Health Insurance Portability and Accountability Act of 1996 (HIPPA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This document may be updated without notice, so please review it each time you visit us. A copy of this statement is always available upon request.

All information revealed by you in a counseling or therapy session and most information placed in your counseling/therapy file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered "protected health information" by HIPAA. As such, your protected health information cannot be distributed to anyone else without your expressed informed and voluntary written consent or authorization. The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in your therapist's/counselor's Professional Disclosure Statement and Consent for Treatment.

Use or disclosure of the following protected health information <u>does not require</u> your consent or authorization:

1. Uses and disclosures required by law, such as files court-ordered by a Judge.
2. Uses and disclosures about victims of abuse, neglect, or domestic violence, such as the Duties to Warn, explained in your therapist's/counselor's Disclosure Statement
3. Uses and disclosures for health and oversight activities, such as correcting records or correcting records already disclosed.
4. Uses and disclosures for judicial and administrative proceedings, such as a case in which you are claiming malpractice or breach of ethics.
5. Uses and disclosures for law enforcement purposes, such as if you intend to harm someone else (see Duties to Warn in your therapist's/counselor's Disclosure Statement)
6. Uses and disclosures for research purposes, such as using client information in research, always maintaining client confidentiality.
7. Uses and disclosures to avert a serious threat to health or safety, such as calling Probate Court for a commitment hearing.
8. Uses and disclosures for Workers' Compensation, such as the basic information obtained in therapy/counseling as a result of your Worker's Compensation claim.

Patient Initials Click or tap here to enter text.

Your Rights as a Counseling/Therapy Client under HIPPA

- As a client, you have the right to see your counseling/therapy file. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.

- As a client, you have the right to receive a copy of your counseling/therapy file. This file copy will consist of only documents generated at Acceptance in Abundance and client Collateral documentation received. You will be charged copying fees at $.25/page. Psychotherapy notes are afforded special privacy protection under the HIPPA regulations and are excluded from this right.

- As a client, you have the right to request amendments to your counseling/therapy file.

- As a client, you have the right to receive a history of all disclosures of protected health information. You will be charged copying fees at $.25/page.

- As a client, you have the right to restrict the use and disclosure of your protected health information for the purposes of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish to disclose.

- As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated. Prior to your counseling or therapy, you will receive:

An exact duplicate of these two pages and Professional Disclosure Statement and Consent for treatment, both for your personal records. It will be necessary for you to sign a certificate indicating that you have received, read, and understand both documents. This certificate will be placed in your counseling/therapy file. Please do not sign the certificate if you do not understand any part of the HIPAA Client's Rights or the Professional Disclosure Statement and Consent for Treatment. I will be happy to explain these documents further.

Patient Initials Click or tap here to enter text.

Personal Disclosure Statement and Consent for Treatment

Welcome and thank you for letting me be part of your journey. This document is designed to inform you about my background and to ensure that you understand our professional client-counselor relationship.

Contact Information: I currently only work remotely. My hours are 8:30AM – 5:00PM Monday – Friday. My telephone number is (864)396- 8188 (the voicemail is confidential). I can also be contacted via email: acceptanceinabundance@gmail.com

Email and Text Messages: Email and text messages may be utilized for scheduling or non-therapeutic communication purposes. They **are not to be used for counseling or emergency/crisis purposes.**

In case of an Emergency: I do not work on-call and generally not available 24 hours a day. Voicemails and text messages are checked and returned regularly but are not to be used for emergencies or crisis. In case of an emergency please call 911 or go to the emergency room.

Education, Experience, & Counseling philosophy: I am a Licensed Professional Counselor Associate (LPC-A) Nationally Certified Counselor (NCC). I have taken and passed both the National Clinical Mental Health Counselor Exam (NCMHCE) and the National Counselor Examination (NCE). I received my Bachelor of Science in psychology from Charleston Southern University and my Master of Science in clinical mental health counseling to include a Graduate Certificate in Contemporary Theory in Mental Health Services from Capella university. The graduate program I completed is accredited by the Council of Accreditation of Counseling and Related Education Programs (CACREP). I have worked in the mental health profession for a little under five years in various settings including inpatient, outpatient, residential, and community settings. I also proudly served my country in the USAF granting me an in-depth understanding of the active military/veteran population. My core values include *Nonjudgment, Autonomy, authenticity, Patience, kindness, Accountability, & integrity*

I enjoy working with all individuals from diverse backgrounds, meeting clients where they are and assisting them in reaching their goals. I have experience in the area of mood disorders, PTSD, anxiety, grief, eating disorders, neurodevelopmental disorders, schizophrenia, substance abuse, personality disorders, anger management among many other mental health and emotional concerns.

I foster a client-centered CBT & DBT approach while incorporating various interventions. Some of my trainings/certifications include; certified in CBT for depression & suicide, DBT,

Collaborative Assessment and Management of Suicidality (CAMS-Care), Applied Suicide Intervention Skills Training (ASIST), Individual Placement Support (IPS), & Anger Management. I believe creating a safe and nonjudgmental space and building a genuine rapport is essential to aiding individuals in reaching personal goals to improve the quality of life. I also strongly base my services on the ACA Code of Ethics and abide by all state, federal, & ethical regulations. Furthermore, I am a strong believer in self-care therefore outside of work I enjoy spending time with family, writing, reading, traveling, cooking & watching TV.

Services and Informed Consent: As a counselor it is my responsibility to ensure the benefit of all clients and act to avoid harm. I offer **Comprehensive evaluation, diagnosis, and assessment, couple, and marital development, individual, family, & group counseling, and collaborative/consultation and coordination with primary physicians, schools, human services agencies, employers, attorneys, and courts**. With the services provided clients need to be aware:

- Treatment is not always guaranteed successful and can elicit unexpected, emotionally sensitive areas.
- I am not a physician and cannot prescribe medication.
- I may need to consult with your physician, attorney, or other counselor.
- I am not available 24 hours a day.

Diagnosis: Most health insurance companies require a diagnosis be rendered illustrating your mental condition before they agree to pay for services. In the event a diagnosis is required I will render a diagnosis in accordance with the ACA Code of Ethics to ensure no harm. I will discuss your diagnosis with you in detail. If you have any questions, please do not hesitate to ask.

Appointments and Fees: My sessions are generally 60 minutes in duration. Although intake assessment may take up to 90 minutes. Group sessions are usually 90 minutes. It is requested that cancellations be given with 24-hour notice. Screenings are free, Individual, couple & marital, and family sessions are $125.00 per session, Intake/Diagnostic sessions are $160.00 as they require more time. Anger Management fee is $50 per group session, $65.00 for one individual (Optional upon request), Exit Interview $65.00. Present Parenting is $50.00 per group session, $65.00 for one individual (Optional upon request), Exit Interview $65.00. **It is customary to pay for professional services at the time they are rendered – before each session. It is the professional and ethical responsibility of this office to prevent your bill from accumulating. If a client is unable to adhere to or agrees to the payment contract, services will not be rendered, and referral sources will be made available.** Furthermore, additional services include:

- Reports/letters (Extensive) $55.00
- Reports/letters (Brief) $30.00
- Court Appearance – per hour $150.00 * **with/without testimony**
- Observations/Consultations – per hour $100.00

***Any service that requires a me to attend a function (i.e., IEP meeting, court testimony deposition, treatment planning meeting) will be billed in hourly increments and will include drive time, wait time, etc. in addition to the actual participation in the task.**

No-show or Late Cancelation: The counselling relationship requires a partnership among client and counselor therefore, it is imperative that clients are willing to put forth effort to work towards desired outcomes. Therefore, if you have a scheduled time, it is valuable time set for your growth. However, it is understood that sometimes you might forget your appointment (a No Show) or need to cancel your appointment (a late cancel). Cancellations or "no shows" without 24-hours' notice will be charged full price for missed session. In extreme circumstances such as death, accident, illness, or hospitalization, fees may be waived. If continued No shows or cancellations without 24 hours' notice occur, I will work with client to determine the cause and/or provide alternative resources for services.

Confidentiality: The information shared in therapy sessions is usually considered confidential by the state of South Carolina and federal regulations. Furthermore, your records can be subpoenaed by South Carolina with a court order, signed only by a judge. This information is considered privileged in the federal court system. As counselors, we are mandated by law through "duties to warn" to breach confidentiality if any of the following are discovered:

- You are threatening self-harm or suicide.
- You are threatening to harm another or commit homicide.
- A child has been or is being abused or neglected.
- A vulnerable adult has been or is being abused or neglected.
- You disclose that you have a disease commonly known to be both communicable and life threatening, I may be justified in disclosing information to identifiable third parties, if at high risk of contracting the disease.
- If you request your protected information, be released to someone, in which case you must sign a Release of information.

Referrals, Complaints & Termination: If for any reason you feel that I am not meeting your therapeutic needs, I encourage your feedback and will attempt to adjust my approach to better fit your need. If I am unable to resolve your concerns. I am happy to provide you with referrals to where your needs can be better met. If it is determined that there is an inability to be of professional assistance, I will not begin or continue services.

I am licensed through SC Board of examiners for the Licensure of Professional Counselors and Marriage and Family Therapists. The Licensure of Professional Counselors Board can be contacted in Columbia, South Carolina at 803-896-4652 (mailing address is P.O. Box 11329, Columbia, South Carolina 29211-1329).

Before your counseling or therapy session, you will receive the following:

☐Professional Disclosure Statement/Consent for Treatment and Confidentiality policy

☐HIPAA Notice and Rights information

☐Authorization and consent to participate in Telehealth Therapy/Consultation

☐Authorization to Release Form

☐Emergency Contact Form

It will be necessary for you to sign an acknowledgment form indicating that you have received, read, and understand both documents. These documents will be placed in your counseling/therapy file. Please do not sign the certificate if you do not understand any part of the Professional Disclosure Statement/Consent for Treatment and Confidentiality policy or HIPAA Notice and Patient Rights and information.

Acknowledgement of Informed Consent

Name Click or tap here to enter text. **Date** Click or tap here to enter text.

Date of Birth Click or tap here to enter text. **Social Security #**Click or tap here to enter text.

Address Click or tap here to enter text.

I acknowledge that I have received, read and been given the opportunity to ask questions about the **Professional Disclosure Statement, Consent for Treatment & Confidentiality Policy, the HIPAA Notice, and Patient's Rights Information.** I further acknowledge that I seek and consent to treatment for minor child or myself. My signature below confirms that I understand and accept all the information contained in these documents.

Click or tap here to enter text. Click or tap here to enter text.

Signature of Patient Date

Click or tap here to enter text. Click or tap here to enter text.

Deshandra Johnson NCC, LPCA Date

Other Participants in Counseling Services

☐ Family Member: _____ Initials: _____

Restrictions: _____

☐ Family Member: _____ Initials: _____

Restrictions: _____

☐ Teacher: _____ Initials: _____

Restrictions: _____

☐ Other School Staff: _____ Initials: _____

Restrictions: _____

☐ Other: _____ Initials: _____

Restrictions: _____

Acknowledgement of Informed Consent

To Treat a Minor

Name of minor patient:

Click or tap here to enter text.

Date of birth: Click or tap here to enter text.

This is to certify that you give permission to Acceptance in Abundance LLC for the treatment of your child, _____.
Treatment may include individual or group psychotherapy, and counseling. This treatment may also include referrals to other appropriate State, County, or other professional agencies.

One of my stipulations in treating your child is that you as a parent/guardian also be involved in the therapeutic process. By signing this consent form, you are also agreeing to attend occasional sessions at which we request your presence.

In addition, you as a parent/guardian agree to the following stipulations:

- Although your child is a minor, he/she has the right to confidentiality. This confidentiality is crucial for a child to feel safe and secure in the counseling environment and a necessary ingredient for treatment success. You agree to honor this right to confidentiality. Children age 14 and older have the right to full patient privilege. Parents of children younger than 14 have the right to information regarding the minor's treatment so long as it is in the best interest of the child.
- In cases of divorce or parental conflict, you agree to not request that I participate in any court proceedings, to include but not limited to, testifying, providing records, or writing letters of summary or recommendation.

**I have a legal right to ☐ sole / ☐ shared medical decision making regarding the following children:

I understand that I may revoke this authorization by submitting my request in writing to Acceptance in Abundance LLC.

Signature of Parent or Legal Guardian Name (please print) Date

Patient Initials Click or tap here to enter text.

_____ _____

Deshandra Johnson NCC, LPCA Date