REFLECTIONS PROFESSIONAL COUNSELING, LLC
Andrea Stickel, MA, LPC

Consent to Treatment

Thank you for choosing Reflections Professional Counseling. Counseling sessions will be 50 minutes in length. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, state and federal laws, and your rights. If you have any other questions or concerns, please ask and I will try my best to give you all the information that you need.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses ***intentions or a plan to harm another person***, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client ***discloses or implies a plan for suicide***, the health care professional is required to notify legal authorities, necessary medical intervention, and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is mandated to report this information to the appropriate social service and/or legal authorities.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____
Client Signature (Client's Parent/Guardian if under 18) Today's Date

Emergency Situations:
If the therapist is unavailable during an emergency situation outside of normal business hours, you agree to call 911 or go to the nearest emergency room. You may also call one of the national hotlines shown below:

National Emergency Hotlines

National Hope Line Network
1-800-SUICIDE
1-800-784-2433

National Suicide Prevention Lifeline
Life Line Chat
1-800-273-TALK
1-800-273-8255

National Graduate Student Crisis Line
Immediate 24 Hour Help for Grads in Crisis
1-800-GRAD-HLP
1-800-472-3457

Vet2Vet Veteran's Crisis Hotline
1-877-VET-2-VET
1-877-838-2838

Confidential Live Veterans Chat
Veteran's Crisis Line
1-800-273-8255 PRESS 1

TTY – Hearing & Speech Impaired
1-800-799-4TTY
1-800-799-4889

Postpartum Depression
1-800-PPD-MOMS
1-800-773-6667

HIPAA NOTICE OF PRIVACY PRACTICES

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

Effective July 12, 2012
We only release information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes our policies related to the Use and disclosure of a client's protected health information for the purpose of provide services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT Use and disclose health information to:

- Provide, manage, or coordinate care
- Consultants and for supervision
- Referral sources

PAYMENT Use and disclose health information to:

- Verify insurance and coverage
- Process claims and collect fees

HEALTHCARE OPERATIONS Use and disclose health information for:

- Review of treatment procedures
- Review of business activities
- Certification
- Staff training
- Compliance and licensing activities

OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT

- Mandated reporting
- Emergencies
- Criminal damage
- Appointment scheduling
- Treatment alternatives
- As required by law

CLIENT RIGHTS: In the Notice of Privacy Practices, counselors are required to inform clients as to their rights under state and federal law.

Right to request where we can contact you (in Intake form)

Right to release your client records

- Written authorization to release records to others as needed
- Right to revoke release in writing
- Revocation is not valid to the extent you have acted in reliance on such previous authorization

Right to inspect and copy your client records

- Right to inspect and copy records
- Counselor may deny this request
- Charges for copying, mailing, etc. may apply.

Right to add information or amend your client records

- May request to amend record
- You have 60 days to request an amendment
- The request may be denied
- If denied, you have the right to file disagreement statement
- Disagreement statement and therapist's response will be filed in the record
- Amendment request must be in writing

Right to Accounting of disclosures

- For a six year period beginning with the date the counselor came in compliance
- Exceptions:
    - Disclosure for treatment, payment or healthcare operations
    - Disclosures pursuant to a signed release
    - Disclosure made to client
    - Disclosures for national security or law enforcement

Right to request restrictions on uses and disclosures of your client information

- Must be in writing
- Therapist is not obligated to agree

Right to complain

- Please contact your therapist first

- If not satisfied, you have the right to complain to the U.S. Department of Health and Human Services and/or state licensing board. Information provided on the disclosure statement in this packet.
- No retaliation for complaints filed.

Right to receive changes in policy

- May request any future changes
- Request to privacy officer

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court. Or if I stop treatment, and later wish to start up again, I may lose my appointment spot.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel at least 24 hours ahead of time, and do not show up, I will be charged according to the therapist's "No-Show/Late Cancellation" Policy. Insurance cannot be charged for this. The first time will result in a $25 charge. The second time will result in a $100 charge. Further appointments cannot be scheduled until these are paid.

Appointments are 50 minutes in length and the rate is $120 per hour. I will bill insurance if your insurance is one that I am partnered with.

In the event I decide to stop coming to therapy, this therapist will make efforts to contact me twice – either by email or phone calls (whichever method you give I permission to contact as listed on the Intake Form) – to see if I want to continue to schedule further appointments. If I don't respond to this therapist after two contacts, therapist will "close" my file and send a letter to me notifying me that she is no longer my therapist of record.

My signature below shows that I understand and agree with all of these statements and I/we have been provided a copy of the Notice of Privacy Practice, client rights information, and the therapist's disclosure statement, as required by state/federal law.

_____ _____

Signature of client Date

_____

Printed name