Wilson Counseling
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FOR YOUR RECORDS

Please **sign** the corresponding signature line on the Permissions and Consents form

1. **ASSIGNMENT OF BENEFITS:** I request payment of private insurance and/or government benefits for my treatment be made to Wilson Counseling, LLC.

2. **PRACTICE POLICIES AGREEMENT:** I have been provided a copy of and read the Notice of Practice Policies and agree to the terms therein.

3. **PERMISSION TO TREAT FOR MYSELF:** I understand that I will be taking part in mental health services which are psychological in nature. I hereby give permission for Wilson Counseling to provide services.

4. **CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION:** When we evaluate, diagnose, treat and/or refer you or the person you represent, we will be collecting what the law calls Protected Health Information (PHI) about you. We need the information to decide what treatment is best for you and to provide that treatment. The Notice of Privacy Practices (NPP) that was given to you explains in more detail your rights and how we can use and share your information as regulated by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information. We may share your PHI with others who provide treatment to you, who need it to arrange payment for your treatment, or for administrative purposes. In other situations, we can release information about your treatment only if you sign a written authorization form. Please read the Notice of Privacy Practices carefully. If you have any questions, we will try to answer them. After you have signed this consent, you have the right to revoke it in writing and we will comply with your wishes about using or sharing your information from that time on, but we may have already used or shared some of your information which cannot be changed after the fact. I hereby give permission for the above-named child's PCC representative to sign a Release of Information on behalf of the child for information to be provided to the Court, attorneys and/or other persons participating in the care of the client as part of wrap-around services and as specifically requested.

5. **SESSION RECORDING POLICY:** Therapy sessions shall not be recorded in any fashion without express agreement and permission of both client and clinician. By signing below, client understands that any session recorded without permission shall obligate client to provide clinician with written transcript of session prepared by a neutral party. Said transcript shall be signed and notarized as true and correct. Cost of any transcription shall be sole responsibility of client. Client is encouraged to maintain handwritten notes of pertinent points from sessions to provide opportunity for later review to assist in reaching therapeutic goals.

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6. **CLIENT TEXTING/EMAIL CONSENT:** The transmission of client information by email and/or texting has several risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks: 1) Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients. 2) Email and text senders can easily misaddress an email or text and send the information to an undesired recipient. 3) Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy. 4) Employers and on-line services have a right to inspect emails sent through their company systems. 5) Emails and texts can be intercepted, altered, forwarded or used without authorization or detection. 6) Email and texts can be used as evidence in court. 7) Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party. Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Therapist is not liable for breaches caused by third party. Email and texting are not appropriate for urgent or emergency situations. Provider cannot guarantee that any email and/or text will be read and responded to within any particular period of time.

7. **PERMISSION TO TREAT FOR MY CHILD:** I understand that I will be taking part in mental health services which are psychological in nature. I hereby give permission for Wilson Counseling to provide services. I understand that consent from both custodial parents is required for treatment services to be provided. I understand that both custodial parents will be provided opportunity to participate in treatment planning and, when appropriate and recommended by the treating clinician, participate in therapy sessions. I understand that the child is the identified client and billing will be made through insurance coverage on that child for client and/or family sessions. I understand that the decision to meet with me, my attorney, any other party or other attorney in any custodial or divorce proceeding is at sole discretion of the clinician.

   *** JOINT CUSTODY PERMISSION TO TREAT:** For children whose parents hold legal joint custody, written permission from both parents to participate in treatment is required by law. I, as JOINT CUSTODIAL PARENT hereby give permission for the above-named child to receive and participate in counseling/mental health services with Wilson Counseling, LLC.

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8. **TELEHEALTH CONSENT:** In the event that you and your therapist elect to utilize telehealth, you are going to have a clinical encounter using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you. Since 1994, the technology has connected tens of thousands of clients and providers in Kentucky. The information be used in diagnosis, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a client to remain within the facility and obtain serves from providers at distant sites.
- Client remains closer to home where local health care providers can maintain continuity of care.
- Reduced need to travel for the client or the provider.

The Process:
You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any telemental health staff in the room with you, if you are unsure of what is happening. If you are not comfortable with seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to ensure this videoconference is secure and no part of the encounter will be recorded without your written consent.

Possible Risks:
There are potential risks associated with the use of telemental health which include, but may not be limited to:

- A provider may determine that the telemental health encounter is not yielding sufficient information to man an appropriate clinical decision.
- Technology problems may delay the mental health evaluation for today's encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By Signing this Form, I Understand the Following:

1. I understand that the laws that protect privacy and confidentially of medical information also apply to telemental health and that no information obtained in the use of telemental health which identifies me will be identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of telemental health in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that if the provider believes I would better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit.
4. I understand that I may expect the anticipated benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.
5. I agree that I am responsible to Wilson Counseling, LLC for charges resulting from the services rendered using videoconferencing technology at their prevailing rates.

Client Consent to the Use of Telemental Health:
I have read and understand the information provided above regarding telemental health and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemental health in my care.

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NOTICE OF PRIVACY PRACTICES

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

I. Uses and Disclosures for Treatment, Payment and Health Care Operations: Your treatment provider may use or disclose your Protected Health Information (PHI) for treatment, payment and health care operations purposes. To help clarify these terms, here are some definitions:

- PHI: Refers to information in your health record that could identify you.
- Treatment: Refers to the service provided, coordinated or managed health care, and other services related to your health care.
- Payment: Refers to when your provider obtains reimbursement for your healthcare.
- Health Care Operations: Refers to activities that relate to the performance and operations of the practice.
- Use: Refers to activities only within the practice group such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- Disclosure: Refers to activities outside of the practice group such as releasing, transferring or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization: Your treatment provider may use or disclose PHI for purposes outside of treatment, payment or health care options when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. When your treatment provider is asked for information for purposes outside of treatment, payment or health care options, an authorization will be obtained from you before releasing this information. An authorization will also be needed before your psychotherapy notes are released. "Psychotherapy notes" are notes that your therapist may have made about conversations during a private, group, joint or family counseling session and that have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorization of PHI or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) your therapist has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization: Your therapist may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If your therapist has reasonable cause to believe that a dependent child is neglected or abused, he or she must report this belief to the appropriate authorities, which may include the Kentucky Cabinet for Health and Family Services or its designated representative; the Commonwealth Attorney or the County Attorney; or local law enforcement agency or the Kentucky State Police.
- Adult & Domestic Abuse: If your therapist has reasonable cause to believe that an adult has suffered abuse, neglect or exploitation, he or she must report this to the Cabinet for Health and Family Services.
- Health Oversight Activities: The Kentucky Social Work Board may subpoena records that are relevant to its disciplinary proceeding and investigations from your therapist.

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- Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and records thereof, such information is privileged under state law and will not be released without the written authorization of you or your personal or legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Harm Self: If you communicate to your therapist a threat to harm yourself, he or she may seek hospitalization for you or contact family members who can help provide protection.
- Serious Threat to Health or Safety: If you communicate to your therapist an actual threat of physical violence against a clearly identified or reasonably identifiable victim or an actual threat of some specific violent act, he or she has a duty to notify the victim and law enforcement authorities.
- Workers' Compensation: If you file a Workers' Comp claim, you waive the psychotherapist-patient privilege and consent to disclose your health information reasonably related to your injury or disease to your employer, Workers' Comp insurer, special fund, uninsured employers' fund or administrative law judge.

Patient's Rights and Therapist's Duties

- Patient Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of PHI, however your therapist is not required to agree to your requested restrictions.
- Patient Right to Receive Confidential Communications by Alternate Means and Alternate Locations. You have the right to request and receive confidential communications of PHI by alternate means and alternate locations. For example, you may not want a family member to know you are receiving treatment and make request bills be sent to another address.
- Patient Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of your PHI for as long as it is maintained in the record. Your access to PHI may be denied under certain circumstances and in some cases you may have this decision reviewed. On your request, your therapist will discuss with you the details of the request and denial process.
- Patient Right to Amend. You have the right to request an amendment of your PHI for as long as it is maintained in the record. Your request may be denied. On your request, your therapist will discuss with you the details of the amendment process.
- Patient Right to an Accounting. You generally have the right to receive an accounting of disclosures of PHI. On your request, your therapist will discuss with you the details of the accounting process.
- Patient Right to a Paper Copy. You have the right to obtain a paper copy of this notice upon request, even if you have agreed to receive the notice electronically.
- Your therapist is required by law to maintain the privacy of PHI and to provide you with a notice of his or her legal duties and privacy practices with respect to PHI.
- Your therapist reserves the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, he or she is required to abide by the terms currently in effect.
- If these policies are reviewed, the new version will be posted in our waiting room. You will be provided with a revised notice upon request.

Complaints: If you are concerned that your therapist or this practice has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact Kim Wilson, MSSW/LCSW, President of Wilson Counseling, LLC. You may also send a written complaint to the Secretary of the US Department of Health and Human Services. Ms. Wilson can provide you with the appropriate address upon request.

Effective Date, Restrictions and Changes to Privacy Policy: This notice went into effect July 1, 2014.

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STATEMENT OF PRACTICE POLICIES: This document contains important information about professional services and business policies. You can discuss any questions that you may have when you meet with your therapist. When you sign, it will represent an agreement between you, the client (or the client's guardian/representative), and your therapist.

COUNSELING SERVICES: Psychotherapy is the process of a psychotherapist talking with you about your problems in order to promote your well-being. Methods vary. You may ask about therapy orientation, experience, and procedures used. For psychotherapy to be most successful, it calls for effort on your part, such as working on topics discussed, both during and between sessions. Since it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness or helplessness. However, it has been shown to have many benefits, such as better relationships, solutions to problems, and reduction in feelings of distress. After your first session, your therapist will tell you whether he or she can treat you for your problem, what your work can be expected to include, and goals for your treatment. At that time, you can decide whether you want to work with your therapist to resolve your problems. You have the right to end therapy at any time, without any obligation beyond payment due for completed sessions. Should you decide to withdraw from therapy early, you are asked to attend one more session to discuss your reasons. Therapy termination before completion can be the result of misunderstanding or the painfulness of what you are dealing with at that time. You are encouraged to talk with your therapist before you make a final decision.

SESSIONS: Your therapist will usually schedule one session (one appointment hour of 50-55 minutes duration) as often as therapeutically indicated and as agreed by you. As you progress in therapy, appointments typically become less frequent. If children will be coming with you, please bring another adult to supervise them while you are in session. If you have to cancel an appointment, please give 24 hour notice. You may be billed $25 after the 3rd cancellation with less than one day's notice. Fees are at therapist discretion based on circumstances. Please note that insurance companies do not pay for cancelled sessions.

PROFESSIONAL FEES: The hourly fee for psychotherapy is $130.00 after the first session. The hourly fee for the first session is $165.00. For other professional services, such as report writing, telephone conversations lasting longer than 10 minutes, consulting with other professions, preparation of records or treatment summary, please see our Fee Agreement. Because of the increased professional challenges for legal involvement and classification as an expert witness, fees are higher for such services If you request participation in legal proceedings, including custody cases, you will be expected to pay for all professional time, including preparation and travel.

INSURANCE REIMBURSEMENT: Health insurance policies will usually provide some coverage for mental health treatment. Be sure to check whether your insurance police requires you to request authorization before your first session. Office staff will assist you in obtaining the insurance benefits to which you are entitled. Note that in all cases, you (not your insurance company) are responsible for full payment of fees. You should carefully read the

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section in your insurance coverage on mental health services. If anything is not clear to you even after calling your insurance company, we are willing to contact the insurance company on your behalf. You should be aware that a health insurance company usually requires that your therapist provide a clinical diagnosis and sometimes additional information such as treatment plans and progress notes. Your therapist will attempt to release only the minimum of information that is necessary for the purpose requested. By signing this Agreement, you agree that your therapist may provide requested information to your insurance carrier. Note that you have the right to pay for services yourself to avoid having information sent to your insurance company (unless prohibited by contract).

BILLING AND PAYMENTS: You will be expected to pay your part of the fee at the time of each session, unless otherwise agreed. In circumstances of unusual financial hardship, negotiation of a fee adjustment or a payment installment plan can be discussed. Overdue accounts will be charged a monthly re-billing fee of $5. If you have not paid on your account for more than 60 days, legal means to secure payment of your bill may be pursued. You will be responsible for the legal fees and court costs, including reasonable attorney's fees, for this collection process. In most collection situations, the only information released is the client's name, address, phone number, the nature of the services provided, and the amount due. Wilson Counseling very much appreciates payment at the time of service.

CONTACTING YOUR THERAPIST: Therapists are in session through the majority of the day and are often unable to take your call immediately. Please leave a message with your name and number and a short statement describing reason for the call. Your therapist will attempt to return your call on the same day with the exception of weekends and holidays. Outside of office hours, the Helpline at 270.843.4357 is available. For emergencies, contact or go to your nearest emergency room. If your therapist will be unavailable for an extended time, you will be provided with the name of another therapist whom you may contact in case of need.

THIS AGREEMENT: After you have read this Statement of Practice Polices, please indicate your agreement by signing at the designated place on the Permissions form. (Revised February 2018)

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