

Inclusive Counseling

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Informed Consent and Privacy Practices for Psychotherapy 2024

GENERAL INFORMATION

The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding of how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

Upon your authorization and consent, I will be offering you mental health therapy. I am a licensed therapist, contracted to offer services at Inclusive Counseling.

All treatment carries the risk of unsuccessful results, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of:

- The nature of the treatment, including other care and/or treatment available to you.
- Potential benefits, risks, or side effects of the treatment.
- The likelihood of achieving treatment goals
- Reasonable alternatives and the relevant risks, benefits, and side effects, if any, related to such alternatives, including the possible results of not receiving care or treatment.

Except in cases of emergency, a new treatment approach (e.g., new therapy form) will not be performed until you have had the opportunity to receive this information and have given your consent. You have the right to give or refuse consent to any proposed treatment at any time prior to its performance.

At our first appointment and throughout your treatment, we can discuss the expectations, risks, and benefits of mental health therapy. As listed below:

Risk, Benefits, and Alternatives:

- The benefits of therapy are decreased suffering from mental health symptoms which include (but are not limited to): decreased irritability, decreased symptoms of anxiety and/or depression, decreased interpersonal conflict, and decreased impulsivity. You are also likely to experience an increase in self-control, an increase to your quality of life, and an increased ability to achieve your goals.
- Risks of mental health therapy include (but are not limited to) increased anxiety and depression when working through difficult memories and behaviors, exhaustion after therapy sessions, and difficulty staying motivated for therapy.
- Alternative methods of treatment include (but are not limited to): seeing a different mental health therapist, consulting with a medical doctor or nurse practitioner for medications, and consulting with your primary care provider for other referral options. If your mental health symptoms include suicidal/homicidal thoughts/urges, your referral options also include higher levels of care such as partial hospitalization, intensive outpatient treatment, or hospitalization. If your symptoms include substance abuse, your referral options also include detox, medication management, or intensive outpatient treatment.

CONFIDENTIALITY

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client-held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts themselves in a way that there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years or a person of any age with a developmental disability or an elderly person or an animal/pet.
4. Suspected neglect of the potential parties named in items #3.
5. If a court of law issues a legitimate subpoena for information stated on the subpoena.
6. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
7. In legal proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if they determine that the issues demand it
8. If a client chooses to engage in telehealth, they must be in a secure location with no other people present. If anyone should enter the space, the client is to alert the therapist immediately. The therapist will do the same.

Occasionally I may need to consult with other professionals in their areas of expertise to provide the best treatment for you. Information about you may be shared in this context without using your name or any identifying factors.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to exchange a pleasantry with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

You should also be aware that most insurance companies require you to allow us to provide them with a clinical diagnosis. Sometimes we must provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. We will try to keep information shared with your insurance company limited to the minimum necessary. If you choose to use your insurance, you are agreeing to allow them access to your files.

Should your therapist leave Inclusive Counseling, your records will be kept with Inclusive Counseling unless you sign a release of information to have them sent elsewhere. Should you need your records in the future you can request them, in writing, from Inclusive Counseling.

CONFIDENTIALITY WITH MINORS

If the client is a minor, the legal guardian(s) are legally entitled to some information about their therapy. I will discuss with the minor and guardian(s) about what information is appropriate for them to receive and which issues are more appropriately kept confidential. Trust is paramount in building a therapeutic relationship, it is requested that guardian(s) do not insist on receiving information if the therapist has a reasonable explanation of why it would be detrimental to release said information.

Please refer to the HIPAA Privacy Notice for more information related to your private health information.

CUSTODY AND WORK WITH MINORS

Your therapist is required to ask for, and obtain, a copy of any custody documentation from the courts if your child is not residing in the home with their legal mother and father. This includes:

- Adoption
- Foster Care
- Divorce
- Custody agreements if parents were never married

If such a document does not exist because the parents never went to court, the therapist will document your statement about the circumstances for their records.

Any adults with legal rights to the child (ie: both parents, regardless of the quality of the relationship) will be notified that the minor has entered treatment and will be invited to participate in treatment. The therapist will not mediate payment between two adults with legal

responsibility for the minor client; payment is due at time of service or services will not continue.

COURT SUBPONEAS

1. At Inclusive Counseling, there is a \$500 retainer for court appearances; the fee is \$160/hour door to door, paid with \$500 retainer due 10 business days prior to the hearing. If the total cost ends up being less than \$500, you will receive the difference in a refund. If it is more than \$500, you will owe the difference.

2. If you do not want to pay the fee, I can write a letter instead. The letter will fully cover everything I will say in court, including treatment dates, diagnoses, goals, and the child's participation and progress in treatment. The fee for a letter is \$40 for every 15 minutes required to write the letter.

3. Please note: I will remain impartial, regardless of who subpoenaed me. I will also not speak to parenting abilities, who should or should not have custody, or where the child should live. I will only speak to the child's mental health diagnosis and treatment (per Ohio Administrative Code 4757-6-01).

SOCIAL MEDIA

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, TikTok, Discord, Twitter, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy and furthermore, it is against the laws and rules of the Ohio Social Worker, Counselor, Marriage, and Family Therapist Board. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

RECORDS KEEPING

Per Ohio Revised Code 4757-5-09, Inclusive Counseling is required to keep treatment records for a minimum of seven years. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence or with another mental health professional so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

All contact will be documented. This includes records of text message, phone calls, emails, and sessions (in person, telephone, or teletherapy).

The fee for records request are: \$1.00 per page for the first 10 pages; \$0.75 per page for pages 11-50; and \$0.25 per page for pages 51 and higher.

NON-DISCRIMINATION

We will not discriminate against you based on any factors. This includes but is not limited to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, veteran status, immigration status, or mental or physical challenge. We will seek continuing education on the topics of implicit bias, and we will continue to work to remain non-biased. Please feel free to discuss any experienced discrimination, including microaggressions, with your therapist.

ANTIRACIST STATEMENT

Inclusive Counseling agrees to continuously assess our competencies in antiracism, intersectionality, and justice. We will make every reasonable effort to increase our competencies including but not limited to: engaging in consulting discussion, non-defensively receiving feedback from others about racist and biased behavior, completing self-reflective exercises about race and intersectional beliefs, increasing race-specific knowledge through education activities and seeking learning opportunities to foster growth in specific antiracist and antibias competencies, and making repairs to clients when racist and biased behavior is identified. We also commit to clearly naming invalidation, racism, bias, and prejudice within any team meetings or therapy groups. When unsure, we commit to being open to feedback and dialogue.

COMMUNICATING THROUGH EMAIL OR TEXTING

If you elect to communicate with your therapist by e-mail or text messaging at some point in our work together, please be aware that e-mail and texting is not completely confidential. There are risks associated with e-mail and text messaging as outlined below:

- All e-mails and text messages are retained in the logs of the e-mail/phone/internet service provider.
- Although under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers.
- Copies of e-mails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- E-mail and text senders can easily misaddress an e-mail or text and send the information to an undesired recipient.
- E-mails and texts can be intercepted, altered, forwarded, or used without authorization or detection.

Conditions for the use of email and texts:

- As your therapist, I cannot guarantee but will use reasonable means to maintain the security and confidentiality of e-mail and text information sent and received, including a passcode lock on my phone.

- E-mail and texting are not appropriate for urgent or emergency situations. I cannot guarantee that any e-mail and/or text will be read and responded to within any particular time-frame.
- E-mail and texts should be concise. Unless we have agreed to a specific exception, sensitive or complex situations should be discussed in a phone call or during a scheduled appointment, not in an e-mail or text.
- If texts or e-mails contain information relevant to your treatment, they may be retained in your medical record, or a summary of the content may be included in a clinical note in your record.
- If you choose to use e-mail or text messaging, you agree that I may reply to your email and text messages, and that I may include any information that I deem appropriate, including information that would otherwise be considered confidential.
- You agree that if you do not receive a timely response from an e-mail or text message to me, that you will follow up with a phone call to me.
- If you choose to use e-mail or text messaging, you agree not to hold me liable for improper disclosure of confidential information that is caused by you or any third party
- Communication outside of therapy does carry a fee and is not billable through your insurance

CONSENT FOR TELEHEALTH

1. I understand that my therapist may need me to engage in a telehealth consultation and treatment.
2. My therapist explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit since I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing, so long as it is private.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that the therapist or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I had a direct conversation with my therapist, during which I had the opportunity to ask questions regarding this format. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
6. I agree that I will not log onto a telehealth call while driving. If any clients logs into a telehealth call while driving, the therapist will tell you how long they will wait for you to pull over, park, and rejoin the call; they will then end the call promptly.
7. I understand that I need to discuss any potential desires to record sessions and work with the therapist on coming to an agreement as to whether or not this action is mutually agreeable.

CONSENT TO USE THE TELEHEALTH BY SIMPLE PRACTICE SERVICE

Telehealth by Simple Practice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by Simple Practice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911 or arrange transportation to the nearest emergency room.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Simple Practice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by Simple Practice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice, or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by Simple Practice Service – or that such information is current, accurate or up to date. I will not rely on my health care provider to have any of this information in the Telehealth by Simple Practice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. I will not allow anyone else in the room while I am having session.

Telehealth Communication Plans and Policies

If there is a technical failure, both parties should re-launch the program and attempt to reconnect. If this is not successful, the therapist will call you at the phone number provided at intake.

You will be emailed your telehealth session link 24 hours prior to your appointment. Please reach out if you did not receive it and we can resend it. Please plan on signing on for your session 5-10 minutes prior to be sure that your webcam, microphone, and internet connection are all working as expected.

Please note that for us to provide Tele-Mental Health services the clinician that you see must be licensed in the state in which you live. All session times are in EST.

Ensuring Safety and Appropriateness of Telehealth Practice

Please see our website under the resources tab for crisis hotlines and international mental health agencies. Feel free to let your therapist know if you need more unique or targeted referral options due to your circumstances (ie: cultural, regional, religious, etc.)

Risks of telehealth

- There can be difficulty for both parties to pick up on visual, non-verbal, or gestural cues
- Differences in connection speed can lead to disconnection or interruption
- We will make every effort to eliminate disruptions and interruptions on our end, however we cannot predict whether you will feel completely secure in the privacy of the session
- Feeling anxiety if symptoms increase during session
- Loss of confidentiality if using a public computer, a computer on a shared network, or if others are present in your setting.

Benefits of telehealth

- Tele-Mental Health services offer flexibility to meet you where you are with a variety of barriers such as transportation, illness, and/or mental health symptoms
- Reduction of stigma
- Reduced time away from work
- Ability to keep appointments if quarantining due to COVID exposure

TERMINATING TREATMENT/ATTENDANCE AND CANCELLATIONS:

You have the right to discontinue treatment at any time and for any reason. Similarly, your provider also has the right to discontinue your treatment but will provide you with at least 30 days advance written notice of such discontinuation and may assist you in finding a new treatment provider. At any time, you are welcome to discuss termination or transfer of care. Please know that I am open to having those discussions and would help you find a provider to fit your needs.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

Attendance in therapy is of the utmost importance. If you have not arrived to your session (in person or virtual, within 15 minutes of the session start time, it will be canceled and labeled a no-show. This means you could be charged the no-show fee. If you are a Medicaid client, there is no fee for no-showing; rather you will be marked down as no-showing and if you no-show or late cancel twice in 6 months, therapy can be terminated due to poor attendance. The rule relating to a client having two absences in 6 months applies to all clients; regardless of their payor source. Poor attendance is a reason that your therapist may terminate treatment. If you frequently cancel, even with 24 hours' notice, your therapist may still address this behavior and/or set a new "rule" as poor attendance impedes your progress and disrupts the therapists ability to keep a consistent schedule.

COMPLAINTS OR CONCERNS:

If you have any concerns or complaints about your treatment, you may direct them to your states Social Work licensing board. In professional relationships like patient/client-therapist, sexual intimacy is never appropriate and should be reported to your state's social work licensing board. You can also verify my license to practice therapy and its status at:

Ohio Social Work Board

Ohio Counselor, Social Worker, and Marriage and Family Therapist Board,

77 South High Street, 24th Floor, Room 2468, Columbus, OH 43215-6171

Phone (614) 466-0912. Website: www.cswmft.ohio.gov

Kentucky Social Work Board (if applicable)

Kentucky Social Work Board 125 Holmes St #310, Frankfort, KY 40601 Phone (502) 564-2350 Website: <https://bsw.ky.gov/Pages/index.aspx>

- If you are experiencing a mental health emergency after hours, please call 911 or go to your nearest emergency room to be evaluated. You can also access a list of 24/7/365 resources on my website: <https://www.inclusivecounseling.net/resources>
- If you need to use any of the above listed emergency resources, please send me a message as well and I will get back to you as soon as possible.

HIPAA NOTICE:

NOTICE OF PRIVACY PRACTICES

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

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.

- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a

coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
- 10 Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

By signing this form, I certify:

- **That I have read or had this form read and/or had this form explained to me.**
- **That I fully understand its contents including the risks and benefits of the procedure(s).**

- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.