

CLIENT INFORMATION PACKET

Manda P. Turetsky, MS, MBA, EdS, EdS, LPC

Flourish Consulting

Located at: Cornerstone Family Services

2993 Sandy Plains Rd. Suite 115

Marietta, GA 30066

770-380-1288

Fax: 678-264-0902

Thank you for choosing Manda Turetsky, MS, MBA, EdS, LPC to provide your mental health and personal growth services. This packet will allow me to learn about you, and provide important information about counseling services. Please take the time to read each portion carefully, and be sure to note any questions you might have so that we can discuss them in our first session.

Couples should print out two copies of this packet and fill them out separately. Please bring the completed pages with you to our first session. Thanks!

CHECKLIST

- *Please fill out completely the **Client Information Form** on pages 2-5.
- Read carefully the Informed Consent on pages 6-10.
- *Sign and Return the **Consent to Treatment** on page 11.
- *Read and Sign the **Financial Policies** on page 13-14.
- *Sign and return the **Client Notification of Privacy Rights** on page 14.
- If desired, fill out and sign the Release of Information on page 17. (optional)

CLIENT INFORMATION FORM

Today's Date _____

Client's Name _____

Date of Birth _____

Parent/Guardian's Name (if applicable) _____

Relationship _____

Home Address _____ City _____ Zip Code _____

May I send information to this address? Yes No

If No, please provide an address where information can be mailed: _____

Home Phone Number _____

May I contact you at this number?

Yes No Disguised

Cell Phone Number _____

May I contact you at this number?

Yes No Disguised

Work Phone Number _____

May I contact you at this number?

Yes No Disguised

If there are any further restrictions when calling you, please list them here _____

Education Level Completed _____ Occupation _____

Person to notify in case of emergency _____ Phone _____

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: _____

How did you hear about me/CFS? _____

Please briefly describe the concern(s) that bring you to counseling/coaching:

How many weekly sessions do you anticipate to address these concerns?

1-5 6-10 11-20 20+ I don't know

MEDICAL HISTORY

Please explain any significant medical problems, symptoms, or illnesses:

Current Medications Purpose Dosage Frequency Side Effects

Please include over-the-counter medications and vitamins

Past Medications Date(s) Purpose Dosage Side Effects

Do you smoke or use tobacco? Yes No If yes, how much per day? _____
Do you consume caffeine? Yes No If yes, how much per day? _____
Do you drink alcohol? Yes No If yes, how much per day/week/month? _____
Do you use any illicit drugs? Yes No If yes, which? _____
Do you exercise? Yes No If yes, how often? _____

Have you ever talked with a mental health professional before today? Yes No

If yes: Date(s) Type of Treatment Reason Professional Seen

Would you like me to contact any of your previous providers? Yes No

If yes, please provide their contact information: _____

RELATIONSHIPS & SOCIAL SUPPORT

Are you currently in a relationship? Yes No If yes: Married Partnered

How long in current relationship? _____

Please rate your current relationship satisfaction: 1 2 3 4 5 6 7 8 9 10

Any previous marriages/significant relationships? Yes No

Do you have children? Yes No

If yes, please list names & ages

Please list other people or groups who are important social support for you:

Is spirituality an important part of your life? If so, what would you like me to know?

FAMILY HISTORY

How would you describe your relationship with your mother?

How would you describe your relationship with your father?

Are your parents still living? _____ Still married? _____

If they divorced, how old were you when they separated or divorced, and how did this impact you?

Were there any other primary care givers who you had a significant relationship with? If so, please describe.

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings?

Briefly describe one event or situation from the past (the first one that comes to mind is fine), which you feel had an impact on who you are today, or on the issue that brings you to counseling.

CHECKLIST OF CONCERNS & SYMPTOMS

Please check all concerns that apply, even if they do not seem relevant to your current issue.

Difficulty with....	Now	Past	Difficulty with....	Now	Past	Difficulty with....	Now	Past
Anxiety			People in General			Nausea		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger/Temper			Marriage/ Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears/Phobias			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often make careless mistakes		
Drugs			Hurting Self			Fidgeting		
Alcohol			Thoughts of Suicide			Speaking without thinking		
Caffeine			Sleeping too Much			Impatience		
Frequent Vomiting			Sleeping too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking too early			Easily Distracted		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head injury			Chills/Hot Flashes		

FAMILY HISTORY OF.... (check all that apply)

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		"Nervous Breakdown"	

Any additional information you would like to include:

INFORMED CONSENT

Manda P. Turetsky, MS, MBA, EdS, LPC (Flourish Consulting)

GA License #LPC006142

Located at: Cornerstone Family Services, LLC

2993 Sandy Plains Rd. Suite 115

Marietta, GA 30066

The following contains important information about the professional services provided by Manda Turetsky, LPC. This document is designed to inform you about what you can expect from therapy, and from me as a professional. This includes confidentiality, emergencies, and several other important details regarding your treatment. Please read carefully, since this document is the agreement that allows me to provide therapeutic services to you. Counseling is a collaborative experience, and I welcome your questions, concerns and suggestions throughout the process.

BACKGROUND & EDUCATION

I attained my Master of Science (MS) in Professional Counseling from Georgia State University in May 2008; and an Educational Specialist degree (EdS) in Professional Counseling in May 2010. As part of my educational and post-graduate experience, I have been working directly with clients since June of 2007. I am a certified mediator, and I also have advanced training in several of my specialty areas. I seek ongoing education as part of my professional commitment to provide my clients with the most current treatment modalities. My license number is #LPC006142; please note that should you need to reference it, I am listed with the Secretary of State's Office as Amanda Pullen Turetsky.

I also hold a Master of Business Administration (MBA) and a Bachelor of Arts in English, both from the University of Georgia in Athens. Previous to my work as a counselor, I worked for several years in the corporate marketing and non-profit development realms. I have consulted with organizations to train employees and managers in interpersonal skills. When I am not counseling, I often spend time writing articles, web content, and even some fiction. I have traveled extensively, including spending six months backpacking in Europe a few years ago.

THEORETICAL VIEWS AND CLIENT PARTICIPATION

I believe that therapy is most effective when it is engaging and empowering. Our sessions will be based on a collaborative partnership in which we work together to help you find the solutions that work best for you. While I can serve as a guide on this journey; ultimately, the answers are yours to discover. During our therapeutic relationship, I will help to create a safe, supportive environment; and invite you to explore the issues that bring you to counseling and to find or create the solutions that work best for you.

Like many things in life, the benefits of therapy are closely related to the effort put into the process. Clients who take an active role in counseling, work between sessions, and express themselves honestly will generally derive the most benefit. As the client, you are in control: you may choose to alter the direction of therapy or discontinue at any time.

SERVICES PROVIDED

At your first session, I will speak with you about the reasons that you scheduled your first appointment. During this time a decision will be made between client and therapist as to whether or not we are a good fit for treatment or if an outside referral will be made to someone with more expertise in your area of need.

Each therapy session typically lasts 45-50 minutes. The duration of the therapeutic process varies for each client. Some clients may feel resolution to their concerns in just a few sessions while others may take years to complete their process. In most cases, therapy is more effective when both client and therapist make a regular, weekly commitment to work together – particularly during the initial 6 to 10 weeks of therapy. Some treatments may require more frequent meetings; we will discuss this when we develop a treatment plan.

Together, we will periodically evaluate your progress toward the goals that brought you to counseling and adjust as necessary. If at any time you wish to stop receiving services from me, I ask that you schedule one final session in order for us to have appropriate closure and to address any remaining needs that you may have.

RISKS

Given the work required for personal growth and change to occur, therapy includes risks. Since therapy involves discussing difficult aspects of life, you may experience uncomfortable feelings or strong reactions. Making and adapting to changes in your life may have a profound impact on you and your relationships as well as challenge long-held assumptions or behaviors. Reasonable efforts will be made to discuss the potential impact, positive and negative, that may result from the changes you make in your life as a result of therapy.

Due to the overall complexity of the process and the multiple variables brought into it by each client, there are no guarantees for successful therapy. While I believe that the simple, courageous act of coming to therapy can be a step in the right direction for many people, I cannot promise any particular results. I encourage you to ask questions and give honest feedback about your progress as we move forward so that we can change directions, increase your level of treatment, or find a more appropriate practitioner as needed.

CONFIDENTIALITY

The information you share with me both written (i.e. intake paperwork) and verbally is part of your Protected Health Information (PHI) and is considered confidential. A detailed description of PHI is included with this intake packet. I will not release your information to anyone, including your family and insurance company if you are a legal adult, without *written* consent. If you are a minor, it is the legal right of your parents to have access to the information that we discuss in our sessions. I will discuss with each minor client and their parent/guardian the expectations of exchange of information between parent/child, therapist/child, and therapist/parent for their particular situation.

It is important that you understand the legal limitations to confidentiality which include, but are not limited to:

- 1) When individuals express intent to harm themselves or others, the therapist may be required to break confidentiality to assure the health and safety of all concerned.
- 2) Therapists are mandated by law to report to the appropriate state authorities information documenting child and/or elder abuse or neglect.
- 3) When a judge orders that information be disclosed. I cannot guarantee that an appeal will be upheld, but I will do everything in my power not to disclose your confidential information.
- 4) The PATRIOT Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.

Your confidential files will be routinely accessed only by me (your therapist) and, on occasion, administrative personnel employed by CFS. Administrative assistants will only access the portions of your file pertinent to administration, such as your contact information and payment history, not your medical records or psychotherapy notes. In the event of an emergency, your file may also be accessed by Jennifer Vann, LMFT,

Director of Therapy Services at Cornerstone Family Services, for the purpose of notifying you of the emergency and arranging for continuity of your care.

WAIVE RIGHT TO SUBPOENA

In order to protect you and the information you and/or your child(ren) provide to me during our sessions I ask each client to waive their right to call me as a witness to court for any reason. The communication that you/your child(ren) provide during session is considered privileged by O.C.G.A. §24-9-21(7) and covers communication provided by “a licensed...marriage and family therapist... during the psychotherapeutic relationship.” If you anticipate the need for a therapist’s involvement in court activity I will be happy to refer you to someone who is more suited to meet your needs.

COMMUNICATION

The most effective way to communicate with me is in person, within the regular 45-50 minute session time. Any phone consultations should be mutually agreed-upon in advance, and will be billed at the regular rate every 15 minutes (see “Fees” below). Psychotherapy by telephone is **not** ideal, however, and frequent phone consultations between sessions may be an indication that you need additional support – such as more frequent sessions, group therapy, or more intensive treatment.

Clients who choose to contact me by e-mail should be aware that I cannot guarantee the confidentiality of e-mail communication, and I discourage the use of e-mail to address clinical issues for a number of reasons. Please note that e-mail communication should be used only for scheduling/logistics issues; and I cannot respond to the clinical content of e-mail messages. I do not communicate with current or former clients via text message, Instant Messages (IM) or social networking sites (like Facebook, MySpace or LinkedIn).

FEES

Clients seen by Manda Turetsky, LPC agree to pay \$120.00 per 45-50 minute session. Any services beyond the standard 45-50 minute session – such as a phone consultation exceeding 10 minutes, paperwork outside the ordinary course of treatment, or reports prepared for third parties – will incur additional fees to be discussed prior to service provided. Ordinary phone consultations of 10 minutes or less will not be billed unless they become frequent and I feel they need to be addressed clinically. Conversations lasting more than 10 minutes will be billed at \$20 for the first 15 minutes and \$40 for every 15-minute increment started thereafter [parents: please note this includes consultation by phone and/or in the office before or after your child’s session]. You are responsible for the full payment at the time service is provided.

Cash, checks and credit cards will be accepted as forms of payment. *If you are using a credit card a processing fee of \$3.00 will be added to your session fee, and the charge will appear on your statement as Cornerstone Family Services.* I will be happy to provide you with a receipt for payment upon request. Receipts of payment may also be used as a statement for insurance if applicable to you. Please note that there is a \$30 fee for returned checks. Should you miss a payment for any reason, therapy sessions may be postponed until the full payment is rendered.

Periodically, I am able to provide a limited number of reduced-fee or scholarship slots in my case load. If you feel that you qualify for one of these slots and would like to apply, please inform me *before* our first session (or when a financial hardship occurs, if applicable). Because these slots are limited there may be a waiting list; and you may be asked to schedule at off-peak hours. If there are no slots immediately available, I will be happy to provide you with other low-cost referrals.

INSURANCE

The services I provide are fee-for-service, which means I do not accept or file insurance on behalf of my clients. At your request (and with your written permission), I will be happy to provide you with a “superbill” – a statement of diagnosis, sessions attended and fees paid – so that you may file with your insurance company for reimbursement if you choose to do so. **Please be aware that submitting information to your insurance company for payment compromises your confidentiality;** your diagnosis code and other information may be kept on file by your insurance company and transmitted to others in the future. This could have a detrimental impact on future employment or insurability. I encourage clients to consider carefully before submitting mental health claims for insurance reimbursement.

Should you choose to seek reimbursement, please note that insurance companies have many rules and requirements specific to certain plans. It is your responsibility to understand the requirements and limitations that apply to your particular plan. I cannot guarantee payment of any claim, nor am I able to speak with the insurance company on your behalf.

EMERGENCIES

The therapists at CFS do **not** provide emergency services. I do not carry a pager and I am not available at all times. If this does not feel like it will be sufficient support for you, please inform me and we can discuss additional resources or transfer your case to a therapist or clinic that has 24 hour availability.

Generally, I will return phone calls within 24-48 hours. Should I be out of town, I will make every effort to alert you of my absences. If you have a mental health emergency at any time, I encourage you not to wait for a call back, but to do one of more of the following:

- 1) Call Ridgeview Institute at 770.242.4567 or Peachford Hospital at 770.454.5589
- 2) Call 911
- 3) Go to the emergency room of your choice
- 4) Cobb County Mental Health Crisis Line 770.422.0202
- 5) Fulton County Mental Health Crisis Line 404.730.1600

ETHICAL CONSIDERATIONS

I am committed to professional behavior that is consistent with the Code of Ethics of the American Counseling Association. You may view the Code of Ethics on the “Resources” page at www.counseling.org.

In order to maintain ethical standards I find it helpful to occasionally consult with other professionals. In these consultations I do not reveal the identity of my client(s). The consultant is also bound to keep any information about a case confidential by the ethical standards of their own professional association. I do not consult with therapists who are not bound by such ethical standards.

INFORMATION SPECIFIC TO CERTAIN CIRCUMSTANCES

WORKING WITH CHILDREN/ADOLESCENTS

Due to the importance of trust between client and therapist, when the client is a minor child I will offer parents general information about the therapeutic process and overall themes, but not specific details about what information is exchanged during each session. If, at any time, I feel like your child is engaging in dangerous behavior I will immediately inform you of the situation, or have your child do so as part of the therapeutic process. It is important that your child feel that my office is a place where they can trust me enough to share the sensitive things that may be underlying the presenting problem.

I am sensitive to a parent's needs to be involved in the process and that is why parenting and family sessions are typically a regular occurrence during the treatment process. I will not provide you updates after each session, however if you need to speak with me about your child's behavior please call **prior** to their weekly session or arrange a time to come in and speak with me. Please note that additional fees for phone updates lasting longer than 15 minutes will apply (see fee section above).

COUPLES, GROUPS & CONFIDENTIALITY

If you are participating in therapy as part of a couple or a member of a group, please be aware that, though every effort will be made to do so, I cannot completely guarantee your confidentiality will be kept by others participating in the therapy session. The legal concept of privilege also does not apply when more than one client participates in a therapy session. In most cases, this will not impact my ability to keep all information confidential; but in certain (very rare) situations involving legal proceedings I may be unable to assert privilege to protect the content of our sessions. **In all cases, I will always exhaust every legal option available before being compelled to break confidentiality.**

COUPLES THERAPY

In couples' therapy, my client is the couple as a unit, rather than each individual separately. This means that we will work toward agreed-upon goals together, and in the best interest of both partners, rather than exploring the agenda of one person or the other. During relationship counseling, I often recommend that one or both partners seek a separate therapist to work on individual issues that are impacting the relationship; in this case, I will be more than happy to make a referral or recommendation for you.

Please note that in couples' therapy, I do not agree to keep secrets between partners. Information disclosed by either partner in any context may be discussed with the other partner at any time.

CONSENT TO TREATMENT

By signing below you agree that you have read (or have had read to you) all of the above sections of the Informed Consent document and that you understand the risks and benefits associated with the therapeutic process. You understand that you can ask questions about the process at any time. You agree to pay the disclosed fee for services rendered and to provide 24 hours notice to cancel your appointment.

Client Signature (or Parent/Guardian)

Date

Client Signature

Date

Therapist Signature

Date

ALL CLIENTS, initial here:

_____ I have read & agree to the "Waive Right to Subpoena" section.

_____ I have read & agree to the "Cancellation" section.

COUPLES and **PARENTING SKILLS CLIENTS**, initial here:

_____ I have read & agree to the "Couples, Groups & Confidentiality" section.

_____ I have read & agree to the "Couples' Therapy" section, including the "No Secrets" policy.

PARENTS of **MINOR CLIENTS**, initial here (if the child is being seen in therapy):

_____ I have read & understand the "Working with Children" section.

GROUP THERAPY MEMBERS, initial here:

_____ I have read & agree to the "Couples, Groups & Confidentiality" section.

FINANCIAL POLICIES

Manda Turetsky, MS, MBA, EdS, LPC
Flourish Consulting, LLC
at Cornerstone Family Services
2993 Sandy Plains Rd., Ste. 115
Marietta, GA 30066

Scope of Professional Services: By becoming a client of Flourish Consulting, LLC, you are entering into a contract for Manda Turetsky's professional time and services each time you set an appointment. Professional services are not only provided during the appointment time, but also during the 24 hours prior to and following the appointment. These services involve preparation for your scheduled session, case review, case notes, and consultations with other professionals as agreed in writing to assist with your treatment. By entering this contract for my professional time, you are specifically contracting for services to prepare for your session in advance.

Cancellations: My cancellation policy, therefore, requires 24 hours advance notice in order to be released from the contract for time and services. Should you fail – *for any reason* – to cancel an appointment within the 24 hour minimum time period prior to the scheduled session, you will be charged the **full fee** for the missed session. The fee is due and payable before the start of the next session; additional sessions will not be scheduled for clients with outstanding balances due to missed sessions. Please note that insurance companies do not reimburse for missed sessions.

Out of fairness to all clients, please note that this policy includes last-minute cancellations due to illness, emergencies or childcare concerns. Sometimes, mild illnesses such as headaches or stomach pain can indicate anxiety or avoidance about therapeutic issues. In these cases, it is often in your best interest to attempt to attend your session and confront the issue directly.

Self-Payment, Health Insurance and Reduced Fee Slots: Flourish Consulting is a self-pay only practice. I do not participate on insurance panels, nor do I file insurance claims on behalf of my clients. Clients who have out-of-network benefits with their insurance policy may wish to explore the option of applying for reimbursement using a superbill (insurance receipt), which I will provide at your request. Superbills include treatment dates, fees paid, diagnosis, and type of sessions attended. Additional information, such as treatment plan or session summaries, will be provided by written request only, and additional fees are charged for the preparation of these items.

It is important for clients to know that once you submit – or request that I submit – information to an insurance company, I can no longer guarantee the confidentiality of that information. Insurance companies are not bound by the same laws or ethical codes as health professionals. Once released, information such as your treatment history and diagnosis code may be available to future insurers, employers, and others for an indeterminate period of time. In some circumstances, a mental health diagnosis can ‘follow’ an individual indefinitely, and may prevent you or your child from attaining certain types of employment and/or obtaining health insurance in the future. While these types of consequences are rare, they are a serious issue that I recommend giving serious consideration before filing insurance.

Clients who are experiencing financial hardship and cannot afford to pay the full fee for services may choose to apply for a Reduced Fee/Scholarship Slot if one is available. Scholarship slots are generally at off-peak times and/or may require some scheduling flexibility on the part of the client. Clients paying a reduced fee will be asked to re-evaluate their financial needs and ability to pay periodically, so that slots can be made available to others who need them.

Credit Cards and PayPal: Flourish Consulting accepts and prefers cash and personal checks at the time services are rendered. Clients who wish to use credit cards or instant transfer to pay for their sessions must do so via the PayPal system (www.paypal.com). For clients unfamiliar with the PayPal system, I will be happy to provide written instructions and/or a tutorial by telephone as needed in advance of our first session.

PLEASE READ: The following guidelines apply to all payments made via PayPal:

- On top of the agreed-on session fee, there is an **additional \$3 charge per session** paid by credit card.
- Clients must have the following resources to utilize PayPal for session fees:

- A valid, working e-mail address
- A major credit card or bank account confirmed through PayPal (please note that the process of confirming a bank account with the PayPal system can take 3 or 4 days)
- Reliable Internet access
- You may choose to create a PayPal account for convenience, or to pay as a “guest” and re-enter your payment information each time.
- Payment can be made by:
 - Visiting www.PayPal.com and selecting the “Send Money Online” option
 - Enter the amount of your session fee plus the \$3 charge
 - Select the “Buying Something” option and click “Continue”
 - The “to” e-mail address should be: manda@flourishconsulting.com, with your own e-mail address in the “from” field.
 - Follow PayPal’s instructions for entering and confirming your payment information
 - If applicable, under the ‘purchase’ tab, select “This purchase is for... Services.”
 - On the confirmation page, scroll to the bottom and enter “Payment for [Client Number]” as the subject line. I will assign you a client number for use with the PayPal system.
 - Please do not enter a personal message, it will not be read.
- As the client or parent/guardian, it is your responsibility to learn to use the PayPal system before the first session you wish to pay by credit card, and to contact me with any questions or concerns as needed.
- Session fees must be paid in advance of your appointment. For the best use of your time, I recommend making a payment the day before your session so that I can confirm the payment in advance. If payment has not been made or confirmed in advance, clients may choose to take the first few minutes of their session to make the payment in the office with the therapist, or to pay by cash or check.
- Clients who are unable to make a payment at or before the time of the session may have their session canceled and will be charged subject to the cancelation policy above.
- The e-mail address manda@flourishconsulting.com is for use with PayPal payments *only*. Do not send questions, scheduling requests, or personal information to this e-mail address. E-mail is NOT a confidential method of communication appropriate to the therapy relationship, and any e-mails received will be deleted without a response.

PLEASE READ: While I have the utmost confidence that PayPal is a highly reputable and reasonably secure way to send your payment, all clients choosing to pay in this way do so at your own risk. Neither Manda Turetsky, LPC; Flourish Consulting, LLC; or Cornerstone Family Services will be held responsible for errors, loss of funds, or other problems that may be incurred by using the PayPal system. While the risk of compromise of confidentiality is minimal, please note that any use of a third-party system (such as PayPal) may expose your relationship to Flourish Consulting, LLC, in the unlikely event of a security breach or other event.

Please sign below to indicate that you have read and understand the financial policy, cancelation rules and PayPal guidelines.

Client Signature

Date

Client Signature

Date

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records (“privacy rules”), and storage and access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion.

Please read this document as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Manda P. Turetsky, MS, MBA, EdS, LPC

I, _____, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

Client Signature or Parent if Minor or Legal Charge

Date

If Legal Charge, describe representative authority: _____

PRIVACY PROTECTION NOTICE (HIPAA)

Manda P. Turetsky, MS, MBA, EdS, LPC

Flourish Consulting, LLC

At Cornerstone Family Services

2993 Sandy Plains Rd., Suite 115

Marietta, GA 30066

770-380-1288

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This notice shall go into effect January 1, 2009 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

I. Preamble

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. **PHI consists of three (3) components: treatment, payment, and health care operations.**

Treatment refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you.

Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The **use** of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks *within* my office related to your care.

Disclosures refer to activities you authorize which occur *outside* my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate from the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are *my* notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes.

Most of the time I will be able to limit reviews of your protected health information to only your “designated record set” which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of your care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your “designated mental health record.”

You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service over my therapeutic work and refers to these people as “Business Associates.” I do consult with business associates to assist with my administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child or Elder Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out “Duty to Warn” Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s)).

V. Client’s Rights and My Duties

You have a right to the following:

- *The right to request restrictions* on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- *The right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;
- *The right to inspect and receive a copy* of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- *The right to amend* material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- *The right to an accounting of non-authorized disclosures* of your protected health information;
- *The right to a paper copy* of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- *The right to revoke your authorization* of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s).

My duties as a Licensed Associate Professional Counselor on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

VI. Complaints

Jennifer Vann, LMFT, the clinical director of Cornerstone Family Services, LLC is the appointed “Privacy Officer” for my practice per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to contact her immediately about this matter. You will always find her willing to talk to you about preserving the privacy of your protected mental health information. You can reach her by letter at 2993 Sandy Plains Rd., Suite 115 Marietta, GA 30066 or by phone at 770-910-2753. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

RELEASE OF INFORMATION

(Optional)

Manda P. Turetsky, MS, MBA, EdS, LPC

2993 Sandy Plains Rd. Suite 115

Marietta, GA 30066

*** This form is required if you would like for me to be able to speak with another professional (such as a psychiatrist, primary care physician, or another mental health professional) about your case. It is also required if you wish me to release information about our sessions to someone else. The form must be completed in full in order to be valid***

Client's name _____ Date of Birth _____

I hereby request and authorize Manda P. Turetsky, MS, MBA, EdS, LPC :

To **release** the information indicated at right to:

Name _____

(Must be an individual's name. No Organizations)

Address _____

Phone _____

Fax _____

To **request** the information indicated at right from:

Name _____

Address _____

Phone _____

Fax _____

Please check the information you would like released:

- All treatment-related Information
- Treatment Summary
- Treatment Plan
- Clinical Assessment
- Psychiatric Evaluation
- Financial Information
- Attendance
- Other (please describe)

For the purpose of: Coordination of Treatment Other: _____

Medical records frequently contain information which may be privileged and/or confidential. This could include remarks furnished by the client, client's family, or medical staff. If, in the judgment Manda P. Turetsky, MS, MBA, EdS, LPC disclosure of the privileged/confidential information will be harmful to the client, release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, AIDS/HIV, psychiatrics/psychological/and other mental health privileged/confidential information. Certain communications are privileged and not subject to release without your consent understate and/or federal law. Please note that once information has been released to the designated party, neither Manda P. Turetsky, MS, MBA, EdS, LPC nor Cornerstone Family Services, LLC are liable for the misuse of information by that party.

After giving due consideration to the above statement, I authorize Manda P. Turetsky, MS, MBA, EdS, LPC to furnish/receive information, including faxed copies of my Protected Health Information, including matters privileged under the laws of the state of Georgia, and applicable federal laws and regulations, to the above person(s). I further agree to indemnify and hold harmless Manda Turetsky, MS, LPC and Cornerstone Family Services, LLC from all liability that may arise from the release of the information herein requested. I understand that this authorization is subject to revocation at any time *in writing* except to the extent that action has been taken in reliance and is only valid for a period of 1 year from the date of my signature unless I specify another date or event here:

Client/Parent/Legal Guardian Signature

Date