Melissa Linning, LPC-MHSP

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 the work of this counseling practice and your work with me as your therapist.

1. **PROFESSIONAL BACKGROUND:** Melissa Linning is Licensed Professional Counselor – Mental Health Services Provider (LPC-MHSP), which states Melissa is able to treat and diagnosis mental health concerns and disorders in the State of Tennessee. Melissa received her bachelor's degree at the University of Tennessee and her master's degree at Lipscomb University. Melissa's background includes specializing in a variety of different therapy approaches such as Applied Behavior Analysis, Substance Abuse Counseling, Cognitive Behavioral Therapy, Trauma Focused Cognitive Behavioral Therapy, Adolescent Community Reinforcement Approach, and Eye Movement Desensitization Reprocessing. Melissa has several years of experience treating adults, adolescents, and children. Her area of clinical focus includes trauma, depression, anxiety, grief counseling, and behavior modification.

2. **APPOINTMENTS:** You can make an appointment by calling the front desk of Cool Springs Psychiatric Group, 615-771-1100 between the hours of 8 am- 5 pm. 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, 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 $100 for each session with individuals, couples, and families. A reduced-rate sliding-scale fee is available for a limited number of clients who display financial need. You may be asked to provide proof of household income before a sliding-scale fee is approved for your counseling sessions. Please come to your appointments a few minutes early to make payment.

   Payment for case review letters and court-ordered appearances will be discussed and agreed upon before services are rendered for these special circumstances.

   I can accept cash, check and credit card. There is a 2.75% processing fee for credit cards.

4. **INSURANCE:** I can accept some insurance plans. It is your responsibility to check if I am in network with your plan. If you choose to file with your insurance company, it is understood that you are giving me permission to reveal confidential information that includes dates of service, diagnosis, billing information, paperwork completed at the initial session, your mental status examination, our comprehensive treatment plan, progress notes, clinical summaries and utilization review reports. This provides the insurance company a record of service as well as allows for utilization review and oversight of quality of care.

**Please be aware that insurance companies will use this information to make decisions on future coverage and can determine that you have a pre-existing condition that would not be covered by future insurance coverage. Some people choose to pay out of pocket to keep this information completely confidential from their insurance company.

**I do not accept Employee Assistant Plans (EAP).

5. **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 healthcare professional or other key providers in your life (e.g., your child's school teacher if your child is receiving counseling services with me).

6. **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.

7. **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. 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 primary care physician 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.

Melissa Linning, LPC-MHSP

HIPAA Notice of Privacy Practices

Notice of Therapist's 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 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" (further referred to as PHI) 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 Tennessee 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. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect 8/3/2014.

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.

Counseling Practice Policies and Processes
&
HIPAA Notice of Privacy Practices

ACKNOWLEDGEMENT

I acknowledge that I have received a copy of Melissa Linning's HIPAA Notice of Privacy Practices and Counseling Practice Policies and Processes. I understand that after I have read the notice I may address any questions to my therapist. By signing below, I acknowledge having read, understood, and agreed to these policies and processes, including the financial agreement, issues of confidentiality and consent to treatment.

_____ _____

Client Signature **Date**

_____ _____

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

_____ _____

Therapist **Date**

Melissa Linning, LPC-MHSP

Client Responsibility for Payment Policy

Co-pays and private pay sessions must be paid at the beginning of the counseling session. A receipt will be provided in the event you would like to submit your bill to your insurance company for possible coverage of these services. If Melissa Linning is billing your health insurance, she is prohibited to submit a claim for services in the event that you do not attend your scheduled appointment. A session is considered a "no show" session when the client misses an appointment that was not canceled or rescheduled within 24 hours of the scheduled appointment time. Because "no show" events are considered a non-covered service, it is the responsibility of the client to pay for any of these missed appointments at the agreed upon insurance or at the full private pay rate. These cannot be submitted to your insurance by you for reimbursement. This policy allows Melissa Linning to maintain consistent billing practices with all clients and requires a commitment by the client to have a financial responsibility tied to the counseling relationship. Employee Assistance Program (EAP) is currently not available. 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

Policy Regarding Adolescents in Therapy

When adolescents participate in therapy, it is important that all custodial parents or guardians are in agreement regarding that participation. By signing below, you acknowledge this and assert that you are the person legally responsible for the adolescent for whom you are seeking services. You also declare that any other person(s) who are legally responsible for him or her are aware of this adolescent's participation in therapy and do not object to his/her participation.

When adolescents are involved in therapy, their parents may, in some circumstances, have the legal right to view records kept on their behalf. However, it is typically in the best interest of the adolescent that these records be kept private. The success of any therapy is generally dependent on a trusting and confidential relationship between therapist and client. For this reason, I will keep all records private and will not disclose the content of therapy sessions to parents except in cases where the adolescent is believed to be in significant danger. I will encourage both the adolescent and the parents to participate in family therapy sessions as needed or as appropriate to help facilitate healthy communication about the ongoing issues discussed in therapy, but this has to be at the discretion of the adolescent receiving therapy. It is only when your adolescent feels that he or she can confide in me that can be of the most help to him or her and your family. Please feel free to discuss this policy with me at any time.

_____ _____

Client's Signature Date

_____ _____

Parent/guardian's Signature Date

_____ _____

Therapist's Signature Date

Instructions: Your personal information and signed consent to begin therapy is required and it is important to have this information on file. Please fill out the necessary information and sign prior to beginning any therapy.

Initial Therapy Intake Form

Client Information.

Client's Name:_____

Client's Date of Birth:_____ Client's Age:_____

Client's Social Security Number:_____

Address:_____

Preferred Phone Number:_____ Can I leave a message? **Yes / No**

Email Address:_____

Occupation:_____ Employer:_____

Client's Marital Status:_____ Length of time in relationship:_____

Name of Spouse/Partner:_____

Religious Preference (if any):_____

If Client is a Minor, Name of Responsible Adult (Guardian):_____

Emergency Contact person:_____ Phone:_____

Relationship to Client:_____

Medical/Mental Health History.

Prescription Drug use (describe):_____

Illegal Drug use (describe):_____

Alcohol use/abuse (describe):_____

Medical problems (describe):_____

History of any hospitalizations (medical and/or psychiatric):_____

_____

Name of Primary Care Physician:_____

Primary Care Physician Phone:_____

Name of Psychiatrist (if applicable):_____

Psychiatrist Phone:_____

Any previous Therapy/Counseling? **Yes / No**

If yes, what type of Therapy and how long did you attend?_____

_____

Was therapy beneficial to you? Why did you feel it helped/didn't help?_____

_____

_____

What do you wish to achieve through therapy at this time?_____

_____

_____

_____

Suicide Information.	**Check all that apply.**
None: no suicidal thoughts	□ I have never had thoughts of suicide.
Mild: some thoughts, no plan	□ I am experiencing these thoughts now. □ I have experienced these thoughts in the past. □ I last experienced this on: Date:_____
Moderate: some thoughts, vague plan, low levels of lethality	□ I am experiencing these thoughts now. □ I have experienced these thoughts in the past. □ I last experienced this on: Date:_____
Severe: significant thoughts, plan is specific and lethal	□ I am experiencing these thoughts now. □ I have experienced these thoughts in the past. □ I last experienced this on: Date:_____

Have you ever actually attempted suicide at any time in your life? **Yes / No**
If yes, please describe when and the circumstances leading up to the attempt as well as follow-up actions after the attempt:_____

Upon my signature below, I hereby attest that all the information furnished is true and correct. Also, by signing I give permission that in the event of a psychiatric emergency Melissa Linning may call my emergency contact person noted above.

_____ _____
Client Signature **Date**

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