Life Without Anxiety LLC

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Office Policies & Informed Consent for Counseling

This form provides you with information that is in addition to that detailed in the Notice of Privacy Practices.

1. **Counseling** is a collaborative process between you and a counselor to work on areas of dissatisfaction in your life and assist you with life goals. For counseling to be most effective, it is important that you take an active role in the process. Counseling activities are governed by the Missouri Division of Professional Registration. I do not take on clients I do not think I can help. Therefore, I will enter our relationship with optimism about our progress. I do not provide custody evaluation recommendation, nor medication or prescription recommendation, nor legal advice, as these activities do not fall within my scope of practice.

2. **Time Parameters**: Individual appointments are scheduled for **50-minute** segments. *Being late for an appointment by 20 minutes or more may require that you reschedule*.

3. **Confidentiality**: As a Licensed Professional Counselor in the State of Missouri, I am bound by the Missouri Administrative Code. In accordance with these rules, information obtained in the counseling session or in written form will **not** be disclosed to any outside person(s) or agency without your written permission except when such disclosure is necessary to "protect *you or someone else* from imminent harm" or is otherwise legally required and/or allowed by law, such as abuse or neglect of a child under 18, elder, or disabled person. This notification may include notifying the victim, notifying the police, or seeking appropriate hospitalization. I may also be required to provide information to the court if provided a court order. If a client files a worker's compensation claim or disability claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought. If any of the above situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize release to other parties. If I run into you outside of the counseling office, I will protect your confidentiality and wait for you to acknowledge me should you choose to do so.

4. **Risks**: In counseling, major life decisions are sometimes made, including decisions involving separation within families, development of other types of relationships, changing employment settings and changing lifestyles. The decisions are a legitimate outcome of the counseling experience as a result of an individual's calling into question many of their beliefs and values. Furthermore, symptoms may be intensified and the emotional experience may be too intense to deal with at this time. I will be available to discuss any of your assumptions or possible negative side effects in our work together. There is no guarantee of what you will experience in counseling.

5. **Cancellation**: If you find it necessary to cancel an appointment, please contact myself at 314-467-0540 or brawleyanxietyhelp@gmail.com at least 24 business hours in advance. ***Cancellations with less than 24 hours advance notice will be charged a $50 no-show fee***. The provider may also terminate counseling in the event the client has missed 3 appointments without calling to cancel 24 hours prior to the scheduled appointment. ***PLEASE INITIAL HERE THAT YOU UNDERSTAND THIS POLICY _____***.

6. **Emergencies**: If an emergency situation for which you feel immediate attention is necessary, please contact emergency services (911) immediately, the 24-hour National Hopeline Network , 800-784-2433, or go to your nearest hospital emergency room. If I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can, within the limits of the law, to prevent you from injuring yourself others and to ensure that you receive the proper medical care. Missouri law provides that a professional may disclose confidential information only to medical or

law enforcement personnel if the professional determines that there is a probability of injury to self or others. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if requested. Please do not use e-mail and faxes for emergencies.

7. **Fees and Payment** will be collected at the time of service; cash, check, or credit/debit card are acceptable forms of payment. Sessions will not continue to be scheduled without payments being made.

8. **Consultation**: Information about you may be discussed in confidence, without revealing your identity, with other counseling professionals for the purpose of consultation and providing you the best possible service

9. **Electronic Transmission**: I cannot ensure the confidentiality of any form of communication through electronic media. You are advised that any email sent to me via a computer in a work-place environment is legally accessible by an employer. I check and respond to email during business hours of Monday through Friday 9am-5pm.

10. **Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to the many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc…), *neither you (client's) nor your attorney's, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.* If you do become involved in litigation requiring your therapist's participation, you will be expected to pay for the professional time even if your therapist is compelled to testify by another party.

11. **Termination:** If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and if I have your written consent, will provide him or her with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other professionals whose services you might prefer.

I have read, understood, agree, and consent to the above conditions of service stated. I have also received the notice of privacy practices on this date and have had the opportunity to ask questions about and understand these policies.

_____

Client Signature Date

(**For Minors Only) I hereby grant permission to _____to counsel/assess my child, _____

_____

Parent Signature Parent Printed Name Date

NOTICE OF PRIVACY PRACTICES – LIFE WITHOUT ANXIETY LLC

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.

I am required by applicable federal and state law to maintain the privacy of your health information and inform you of my privacy practices, legal obligations, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

I am required to abide by the terms of the Notice of Privacy Practices that is most current. I reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that I maintain. The revised Notice will be posted in the waiting room. You may request a copy of the revised Notice at any time.

I will answer your questions about my privacy practices and do ensure that I will comply with applicable laws and regulations. I will also take your complaints and can give you information about how to file a complaint.

I. USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT MAY BE MADE TO CARRY OUT HEALTHCARE OPERATIONS.

I may use and disclose limited information from your record without your written authorization, excluding Counseling Notes as described in Section IV, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

Treatment: I may use and disclose limited information in order to provide treatment to you. For example, I may use information to diagnose and provide counseling service to you. In addition, I may disclose information to other health care providers involved in your treatment.

Payment: I may use or disclose limited information from your record to obtain payment for the services you receive. For example, I may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

Health Care Operations: I may use and disclose information from your record to allow health care operations including quality improvement activities, training programs, reviewing records to see how care can be improved, accreditation, certification, licensing or credentialing activities. For example, I may use information in your record to train another counselor.

II. YOUR INDIVIDUAL RIGHTS

Right to Inspect and Copy. You may request access to the information in your record maintained by me in order to inspect and make a copy of it. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested.

Right to Request Restrictions. You may ask to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment or payment. You must request any such restriction in writing. I am not required to agree to any such restriction you may request.

Right to Accounting of Disclosures. You have the right to request an accounting of any disclosures made by me after August 31, 2015.

Right to Request Amendment: If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

Right to Obtain Notice. You have a right to obtain a paper copy of this Notice upon request.

Right to Complain. You have the right to complain to us about our privacy. You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, I may not make any use or disclosure of information from your record unless you give me your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

III. USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION THAT I AM REQUIRED TO MAKE WITHOUT YOUR PERMISSION.

Communications between a counselor and client are privileged and may not be disclosed without your permission, except as required by law. For example, counselors must report suspected abuse/neglect of a child, elder, or disabled person. I may have to breach confidentiality if you appear to post an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others. Also, I must disclose information to the Department of Health and Human Services, if requested, to prove that I am complying with regulations that safeguard your health information.

I may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, I may disclose information in response to a subpoena or other legal process, even without a court order.

You have a right to receive confidential communications from me. For example, if you want to receive bills and other information at an alternative address, please notify me. I may contact you to provide information or appointment reminders as a courtesy. Please notify me if I am not to leave a telephone message or use electronic communication. You are responsible for remembering your appointment, whether or not you receive a reminder.

I may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

IV. USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Counseling Notes: Notes recorded by your counselor documenting the contents of a counseling session with you ("Counseling Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

Marketing Communications: I will not use your health information for marketing communications without your written authorization.

Other Uses and Disclosures: Uses and disclosures other than those described in Section I & III above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send information to a school, or to your attorney. You may revoke any such authorization at any time.

Consent for the Use or Disclosure of Health Information for Treatment, Payment, or Health Care Operations

In our Notice of Privacy Practices, we provide you information about how Beth Brawley MA, LPC, with Life Without Anxiety LLC can use or disclose your mental health and medical information. As described in our Notice of Privacy Practices, we request your consent for any use or disclosure of mental health and medical information necessary to carry out treatment, payment or health care operations. You have a right to review our Notice of Privacy Practices before signing this Consent form.

By signing this Consent form, you: 1) Acknowledge that a copy of the Notice of Privacy Practices has been provided to you; and 2) Consent to our use and disclosure of your health information for treatment, payment or health care operations, as described in the Notice of Privacy Practices.

You have the right to revoke this Consent in writing at any time, except where we have already used or disclosed your health information in reliance upon this Consent.

_____

Signature of Client or Legal Representative Date

_____

Client's Name (Printed)

NEW CLIENT INFORMATION FORM

CLIENT'S NAME:_____

ADDRESS:_____

CITY:_____ ZIP:_____

HOME PHONE:_____WORK OR CELL PHONE:_____

DATE OF BIRTH:_____

MARITAL STATUS:_____

RESPONSIBLE PARTY (IF OTHER THAN CLIENT)

FULL NAME:_____ RELATIONSHIP TO CLIENT:_____

ADDRESS:_____CITY:_____State:_____ZIP:_____

HOME PHONE:_____WORK OR CELL PHONE:_____

DATE OF BIRTH:_____

GENERAL INSURANCE INFORMATION

Insurance Co. Name:_____Phone Number:_____

Insurance ID Number:_____Insurance Group Number: _____

Policy Holder's Name:_____Policy Holder's Date of Birth:_____

Policy Holder's Address:_____CITY:_____State:_____ZIP:_____

Policy Holder's Home Phone:_____

Policy Holder's Employer:_____

Policy Holder's Relationship to the patient (Please check one) ____ Self ____ Spouse ____ Other_____

SIGNATURE::_____DATE:_____

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Email: brawleyanxietyhelp@gmail.com Website: www.lifewithoutanxietystl.com

Credit Card Payment Authorization Form

Please complete the information below:

I _____ authorize Beth Brawley MA, LPC to charge my credit card for any balances on my account. In the event that I do not cancel an appointment within 24 hours, I authorize that my credit card be charged a $50 cancellation fee.

Counseling/Assessment Services.

_____ Please keep my debit/credit card information on file to charge each visit.
initial

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: Visa MasterCard AMEX Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CCV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

Zipcode of billing address _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the amount indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form. *Please note, this form is kept under triple lock and will be securely destroyed upon completion of services.*