COUNSELING STRATEGIES, LLC
CONFIDENTIALITY AND CLIENT RIGHTS

Thank you choosing to see me for your counseling needs. 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 other questions or concerns, please ask and I will try my best to give you all the information you need.

MY QUALIFICATIONS AND CREDENTIALS

I have a Masters of Education in Community Counseling from the University of Missouri – St. Louis. I am a Licensed Professional Counselor (LPC) with the State of Missouri. I offer individual and family counseling services to children, adolescents, and adults via telemental health. I generally take a solution focused, cognitive behavioral approach to counseling, incorporating mindfulness and psychoeducation as necessary. Areas of particular interest include: giftedness, anxiety, building positive relationships, and successful transitions.

CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's parent/legal guardian. It is not my policy to testify in custody disputes. Noted exceptions are as follows:

- *DUTY TO WARN AND PROTECT*: If a client discloses intentions or a plan to harm another person, I am required to warn the intended victim and report this information. If a client discloses intentions or a plan to harm themselves, the client or client's parent/legal guardian will be directed to seek emergency services in the community to prevent such danger.
- *ABUSE OR NEGLECT*: If a client states or suggests he/she is physically or sexually abusing or neglecting a child or vulnerable adult, or is in danger of physical or sexual abuse or neglect themselves, I am mandated to take steps to protect the client, and required by Missouri State Law to report this information. I do not have any legal power to investigate the situation to find out all the facts. The Department of Social Services will investigate.
- *PROFESSIONAL SUPERVISION*: I sometimes consult other therapists or other professionals about my clients. This helps me in giving high-quality treatment. These persons are also required to keep your information private. Your name will never be given to them, some information will be changed or omitted, and they will be told only as much as they need to know to understand your situation.
- *MEDICAL INSURANCE*: Should you decide to use it, I will be required to disclose specific clinical information (i.e. diagnosis, dates of services) to the insurance company in order to process your claims and for you to receive reimbursement.
- *CHILD/PARENT*: Specific details of the information children share with me in session is not shared with parents so as to encourage children to be honest and forthcoming and to maintain an emotionally safe environment for them. As part of the therapeutic process I encourage children to share information with their parents. I will talk with the parent/legal guardian about how the child is progressing, specific worries or concerns, and things the child and I agree the parent/legal guardian needs to know. At times I will meet with the parent/legal guardian alone or together with the child.
- *COURT ORDER*: A judge in a court of law may require the disclosure of specific information pertinent to a case before the court.

AGREEMENT FOR CLIENT OR PARENT/LEGAL GUARDIAN

I understand that this therapist abides by state and federal regulations regarding health and medical record keeping and confidentiality (most commonly referred to as HIPAA regulations) and that a copy of this document, entitled Notice of Privacy Practices, has been provided for me to review.

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I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

I understand that there are benefits and risks to counseling, which can improve as well as upset the equilibrium in any person, relationship, or family.

I understand that when you meet with me or my child via telemental health, we may talk, draw pictures, play games, or do other things to help you get to know me or my child better and understand me or my child's challenges, strengths, and goals.

I understand that telemental health is the practice of delivering clinical helath care services via technology assisted media or other electronic means between a practioner and a client who are located in two different locations. I understand due to state licensing laws, the client must be located in Missouri at the time of the session.

I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

I understand that their will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

I understand that if I or my child is having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required. I understand that the therapist may need to contact my emergency contact and/or appropriate authorities in case of emergency.

I understand that this therapist is not a psychiatrist and cannot recommend or prescribe medications. I understand that this therapist does not practice law, medicine, finance or any other profession and is not able to give you good advice from these other professional viewpoints.

I understand that I am responsible for paying fees for this service.

FINANCIAL CONSIDERATIONS

I am not a member of any health insurance plans or panels. Health insurance is a contract between you (or your employer) and your insurer; I am not part of that contract. However, I will supply you with an invoice for my services. If requested, I will fill out standard forms with diagnostic (if applicable) and procedure codes for billing purposes, the times we met, my charges, and your payments. You can use this to apply for reimbursement.

I will readily use and share my knowledge and skills in good faith. I ask for your commitment to pay the full fee for my services at the end of each session, unless prior arrangements have been made. Payments are collected through IvyPay, a HIPAA compliant service, that keeps your debit, credit, HSA or FSA card on file. If you need to cancel or reschedule an appointment, please give 24 hours notice. Any uncancelled appointments or those where insufficient notice was given will be subject to a charge at the full rate and must be paid before additional sessions are scheduled. When emergent circumstances arise, exceptions may be made. A good faith estimate of expected yearly costs will be provided annually.

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CLIENT RIGHTS

- *RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION*: It is my normal practice to communicate with you regarding health matters or treatment concerns via the phone number you provided. Sometimes I may leave messages on your voicemail. Communication via text or the e-mail address you provided may also be utilized for non-clinical concerns (i.e. scheduling issues, referral information, clinical forms). You have the right to request that I communicate with you in a different way.
- *RIGHT TO SERVICE WITHOUT DISCRIMINATION*: You and/or your family will not be discriminated against based upon national origin, race, gender, sexual orientation, religion or age.
- *RIGHT TO RELEASE YOUR MEDICAL RECORDS*: You may consent in writing to release/exchange your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that I have acted in reliance on such authorization.
- *RIGHT TO INSPECT AND COPY YOUR MEDICAL AND BILLING RECORDS*: You have the right to inspect and obtain a copy of your information contained in your medical records. Under limited circumstance I may deny your request to inspect and copy. If you ask for a copy of any information, I may charge a reasonable fee for the costs of copying, mailing and supplies.
- *RIGHT TO REQUEST AN AMENDMENT TO YOUR MEDICAL RECORDS*: If you feel that information contained in your medical record is incorrect or incomplete, you may ask me to add information to amend the record. I will make a decision on your request with 30 days, or some cases within 60 days. Under certain circumstance, I may deny your request to add or amend information. If I deny your request, you have a right to file a statement that you disagree. Your statement and my response will be added to your record. To request an amendment, you must contact me directly. I will require you to submit your request in writing and to provide an explanation concerning the reason for your request.
- *RIGHT TO AN ACCOUNTING OF DISCLOSURES*: You have the right to request an accounting of disclosures, if any, which is a list of certain disclosures such as, but not limited to, child or vulnerable adult abuse, disclosures related to suicidal or homicidal threats, and disclosures to the U.S. Dept. of Health and Human Services to evaluate compliance.
- *RIGHT TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES OF YOUR HEALTH INFORMATION*: You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to me directly. However, I am not required to agree to such a request.
- *RIGHT TO A PAPER COPY*: You have a right to a paper copy of his notice whether or not you have previously agreed to receive the notice electronically.
- *RIGHT TO COMPLAIN*: If you believe your privacy rights have been violated, please contact me personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.
- *RIGHT TO RECEIVE CHANGES IN POLICY*: You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from me directly.
- *RIGHT TO TERMINATION:* You have the right to withdraw consent to treatment at any time without affecting your right to future care, services, or program benefits to which you would otherwise be entitled.

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