Real Resolutions Counseling, LLC
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OFFICE POLICY FORM

Informed Consent for Psychotherapy

Welcome to Real Resolutions Counseling, LLC. I am glad you have decided to take that important first step in reaching out for support. I appreciate you giving me the opportunity to work with you. This document provides you with information about my qualifications, treatment approach and methods, and the services offered, as well as to answer any other questions you have about what to expect and the nature of the counseling process.

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 filling in the checkbox at the end of this document.

Therapy

Therapy is a place to identify and build on current strengths, learn problem-solving strategies, develop or enhance coping skills, learn more effective ways to communicate with others and receive support and feedback. The counseling relationship is designed to be one that will facilitate change and growth. My belief is that the therapist and the client both have active roles. My goal is to provide a comfortable and supportive environment conducive to insight, healing and personal growth. My sessions are flexible and adaptive in order to provide you with the necessary experience during each session.

During our first session (intake session), I will gather information about your history, current strengths, struggles/areas of concern, and your thoughts on goals for treatment. This will be a time for you to ask any questions that you may have and to determine if you wish to proceed with ongoing therapy. I strongly believe that individuals should feel comfortable with the therapist that they choose and hopeful about therapy.

Throughout the course of therapy I will be working with you to collaborate over agreed upon goals and skills. An important part of therapy will be to practice new skills and monitor certain behaviors/thoughts at home. There may be times when I will ask you to do some "homework" in between sessions that may consist of reading and completing handouts, keeping records or practicing a specific skill. The length and frequency of therapy together will be determined by your specific needs and goals. We will periodically evaluate your satisfaction and progress. If at any time you have questions or concerns regarding fees, services, or the direction of our sessions, please do not hesitate to address them with me. I welcome any questions and feedback. In the later stage of therapy, we will meet less frequently in preparation for termination. Although you may terminate your therapy whenever you wish, it is very helpful to have at least one session together to summarize your progress, define the work that remains and to say good-bye.

Counseling can have benefits and risks and it is important to consider both when making any treatment decisions. Since therapy involves discussing unpleasant aspects of your life, there is a risk that you may experience temporary uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. Counseling also been shown to have many benefits including improved relationships, a significant reduction in feelings of distress and resolutions of specific problems. I am unable to make any guarantees about how the therapy process will be for you, specifically.

Office Policies, Procedures and Fees

Fees/Payment:

- The standard fee for a 50-minute individual session is $75.
- All fees are due at time of service
- Accepted forms of payment include cash, Paypal, Venmo, Visa, and Mastercard

Cancellation Policy

If you need to reschedule or cancel an appointment, please contact me at least 24 hours prior to your appointment. Not doing so takes away the opportunity to give that appointment to another client. I understand that emergencies happen and will be happy to work with you in those situations. If you cancel within 24 hours, you will be charged $30 for the missed 50-minute session. If you give no notice at all, you will be charged the full fee. Frequent canceling or rescheduling may result in the refusal of future appointments.

Court Policy

If you are involved in a court case that may require my testimony, please notify me prior to treatment. If I am requested to write a letter on any court related matter, I will not be stipulating, in writing or in person, an opinion. I can only provide observations and feedback. At no time will I make a recommendation in regards to custody or any other court related matter.

If a court order is served and is requesting that I be present in person and/or there is a request for records, your consent will be requested before turning over confidential information; however, if the subpoena is from a judge, client consent is not required. When obtaining this consent, the client will be told exactly what has been requested by court and there is not guarantee that the information will be kept confidential. This includes a client's mental health history, current status, and inclusive records, and may not be in the best interest of the client. The therapist relationship does not render the therapist as an advocate; therefore, I will withhold any opportunity to engage in a dual relationship with the client.

**Professional Records **

I keep a record of the counseling services I provide to each client. You may ask to see and/or copy your record by making an appointment specifically for that purpose or I can prepare a summary for you instead. You may also ask me to correct your record.

**Contact Information **

The primary way to get in touch with me is by contacting me on my work phone at (813) 906-8865 or via email at jdobies@realresolutionscounseling.com . I do not answer phone calls during session so please leave a detailed message including the reason for the call and the best number and time to reach you. Voicemail messages and email are confidential, and I will return calls and emails as soon as possible or within 24 hours. If you are in crisis and need immediate assistance, please call 911 or The Crisis Center of Tampa Bay (813-264-1234), call 211, or go to your nearest emergency room.

**Confidentiality **

Protecting your privacy is very important to me. The information in your record is confidential and will not be disclosed to anyone without your written consent, unless required by law. The exceptions to confidentiality include:

1. If you tell me that you are going to harm or kill yourself or someone else, I am required by law to do whatever I can do to prevent that from happening and to ensure your safety and the safety of others. This may require notifying family members, parents, legal guardians, legal authorities and/or the potential victim.
2. If you or your child tells me about incidents of child abuse, or the abuse of a disabled person or the elderly, I am required to report this to the proper authorities.
3. I am required to release your records if they are subpoenaed by a court of law.
4. In addition to the above, there are several other situations where confidentiality cannot be insured, including:
   a. If you provide me with a request to release your records.
   b. If you are in couples counseling, I cannot guarantee that your partner will maintain confidentiality.
   c. If you are in group counseling, I cannot guarantee the members of the group will maintain confidentiality.
   d. If you are 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.
   e. 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.

In addition, 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.

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. OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We 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 we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are 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. We 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 person 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, we may disclose health information in response to a court or administrative order. We 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. We 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 our use in treating you.

   b. For our 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 our use in defending ourselves in legal proceedings instituted by you.

   d. For use by the Secretary of Health and Human Services to investigate our 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: We will not use or disclose your PHI for marketing purposes.
3. Sale of PHI: We will not sell your PHI in the regular course of our business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, we 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 our preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on our 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 our preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with your counselor. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

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

1. Disclosures to family, friends, or others. we 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 your counselor not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say "no" if we 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 We Send PHI to You: You have the right to ask your counselor to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we 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 we have about you. We 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 we may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures We 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 us with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we 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 we correct the existing information or add the missing information. We may say "no" to your request, but we 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.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on September 20, 2013

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.

I am a Licensed Mental Health Counselor the State of Florida and services provided will be in accordance with the Code of Conduct for Mental Health Counselors Licensing Board. If you have a concern about our counseling relationship, I encourage you to address it with me directly. For licensure and compliance information, you may call: (850) 245-4339, or write to Florida Department of Health, 4052 Bald Cypress Way Bin C75, Tallahassee FL, 32399-3260

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

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Name of Client (Print)   Date   Client Signature

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Parent/Guardian (Print)   Date   Parent Signature

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Counselor Signature/credentials   Date