PRACTICE POLICIES 2024 / NOTICE OF PRIVACY PRACTICES / INFORMED CONSENT FOR PSYCHOTHERAPY

All billing, insurance, and related documents will refer to the provider as: Dr. Jeffrey J. Rodman, LPC, LSATP - Here-4-You Counseling. 109 East 6th Street, Front Royal, Virginia 22630 ~ 540-635-3518 (Office) ~ 540-533-0715 (Direct/Cell) - http://www.here-4-you.com ~ jeffrey@here-4-you.com

APPOINTMENTS AND CANCELLATIONS: Cancellations and re-scheduled sessions will be subject to a charge of $150 if NOT RECEIVED AT LEAST 24HOURS IN ADVANCE. This is a personal expense and is not covered/related to/or reduced by third-party payers (Insurance/EAP). This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you will lose that session time. There are no exceptions to this policy and no excusable absence. If you schedule an appointment and either do not attend or cancel with less than 24 hours' notice for any reason you will be charged $150.

The standard meeting time for individual psychotherapy is 50 minutes and 40 minutes for couples/family sessions. These are insurance restrictions are not able to be adjusted for insurance-based clients. At the discretion of the provider, session times can be reduced. Self-pay requests to change the 50-minute session needs to be discussed with the therapist for time to be scheduled in advance.

A $25.00 service charge will be charged for any checks returned for any reason for special handling.

CLIENT FINANCIAL RESPONSIBILITY: You are ultimately responsible for the payment for your treatment and care. It is your responsibility to know your benefits under your health plan or EAP. Please understand that the financial responsibility for services is between you and your health plan/EAP. Your insurance policy is a contract between you and your insurance company/EAP provider.

I will bill your insurance company as a courtesy; however, you are responsible for providing us with the most recent and accurate insurance information and you will be responsible for any charges incurred if the information provided is not correct or up to date. It may also become necessary for you to contact your insurance company to provide them additional information in order for them to process your claim completely.

You are also responsible for required co-payments, co-insurance, applicable deductibles, and any services that are not covered or otherwise denied by your insurance plan/EAP. You are responsible for paying any co-payment at the time of service.

PRIOR AUTHORIZATIONS: It is incumbent on patients to understand if preauthorization is required and if it has been approved before services are rendered.

The healthcare provider may need to assist in initiating prior authorization by submitting a request form to a patient's insurance provider, but this requirement is with the patient and the forms required must be obtained by the patient and provided to the provider. Failure to obtain a required prior authorization may result in patient responsibility for all fees denied by the insurance.

TELEPHONE ACCESSIBILITY: If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone/video sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION: 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, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. 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.

ELECTRONIC COMMUNICATION: I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not

Client Signature: ___________________________________ Co-Client Signature: ___________________________________

use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine. Telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that: (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. (2) All existing confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS: If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

COURT ACTIONS/LEGAL FEES/SOCIAL SECURITY DISABILITY: Clients are strongly discouraged from having their therapist subpoenaed or having them provide records for the purpose of litigation or Disability. Even though you are responsible for all fees, it does not mean that the therapist's testimony will be solely in your favor. The therapist can only testify to the facts of the case and, if qualified to do so by the court, in their professional opinion. Asking a therapist to provide confidential records or testify can damage the trust built in a counseling relationship with a client especially if the therapist is still seeing that client in therapy. If one of our therapists is subpoenaed to testify or provide records in a case where our client is a child, the therapeutic relationship is effectively ended and likely will not continue to provide services to that child/family.

If a therapist with Here-4-You Counseling is to receive a subpoena, then it is best for the attorney or office staff to call the office and set up a time for the subpoena to be served during office hours. The therapist will request a minimum of 72 business hours notice of any Court appearance so that schedule changes for their clients can be made within a reasonable time frame. Please note: If a subpoena or notice to appear is received without a minimum of 72 hours notice, there will be an additional $250 express charge.

When it comes to court/legal/disability action, the following fees are in effect:

- Preparation Time (including preparing, copying, and submission of records): $250/hour (billable in minimum 15-minute increments)
- Phone calls: $250/hour (billable in minimum 15-minute increments)
- Depositions and Court Appearance Time: $250 and then $250/hour
- Time required in Giving Testimony: $250/hour
- Mileage: .65/mile
- Time Away from office due to Depositions or Testimony including Travel Time: $250/hour (billable in minimum 15-minute increments)

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- All attorney fees and costs that are incurred by the therapist as a result of the legal action. Any advisement, opinion, or guidance sought is at the sole discretion of the therapist.
- Report Preparation and Filing document with the court/attorney/disability agency: $100 plus Preparation Time noted above.

A nonrefundable retainer of $250 is due at least 72 business hours before the scheduled court appearance. The remainder of the costs will be billed after the court appearance and will be due upon receipt. If the therapist is subpoenaed and the case is reset with less than 72 business hours notice prior to the beginning of the day of the scheduled subpoena, trial, and/or testimony is not given, then the client will be charged $250 (in addition to the original retainer of $250 for having to appear in court). All fees apply to each party if more than one party has issued a subpoena for the same appearance.

TERMINATION: Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

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

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 of 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 of 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.

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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: 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.

Marketing Purposes. 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:

- 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.
- 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.
- For health oversight activities, including audits and investigations.
- 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.
- For law enforcement purposes, including reporting crimes occurring on my premises.
- To coroners or medical examiners, when such individuals are performing duties authorized by law.
- 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.
- 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.
- 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.
- 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: 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: 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.

Client Signature: ____________________________ Co-Client Signature: ____________________________

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.

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.

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.

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.

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.

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 signing below, you are acknowledging your understanding of HIPAA Notice of Privacy Practices above.

INFORMED CONSENT FOR PSYCHOTHERAPY - GENERAL INFORMATION: The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about 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 signing below and at the end of this document.

THE THERAPEUTIC PROCESS: You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

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 him/herself in a manner in which 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.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.

Client Signature: ___________________________________ Co-Client Signature: ___________________________________

6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. 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.

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

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 speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

ABOUT THE THERAPIST: Dr. Jeffrey J. Rodman specializes in working with individuals and families coping with issues related to mental health, substance abuse, marital, and difficult life issues. Dr. Rodman received his BS in Chemical Dependency Counseling and M.Ed. in Counseling and Development from George Mason University, in Fairfax, Virginia and his PhD in Religion from Christian Bible College in Rocky Mount, NC and became a Licensed Professional Counselor (LPC) in Virginia as of August of 2003 (LPC #0701003571 / NPI #1174780761).

Dr. Rodman holds the following certifications:

- Licensed Professional Counselor (LPC)
- Licensed Substance Abuse Treatment Practitioner (LSATP)
- Certified Clinical Master Hypnotherapist (CCMHt)
- Certified Clinical Criminal Justice Specialist (CCCJS)
- Master Addictions Counselor (MAC)
- Nationally Certified Addictions Prevention Specialist (NCAPS-III)
- Certified Domestic Violence Counselor (CDVC-II)
- Master Certified Life & Success Coach (MCLSC)
- Certified Brain Health Coach (Amen Clinics)
- Master NLP Practitioner
- Master Practitioner Emotional Freedom Techniques (EFT)

He has been a trained Parent-to-Parent Facilitator, a licensed therapeutic foster parent, and a certified trainer in the administration, scoring and clinical interpretation of various substance abuse, mental health, and psychiatric assessment and diagnostic tools. He is a member of the American Counseling Association (ACA) and the American Association of Christian Counselors (AACC).

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on January 1, 2024 and notification is considered as of the signing date below.

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

Printed Name: ____ Date: _______________

Signature: ____ Date: _______________

Parent/Guardian Signature: _________________________________ Date: _______________

Witness Signature: ____ Date: _______________