

INFORMED CONSENT, POLICIES & PROCEDURES

Pastoral Counseling and Consultation Center / The Imago Center of Washington D.C.

Welcome to the PCCC and the Imago Center.

All beneficial counseling takes place within a relationship of trust. It is important, therefore, to clarify what you can expect from counseling and provide you with helpful information regarding your rights and our professional services and business policies.

When you sign this document, it will also represent an agreement between you and your counselor. You can discuss any questions you have when you sign them or at any time in the future.

Professional Disclosure Counselors at PCCC/The Imago Center hold a variety of degrees in the field of counseling and psychology. In each case your counselor is licensed or working toward licensure to provide psychotherapy in Maryland and/or the District of Columbia.

Your Rights You have the right to ask about how we work and what to expect from therapy. You have the right to seek a second opinion from another therapist or end therapy at any point. You have the right to safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to expect that your counselor will not have social or sexual relationships with clients or with former clients.

Confidentiality Our counselors adhere to the ethical and legal standards of the counseling profession. Counseling services as well as the storage and disposal of Protected Health Information (PHI) will be kept confidential within these ethical and legal limitations. In general, the information provided by and to you during therapy sessions is privileged communication and cannot be disclosed without your written consent. Your counselor may ask your written consent to discuss your treatment with another person (doctor, relative, teacher, psychiatrist, etc.).

Your counselor is legally obligated to release information about your treatment without your consent in the following circumstances:

- You pose harm/threat to yourself or others.
- You reveal that a child or an elderly person is being abused.
- You are under the age of 17 and have been sexually or physically abused, raped or the victim of another crime.
- When the information is court ordered by a subpoena or a parole officer.
- You require hospitalization.

Please review and sign the 2 forms below related to your privacy and confidentiality: the Confidential Communications form and the Notice of Privacy Practices.

Informed Consent Psychotherapy has both benefits and risks. Therapy often leads to increased satisfaction in interpersonal relationships, greater personal awareness, and increased skills for managing stress. Risks may include experiencing uncomfortable feelings, such as sadness, anxiety, anger, and frustration, because the process of psychotherapy often involves discussing challenging aspects of your life. Achieving good results from therapy will depend on your full engagement in the process and on your motivation to change.

Please share your questions or feelings about therapy with your counselor whenever they arise, so that you can adjust the therapy together. In the first two sessions you will evaluate your needs and develop treatment goals and objectives so that you can evaluate your progress over time.

Appointments Couples sessions typically last 60 or 90 minutes, and individual sessions last 50-60 minutes and are generally scheduled weekly.

Fees Fees range according to a sliding fee scale based on gross family income and other resources. Credit cards are preferred, but we also accept a check or cash. Checks should be made payable to The Imago Center. In the event any account is referred to collections, the client agrees to pay reasonable attorney fees and court costs if any. Payment is due at time of service.

Insurance PCCC/The Imago Center does not work directly with insurance companies. We will send you a Superbill (a detailed statement of service) at the end of each month, which you can submit to your insurance for possible reimbursement. Most insurance companies reimburse for our services.

Cancellations We have a 48-hour cancellation policy. If you need to cancel or reschedule your appointment, we will not charge a cancellation fee if you notify your counselor 48 hours in advance. Without such notice the full appointment fee will be charged. Continuity is crucial to the effectiveness of therapy.

Contacting your counselor Our counselors check their voicemail daily and will respond to all messages within 24 hours, except for weekends and holidays. If you are experiencing a mental health emergency, please call 911 or go to your local emergency room. A local crisis hotline is also available at 240-777-4000 or 202-561-7000.

Email and text exchanges should be limited to administrative matters such as setting and changing appointments, billing, and related issues.

Discontinuing Services You or your counselor can initiate termination of services at any time. Please discuss any plans or desire to terminate therapy as ending is an important part of the therapeutic process.

Questions If you have questions or would like additional information, please feel free to ask.

Client Agreement

I have read the preceding information, understand my rights as a client, and agree to the policies, procedures, fees and payment arrangements as described above. Signing this form indicates my informed consent to receive treatment.

Client Signature

Date

Client Signature #2 (Couple Therapy)

Date

Client Signature #3 (Family Therapy)

Date

Confidential Communications Consent Form

PCCC/The Imago Center is dedicated to protecting your health care information. Please read the following information concerning written, verbal, and electronic forms of communication. Indicate that you have read and understand the information and which forms of communication you authorize by initialing next to the statements below. We will not communicate any Protected Health Information (PHI) verbally, electronically, or written unless authorized.

Please initial next to the statements below to authorize PCCC/The Imago Center to communicate PHI.

_____ I authorize PCCC/The Imago Center to send invoices containing PHI to my email.

_____ I authorize PCCC/The Imago Center to send newsletters, information about workshops or groups to my email address.

_____ I authorize PCCC/The Imago Center to leave text or voice mail messages on my cell phone.

_____ I understand that cell phones, text messages and unencrypted email are not a secure form of communication.

Client Name _____ (please print)

Client Signature _____ Date _____

Client Name _____ (please print)

Client Signature _____ Date _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Protected Health Information

PCCC/The Imago Center must maintain patient confidentiality as required by applicable federal, state and local laws. PCCC/The Imago Center is also required to establish a consistent process when there is a request for patient information from law enforcement authorities. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

When using, disclosing or requesting protected health information (PHI), every reasonable effort shall be utilized to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. PCCC/The Imago Center will take steps to ensure that the appropriate actions are taken to properly identify and secure all individuals' PHI.

The following individually identifiable health information will be designated as PHI within PCCC/The Imago Center to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996:

- A. Information that relates to the past, present, or future physical or mental health conditions of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; specifically including such information in verbal, written, or electronic form.
- B. Names.
- C. Address information
- D. Telephone numbers.
- E. Fax numbers.
- F. Social Security numbers.
- G. Health plan beneficiary numbers.
- H. Full face photographic images and any comparable images.
- I. Any other identifying number, characteristic, or code used to identify an individual.

When you visit a health care provider, you give information about your physical and mental health. The law identifies this information as PHI. This information goes into your medical or health care record or file. With your written consent, the healthcare provider can use your PHI to provide treatment, process for payment, and administer healthcare operations (TPO).

State and federal laws allow us to use and disclose your health information for these purposes.

Primary uses and disclosures of PHI include:

- A. Treatment: Once you give consent and your treatment begins the information you give about yourself may be used by PCCC/The Imago Center staff members or disclosed to other health care professionals. Example: contact with past counselors, current or past physicians, or other treatment facilities, with written consent from the client.
- B. Payment: The information you give PCCC/The Imago Center about yourself may be used to seek payment from your health plan or from other sources of coverage. Example: your health insurance company may request and receive information on dates of service, the services provided, and the diagnosis and symptoms of the mental health condition being treated.

OTHER DISCLOSURES

The following are descriptions of some other possible ways in which PCCC/The Imago Center may be required or permitted by law to use or disclose your PHI. Law enforcement authorities are not covered entities for the purposes of HIPAA compliance. Therefore, PCCC/The Imago Center shall abide by disclosure restrictions as provided by law and regulation.

Mandatory Disclosure Laws

- A. PCCC/The Imago Center shall disclose PHI to law enforcement personnel and designated protected service personnel pursuant to the mandatory disclosure laws related to victims of child or adult abuse, neglect, or domestic violence.
- B. PCCC/The Imago Center is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Regulations.
- C. PCCC/The Imago Center shall disclose PHI to law enforcement personnel or medical, hospital, or psychiatric hospitalization services in the event of a current or recent (recent defined as within 2 weeks) suicide attempt.

Court Orders or Warrants

PCCC/The Imago Center may disclose PHI to law enforcement in compliance with and limited by relevant requirements (the information sought is relevant and material to a legitimate law enforcement inquiry, and the request is specific and limited in scope to the extent reasonably practicable in the light of the purpose for which the information is sought and de-identified PHI information could not be reasonably used) of a:

1. Signed Court Order
2. Signed Court-Ordered Warrant
3. Signed Subpoena
4. Summons issued by Judicial Officer
5. Crime occurs on the premises

6. Threat to health and safety: PCCC/The Imago Center may disclose PHI in conformance with ethical standards, in good faith, and in compliance with applicable law, to avert serious threat to health and safety of the person, counselor, teacher, family member, or to the public, as is necessary for law enforcement authority to identify or apprehend an individual:
- a. Because of a statement of admission of violent crime that may have caused serious physical harm to a victim.
 - b. Because of the individual appears to be an escapee from a correctional institution or lawful custody.
 - c. For purposes of national security and lawful intelligence of the National Security Act.
 - d. As required by protective services for the President and other under Secret Service Protection.

Court Appearance and Out of the Office Consultations

PCCC/The Imago Center does not provide court/custody evaluations and will not appear in court to testify in divorce/legal/custody cases unless subpoenaed. If your counselor is required to appear in court on your behalf, you are responsible to pay them an hourly rate of \$250 and are also responsible for paying for any court/legal fees they accrue during this process. At your request, your counselor can attend consultations outside of therapy, such as, teacher/school meetings, doctor meetings, etc. Please know that you will be charged your counselor's hourly rate including travel time.

Duties of PCCC/The Imago Center

PCCC/The Imago Center is required by law to maintain the privacy of your PHI and to provide you with this notice of privacy practices. We are required to abide by the privacy policies and practices that are outlined in this notice. All members of our staff are obligated to respect your confidentiality and privacy as outlined in this notice. Similarly, any of our business associates who have contact with your PHI (such as a third party billing company) are obligated to respect your confidentiality and privacy in accordance with this notice. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations.

Your Rights

You have certain rights under the federal privacy standards. These include:

Right to Request a Restriction: You have a right to request a restriction on the PHI we use

or disclose about you for payment or healthcare operations. We will comply with the restriction unless the information is needed to provide emergency treatment to you and as long as it allows us to comply with the law. You may request a restriction by writing, or completing our form for the purpose. In your request tell us: 1) the information you want to limit and 2) how you want to limit our use and /or disclosure of the information.

Right to Request Confidential Communications by Alternative Means: If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or an alternative location. For example, you can request that we only contact you at work.

Right to Inspect and Copy: As permitted by federal regulation, we require that requests to inspect, copy, or release PHI be submitted in writing. You may obtain a form to request access to your records by contacting your therapist at 301-461-5591. If you request a copy of the information, we will charge a fee for the costs of copying, mailing, or other costs associated with your request. Please note that the law does not guarantee you the right of access to, or possession of a mental health therapist's personal or psychotherapy notes. We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

Right to Amend: If you believe that your PHI is incorrect or incomplete, you may request in writing that we amend your information. Your written request should include the reason the amendment is necessary. In certain cases, we may deny your request for the amendment. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right of an Accounting: You have the right to receive an accounting of most disclosures of your PHI for reasons other than payment, treatment, or healthcare operations. This accounting will not include disclosures for which you provided an authorization. An accounting will include the date(s) of the disclosure. We are permitted to charge you for the cost of producing the list.

Rights for Confidentiality in Substance Abuse Treatment: You may have additional rights of confidentiality under 42 CFR Part 2. Ask for a special authorization form, if you wish.

Right to Get Notice of a Breach: You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Right to Receive a Printed Copy of the Notice: You have a right to receive a printed copy of this notice.

Complaints

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the executive director of PCCC/The Imago Center: Carl Siegel PhD, 202-449-3789.

If you believe I have violated your privacy rights, you have the right to file a complaint in writing to me or with the Secretary of Health and Human Services at 200 Independence Avenue SW, Washington, DC 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

The effective date of this notice is April 14, 2003.

I have read and understand PCCC/The Imago Center's Notice of Privacy Practices.

Client's Name (printed) _____

Client's Signature _____ Date _____

Client's Name (printed) _____

Client's Signature _____ Date _____

Printed Name of Parent/Guardian if client is a minor _____

_____ Date _____

Signature of Parent/Guardian if client is a minor _____

_____ Date _____