# Cool Springs Psychotherapy Associates, PLLC

354 Cool Springs, Boulevard, Suite 105
Franklin, TN 37067
Office Phone – 615-771-1100

## Client Responsibility for Payment Policy

Payment for sessions should take place at the beginning of the therapy session. A receipt will be provided to you, if requested. *It is the responsibility of the client to pay for any sessions that are canceled or missed without 24-hours notice prior to that missed appointment.* Clients assume responsibility for the **full amount** of the session fee for missed appointments. This policy allows Cool Springs Psychotherapy Associates to maintain consistent billing practices with all clients and requires a commitment by the client to have a financial responsibility tied to the therapy relationship. If you have any questions about this policy, please discuss them during your opening session.

_____ _____
Client's Signature Date

_____ _____
Parent/guardian's Signature Date
(for clients under 16 years old)

_____ _____
Therapist's Signature Date

_____ _____
Chief Manager's Signature Date

Revised 3/2015

# Cool Springs Psychotherapy Associates, PLLC

354 Cool Springs Boulevard, Suite 105
Franklin, TN 37067
Office Line-615-771-1100

**HIPAA NOTICE OF PRIVACY PRACTICES**
**AND**
**COUNSELING POLICIES AND PROCESSES**
**ACKNOWLEDGEMENT**

**Please read and initial next to each item and sign the form below.**

**_____I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices. I understand that after I have read the notice I may address any questions to my therapist.**

**_____ I acknowledge that I have received a copy of the Counseling Policies and Processes. By signing below, I acknowledge having read, understood, and agreed to these policies and processes; including the financial agreement and issues of confidentiality.**

**_____ I give consent to contact my identified emergency contact in the event of a psychiatric emergency situation.**

**_____ I give consent to be contacted by my therapist by phone and email and that it is acceptable to leave a voice message for me on the number provided.**

**_____ I give consent to my therapist, _____ of Cool Springs Psychotherapy Associates, to provide clinical treatment in the context of the counseling relationship.**

_____ _____
**Client Signature** **Date**

_____ _____
**Signature of Legal Guardian of Client under the age of 16** **Date**

_____ _____
**Therapist** **Date**

_____ _____
**Chief Manager** **Date**

Revised 3/2015

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**Counseling Policies and Processes:**

**Entering into a therapeutic relationship with a counseling professional requires an establishment of trust. When you begin therapy, you are committing your time, money and emotional energy and it is important to fully understand what that commitment will entail. Included below is a summary of the policies and processes that guide your work with me as your therapist.**

1. **PROFESSIONAL BACKGROUND:** I am a Licensed Master Social Worker with the Tennessee Department of Health: Board of Social Workers, which allows me to practice psychotherapy under LCSW supervision in the State of Tennessee. I have worked in the mental health field since 2010 and my scope of practice has included crisis and brief counseling, individual therapy with adults and adolescents as well as clinical work with persons suffering from a severe and persistent mental illness.

2. **APPOINTMENTS:** You can make an appointment by calling 615-771-1100 between the hours of 8:00am and 5:00pm. Since clients are seen by appointment only, unless an emergency requires an immediate appointment, this appointment time is reserved only for you. If it is necessary for you to cancel an appointment, notice of cancellation must be made at least 24 hours prior to your scheduled appointment time or you will be billed for the set appointment fee. If you are experiencing a mental health emergency and cannot reach me, please go directly to your nearest emergency room for assistance or call the Crisis Help Line at 615-244-7444.

3. **FEES AND PAYMENTS FOR COUNSELING SERVICES:** Fees for counseling services are $70 for a 50 minute session with individuals and couples. Payment is due at the beginning of your session time to allow for the remainder of the therapy session to focus on therapeutic issues.

4. **CONFIDENTIALITY:** Tennessee State law and ethical requirements of the State Board indicate that what we discuss in our private counseling sessions is privileged communication, meaning that you as the client control the release of this information to a third party. There are several limits to confidentiality that involve the required release of information in order to keep you and/or others safe from harm. These limits include: clear and imminent danger to self or others; suspected child or elder abuse; a direct court order by a judge ordering me to release records or appear in court to testify. If it would benefit you in your counseling progress, I may ask you to sign a release of information to allow me to

discuss information with your primary heathcare professional or other key providers in your life (ie: a psychiatrist or a previous counselor).

5. **HIPAA NOTICE OF PRIVACY PRACTICES:** Included with this initial introductory paperwork, you should have received a copy of the HIPAA document. I am required by law to provide this to you and to secure your signature. If you should have any questions about this document, please do not hesitate to ask me for clarification.

6. **BENEFITS AND RISKS OF COUNSELING:** Counseling can be of great benefit to a client who fully commits to being open and honest in the counseling relationship. It requires the client to come to the table with their own personal goals for counseling. I cannot create change in your life; you are the change agent in your own life. I cannot guarantee a specific outcome from our time together. Clients are ultimately responsible for their own growth and direction in counseling. Counseling also has risks that may include the experience of intense and unwanted feelings, including sadness, fear, anger, guilt or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the counseling process. Other risks of counseling may include: facing unpleasant thoughts and beliefs, increased awareness of feelings, values and experiences, and recalling unpleasant life events. I am available to discuss any of your problems or possible side effects of our work together. Also, during our counseling sessions, we may discuss additional resources or activities that added to counseling may help further your change and growth. These may include referrals to a PCP for medication evaluation, directions for a specific activity plan of exercise, referrals to a nutritionist, etc. Wellness comes from whole body health that should include an emphasis on mind, body and spirit. After we have met to discuss your concerns, we will create a plan that is individualized to your own goals and desires for counseling outcomes.

**Please feel free to discuss with me any of the policies and processes outlined above. It is important that you clearly understand your rights and responsibilities when entering into a counseling relationship.**

# Notice of Therapists' Policies and Procedures To Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.**

## *I. Preamble:*

The Licensed Professional Counselors and Licensed Masters Social Worker Licensing law provides extremely strong privileged communication protections for conversations between your therapist and you in the context of your established professional relationship with your therapist. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "designated medical record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the patient himself/herself.

HIPAA provides privacy protections about your personal health information, which is called "protected health information" which could personally identify you. PHI consists of three components: treatment, payment and health care operations.

TREATMENT refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a therapy session, talking to your physician about medications or other medical conditions, or talking with your child's teacher about observable behaviors in the classroom.

PAYMENT refers to the reimbursement I receive for providing your mental health care. If you have insurance coverage, filing with your insurance for payment of therapy sessions is an example of this type of sharing of PHI information.

HEALTH CARE OPERATIONS are activities related to the business and quality performance of my therapy practice. Insurance

companies can request documentation reviews to assure my work with you is "medically necessary."

USE applies only to activities within my office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.

DISCLOSURE applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

## *II. Uses and Disclosures of Protected Health Information Requiring Authorization*

Tennessee requires authorization and consent for treatment, payment and healthcare operations. When beginning therapy with me, you will sign this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care. I may use or disclose PHI for purposes outside of treatment, payment and health care operations only when you sign an additional authorization for release of information. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures that you identify in writing. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversations during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may, in writing, revoke all such authorizations to disclose protected health information at any time provided each revocation is in writing. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and Tennessee law provides the insurer the right to contest the claim under the policy.

## *III. Uses and Disclosures with Neither Consent or Authorization*

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse:* If I have reasonable cause to believe or suspect abuse of a child or children, I am required by law to report this abuse to authorities.

- *Elder or Domestic Abuse*: If I have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I must report this to the local protective services agency.

- *Health Oversight Activities*: If the licensing board of professional counselors in TN were to audit activities in my practice, I would be required to release information for quality review purposes.

- *Judicial or Administrative Proceedings*: If you are involved in a court proceeding and a request is for me to directly appear to report on the therapy I have provided, or the records I maintain documenting these therapy meetings are requested, such information is privileged under state law and I will not release the information without your written consent 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 Health or Safety:* There are two types of threats to safety: threats toward you or threats toward others. If you express a serious threat to yourself, or intent to kill or seriously injure an identified person, and I determine that you are likely to carry out the threat, I must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

- *Worker's Compensation:* If you file a worker's compensation claim, I will be required to file periodic reports with your employer which shall include, where pertinent, history diagnosis, treatment and prognosis.

## ***IV. Clients Rights and Therapist's Duties:***

*Client's Rights:*

- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of protected

health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you should provide permission for me to leave a voice message at your home or provide an alternative way to reach you if you are worried about sharing your PHI with those at your home residence. Additionally, if you do not want your bills sent to your home address, you can provide an alternative billing address.

- *Right to Inspect and Copy*: You have the right to inspect and/or copy your protected health information in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and the denial process.

- *Right to Amend:* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. At your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting:* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this notice). At your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy:* You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

- *Right to Revoke Authorization*: You have the right to revoke your authorization of protected health information except to the extent that action has already been taken based on that authorization.

*Therapist's Duties:*

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will present you with a revised copy when you present for a session.

## *V. Questions and Complaints:*

Dr. Stacie Yoquelet is the appointed "privacy officer" for Cool Springs Psychotherapy Associates per HIPAA regulations. If you have any concerns of any sort that your counselor may have somehow compromised your privacy rights, please do not hesitate to speak with her immediately about this matter. You will always find her willing to talk with you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U. S. Department of Health and Human Services.

## VII: *Effective Date, Restrictions and Changes to Privacy Policy*

This notice will go into effect 2/1/2016.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice when you present at this office.