- If a client threatens to harm himself or herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- There are situations where I am permitted or required to disclose information without your consent or Authorization:
 - If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is

protected by the Counselor-privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If the Connecticut Department of Public Health requests information for an investigation of my practice, I am required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, I may disclose information relevant to that claim to the client's employer or insurer.

There are some situations where I am legally obligated to take action, which I believe are necessary to attempt to protect others from harm, and I may have to reveal information about a client's treatment. These situations are unusual in my practice.

- If I know or suspect that a child under the age of 18 has been abused or neglected, the law requires that I file a report with the Connecticut Department of Children and Families. Once such a report is filed, I may be required to provide additional information.
- If I know or suspect that an elderly or disabled adult has been abused or neglected, exploited, sexually or emotionally abused, the law requires that I file a report with the appropriate government agency, usually the Connecticut Department of Social Services (DSS), Protective Services for the Elderly (PSE). Once such a report is filed, I may be required to provide additional information.
- If I believe that disclosing information about you is necessary to prevent or lessen a serious and imminent threat to the health and safety of an identifiable person(s), I may disclose that information, but only to those reasonably able to prevent or lessen the threat.

If one of these situations arises, I will make every effort to fully discuss it with you before taking any action and I will try to limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you of potential problems, it is important that we discuss any questions or concerns that you have now or in the future. The laws governing confidentiality are complex and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information (PHI) about you in professional record storage. This constitutes your Clinical Record and includes information about your reasons for seeking therapy, a description of your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress toward those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, and any reports that have been sent to anyone. If you provide me with an appropriate written request, you have the right to examine and/or receive a copy of your records, except in unusual circumstances that involve a danger to you or others. In those situations, you have the right to have your medical record sent to another mental health provider. In most situations, I am allowed to charge a copying fee of \$1.00 per page (and certain other expenses). If I refuse your request for access to your records, you have a right of review, which I will discuss with you at that time.

In addition, I may also keep a set of Psychotherapy notes for my own use and are designed for me to assist you with best treatment. While the content of Psychotherapy notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive Information that you reveal to me that is not required to be included in your Clinical Record.

While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy notes without your authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that such disclosure would be reasonably likely to be detrimental to your health. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health Professional so you can discuss the contents.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. If your account remains unpaid for 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require I disclose otherwise confidential information. In most collective situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, the costs will be included in the claim.

Social Media

Friending: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Internet

Internet Searches: While my present or potential clients might conduct online searches about my practice and/or me, I do not search my clients with Google, Facebook, or other search engines unless there is a clinical need to do so, as in the case of a crisis or to assure your physical wellbeing. If clients ask me to conduct such searches or review their websites or profiles and I deem that it might be helpful, I will consider it on a case by case basis and only after discussing possible impacts to our professional relationship and your privacy.

However, I am a content expert for the GoodTherapy.org site and am a blogger in the areas of mental health, trauma, grief and mindfulness. I have also been a blogger for the American Counseling Association on a variety of mental health issues. I have a LinkedIn profile for professional networking and a Facebook page, The Mindful Counselor as a means to educate the public regarding mental health issues, motivational items and is meant to be informational but not as a part of therapy.

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E-mail Communications with Deborah Del Vecchio-Scully, LPC

Please read the following disclosures about communicating with Deborah Del Vecchio-Scully, LPC using email:

- As a rule, Deborah Del Vecchio-Scully, LPC does not conduct any therapy via e-mail. However, she may use e-mail to handle certain questions or issues that pertain to therapy and related content, if they can be easily and simply handled by that means. At her discretion, she may also choose to refrain from using e-mail communication for therapeutic reasons. Email should not be used for clinical emergencies. Please contact her by telephone, go to your closest emergency room or call 911.
- E-mail is a non-secure and non-confidential form of communication. Hackers and unauthorized users can also attempt to access emails through malicious software such as spyware or a virus that may be located on your computer unbeknownst to you.
- Many people still feel comfortable communicating via e-mail because they have installed firewalls or other programs designed to detect spyware, viruses, or other dangerous software. However, there is no guarantee that such programs will always be effective.
- Sent and received e-mails are stored on both Deborah Del Vecchio-Scully, LPC's and your computer until deleted. Deborah Del Vecchio-Scully, LPC may or may not delete such e-mails. Generally, mundane e-mails will be deleted while other more substantive e-mails may be kept or printed and put in your file for record keeping purposes. Any such saved e-mails will be kept in a password-protected account that only Deborah Del Vecchio-Scully, LPC has access to.
- In addition, whenever you send an e-mail, it is stored in cyberspace and the authorities can access these e-mails under various circumstances – this is due to the nature in which e-mail is transmitted using the internet and other services or networks. For more information on this, please contact your Internet Service Provider or e-mail service.
- Deborah Del Vecchio-Scully, LPC will use e-mail to respond to e-mails that you send her. If you request that your billing statement be e-mailed to you, she will do so.

By signing below, I agree that I understand the disclosures listed above regarding communicating with Deborah Del Vecchio-Scully, LPC using e-mail. I also agree that if I send an e-mail to her and request a response via email, that I am willing to accept the above-stated risks:

If you do not want to correspond via e-mail, do not sign your name, instead write "Declined."

Print Name: _____ Signature: _____
Date: _____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

I/we consent that _____ may be treated as a client by Deborah Del Vecchio-Scully, MS, LPC.

Printed Name of Client: _____

Signature of Client (Parent or legal guardian if under the age of 16):

Date: _____

Demographics

Name: _____

Street Address: _____ **Town:** _____ **Zip:** _____

Date of Birth: _____

Right to request where we contact you

- Home Yes or No Work Yes or No
- Cell Phone Yes or No By Mail: Yes or No
- If not, how may I contact you: _____

Emergency Contact Information:

Name: _____

Phone Number: _____

Address: _____

Primary Care Physician: _____

Phone number: _____