RIVER CAIRN COUNSELING

****If you are filling this out on behalf of the patient, please answer from the patient's perspective. ****

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Sex: Female_____ Male_____ Address: _____

City: _____ State: _____ Zip Code: _____

May I have permission to mail to this address? YES_____ NO_____

Telephone *(Contact will be attempted in order of numbers listed)*

1. (____) ____ - _____ (circle one) cell/home/work/other

2. (____) ____ - _____ (circle one) cell/home/work/other

May I have permission to leave a phone message? YES_____ NO_____

Is discretion needed when contacting or leaving a phone message for you? YES_____ NO_____

Email *(Please avoid using work emails as possible for your own confidentiality)*

_____ (circle one) personal/work

Preferred form of communication: Telephone: _____ Email: _____

Insurance

Primary Insurance Company: _____

ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Address: _____

Policy Holder SSN: _____ Copay Amount: _____

Secondary Insurance Company: _____

ID #: _____ Group #: _____

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What is the primary reason(s) you are seeking services?

How long have you been experiencing the problems that you are seeking treatment for?

Stressors

Given the list of categories below, how much stress is each currently causing you?

	None	Mild Stress	Moderate Stress	Severe Stress
Family				
Friends				
Relationships				
Educational				
Economic				
Occupational				
Housing				
Legal				
Health				

Mental Health History

Have you ever been diagnosed with a mental health disorder? Yes No

Please list any diagnosis you have experienced in the past and if that diagnosis is still a concern for you:

Do you have a history of inpatient psychiatric treatment? Yes No

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Please list any past inpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

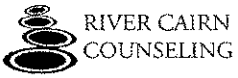
Hospital/ Facility	Treatment Voluntary?	Primary reason for hospitaliztion	How old were you?	Treatment Outcome	Additional Comments

Do you have a history of outpatient psychiatric treatment? Yes No

Please list any past outpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

Provider	Primary reason for seeking treatment	Age of first treatment	Age of last treatment	Outcome	Additional Comments

Have you ever taken any medication for psychiatric treatment? Yes No



If YES, please fill out the table below to the best of your knowledge:

Medication name	Dose	How long? (months)	End Date	Therapeutic effect	Side Effects	Reason for stopping?

Have you ever tried to harm or kill yourself? Yes No
If you answered "no," skip the rest of this question.

Was your intent to die? Yes No
Elaborate below, if desired:

_____
_____
_____

How many times in your life has this occurred? _____

Please describe your most severe episode including date, method, and level of medical attention needed as a result:

_____
_____
_____

Please describe your most recent episode including date, method, and level of medical attention needed as a result:

_____
_____
_____

Have you had any history of violent behavior? Yes No

If YES, please elaborate below:

_____

_____

_____

Substance Use History

Do you have a history of any recreational drug use? Yes No

If YES, please fill out the table below to the best of your knowledge:

Substance(s) Used:	YES	NO	Age of First Use	Age of Last Use	How was it taken? (Circle)	Amount per day	Days per month
Amphetamines / Speed					Oral Nasal Inhaled Injected		
Barbiturates / Downers					Oral Nasal Inhaled Injected		
Opiates					Oral Nasal Inhaled Injected		
Cocaine					Oral Nasal Inhaled Injected		
Psychedelics (e.g. LSD, Ecstasy, bath salts)					Oral Nasal Inhaled Injected		
Inhalants (e.g. glue, aerosols)					Oral Nasal Inhaled Injected		
Cannabis / Marijuana / Hashish					Oral Nasal Inhaled Injected		
Benzodiazepines					Oral Nasal Inhaled Injected		
PCP					Oral Nasal Inhaled Injected		
Nicotine							

Did you receive any treatment for substance abuse? Yes No

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If YES, please fill out the table below to the best of your knowledge:

Treatment Type	YES	NO	How many episodes of treatment?	Age of first treatment?	Age of last treatment?	Any additional treatment information?
Inpatient						
Intensive Outpatient						
Outpatient						
12-Step Program						

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances?
(Please Circle all that apply)

No consequences

Felt that you needed to cut down on your drinking
Been annoyed by others criticizing your drinking
Felt guilty about drinking
Needing a drink first thing in the morning
Increased tolerance
Withdrawal (shakes, sweating, nausea, rapid heart rate)
Seizures
Blackouts
Effects on physical health
Using/consuming more than intended
Unintentional overdose
DUI
Arrests
Physical fights or assaults
Relationship conflicts
Problems with money
Job loss or problems at work/school
Other: _____

Medical History
Who is your primary care physician? _____

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Are you taking any medications currently? (Excluding medications for psychiatric treatment)
Yes No

If YES, please include these medications below:

_____

_____

_____

Please look at the list of physical symptoms below and circle any that you have experienced **in the last several days.**

Constitutional	**Eyes**	**Ears, Nose, Mouth, and Throat**
Chronic pain	Eye pain	Earache
Loss of appetite	Eye discharge	Tinnitus (Ringing in ears)
Increase in appetite	Eye redness	Decreased hearing or hearing loss
Unexplained weight loss	Blurred or double vision	Frequent ear infections
Weight gain	Visual change	Frequent nose bleeds
Fatigue/Lethargy	History of eye surgery	Sinus congestion
Unexplained fever	Sensitivity to light	Runny nose/Post-nasal drip
Hot or Cold spells	Scotomas (Blind spots)	Difficulty swallowing
Night sweats	Retinal hemorrhage (Floaters in vision)	Frequent sore throat
Sleeping pattern disruption	Amaurosis fugax (Feeling like a curtain is pulled over vision)	Prolonged hoarseness
Malaise (Flu-like or Vague sick feeling)		Pain in jaw or tooth
		Dry mouth
Other:	Other:	Other:
None of the above constitutional issues	None of the above eye issues	None of the above ear, nose, mouth or throat issues

Cardiovascular	**Respiratory**	**Musculoskeletal**
Chest pain	Pain with breathing	Swelling in joints
Pacemaker	Chronic cough	Redness of joints

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Cardiovascular	Respiratory	Musculoskeletal
Palpitations (fast or irregular heartbeat)	Chronic shortness of breath	Other joint pains or stiffness
Swollen feet or hands	Chronic wheezing/Asthma	Muscle pain or cramping
Fainting spells	Excessive phlegm	Muscle weakness
	Coughing blood	Muscle stiffness
Shortness of breath with exercise	Nocturnal Dyspnea (Shortness of breath at night)	Decreased range of motion
		Back pain or stiffness
		History of fractures
		Past injury to spine or joints
Other:	Other:	Other:
None of the above cardiovascular issues	None of the above respiratory issues	None of the above musculoskeletal issues

Gastrointestinal		
Excessive flatulence or belching	Heartburn	Change in appearance of stool
Diarrhea	Difficulty swallowing solids or liquids	Blood in stool
Constipation	Recent loss in appetite	Dark/Tarry stool
Persistent nausea/vomiting	Sensitivity to milk products	Loss of bowel control/soiling
Abdominal Pain	Jaundice (yellow skin)	
Other:		None of the above gastrointestinal issues

Allergic/Immunologic	Endocrine	Hematologic/Lymphatic
Frequent infections	Severe menopausal symptoms	Blood clots
Hives	Cold or heat intolerance	Excess/easy bleeding (surgery, dental work, brushing teeth, scrapes)
Anaphylaxic reaction	Excessive appetite	History of blood transfusion
	Excessive thirst or urination	Excessive bruising
	Excessive sweating	Swollen glands (neck, armpits, groin)

Allergic/Immunologic	Endocrine	Hematologic/Lymphatic
Other:	Other:	Other:
None of the above allergic or immunologic issues	None of the above endocrine issues	None of the above hematologic or lymphatic issues

Genitourinary (General)	Genitourinary (Women)	Genitourinary (Men)
Loss of urine control (including bed-wetting)	Unusual vaginal discharge	Slow urine stream
Painful/Burning urination	Vaginal pain, bleeding, soreness, or dryness	Scrotal pain
Blood in urine	Genital sores	Lump or mass in the testicles
Increased frequency of urination	Heavy or irregular periods	Abnormal penis discharge
Up more than twice/night to urinate	No menses (Periods stopped)	Trouble getting/maintaining erections
Urine retention	Currently pregnant	Inability to ejaculate/orgasm
Frequent urine infections	Sterility/Infertility	Any other sexual or sex organ concerns
	Any other sexual or sex organ concerns	
Other:	Other:	Other:
None of the above general genitourinary issues	None of the above sex-specific genitourinary issues	None of the above sex-specific genitourinary issues

Neurological	Integumentary (Skin/Breast and Hair)	Psychiatric
Paralysis	Lesions	In-depth review of psychiatric system appears earlier in document (to be checked by clinician only)
Fainting spells or blackouts	Unusual mole	Feeling depressed
Dizziness/Vertigo	Easy bruising	Difficulty concentrating
Drowsiness	Increased perspiration	Phobias/Unexplained fears
Slurred speech	Rashes	No pleasure from life anymore
Speech problems (other)	Chronic dry skin	Anxiety
Short term memory trouble	Itchy skin or scalp	Insomnia

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Neurological	Integumentary (Skin/Breast and Hair)	Psychiatric
Memory difficulties (loss)	Hair or nail changes	Excessive moodiness
Frequent headaches	Hair loss	Stress
Muscle weakness	Breast tenderness	Disturbing thoughts
Numbness/Tingling sensations	Breast discharge	Manic episodes
Neuropathy (numbness in feet)	Breast lump or mass	Confusion
Tremor in hands/shaking		Memory loss
Muscle spasms or tremors		Nightmares
Other:	Other:	Other:
None of the above neurological issues	None of the above integumentary issues	None of the above psychiatric issues

Please list any health problems and surgeries you have a history of experiencing.

Family History

Do you have any family members with a history of psychiatric illness? Yes No

If YES, please elaborate below:

Is there any additional family medical history?

Developmental and Educational History

During your pregnancy/birth, did your mother have any problems with any of the following:
None of these
Exposure to drugs or alcohol during pregnancy
A difficult pregnancy
Problems with delivery
Other: _____

Did you have any complications after your birth? (e.g. premature birth, jaundice, breathing difficulties) Yes No

Did you have any delays or difficulties in reaching the following developmental milestones?
None of these
Walking
Talking
Toilet training
Sleeping alone
Being away from parents
Making friends
Other: _____

Which options below best describe your childhood home atmosphere?
Normal
Supportive
Parental fighting
Parental violence
Financial difficulties
Frequent moving
Other: _____

Which of the following challenges were experienced during your childhood?
None of these
Tantrums
Enuresis (bed wetting)
Encopresis (fecal incontinence)
Running away from home
Fighting
Stealing
Property damage
Fire setting
Animal cruelty
Separation anxiety
Victim of bullying
Engaged in bullying

Depression
Death of a parent/caregiver
Parental divorce

Which of the following best describe problems you may have had in school?
None of these
Fighting
School phobia
Truancy
Detentions
Suspensions
Expulsions
School refusal
Class failures
Repetition of grades
Special education
Remedial classes

Did you have additional schooling outside of the standard classroom setting?
None of these
Speech classes
Tutoring
Accommodations
Other: _____

What is your highest level of education? _____

If you have any further comments about your developmental or educational history and wish to elaborate further, please do so in the space provided below:

_____
_____
_____
_____
_____
_____

Social History
Which options below best describes your social situation?
Supportive social network
Few friends
Substance-use based friends
No friends
Distant from family of origin

Family conflict
Other: _____

What is your current marital status? _____

What is the status of your intimate relationship?_____

What is the satisfaction level of your intimate relationship_____

What is your sexual orientation?_____

What is your current living situation?_____

Who do you currently live with?
Live alone
Roommates
Partner/Spouse
Parent(s)
Sibling(s)
Children
Other: _____

Do you currently participate in spiritual activities?_____

What is your current occupation status?_____

What is your current yearly income?_____

What is your longest period of continuous employment? (Please include dates and description)
Employment start:_____

Employment end:_____

Description:

_____

_____

_____

What is your longest period of continuous unemployment?
Unemployment start:_____

Unemployment end:_____

Description:

Is there anything else you would like me to know about you?

Thank you for taking the time to complete this!

RIVER CAIRN
COUNSELING

Informed Consent

Welcome to my private practice. Counseling is a relationship that works, in part, because of clearly defined rights and responsibilities held by each person. This document frames those rights and responsibilities, and includes important information about my professional services and business policies. You have certain rights that are important for you to know about because this is your therapy, whose goal is your own personal well-being. There are also certain limitations to those rights that you should be aware of.

CONFIDENTIALITY STATEMENT:

1. You are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA), as outlined with further detail in the **Notice of Privacy Practices**. This means that I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without written permission. You may give written consent for me to share information with whomever you choose, and you can change your mind and revoke that permission at any time.

2. The following are the legal exceptions to your right to confidentiality:

    a. If I have reasonable belief that you are in imminent danger of harming yourself, I may legally break confidentiality and contact law enforcement. Under the provisions of the Health Care Information Act of 1992, only in emergency situations I may also legally speak to another health care provider or a member of your family about you without your prior consent. However, when possible I will explore all other options with you before taking these steps.

    b. If I have reasonable belief that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform the appropriate law enforcement or the Department of Health and Human Services within 48 hours.

    c. If I have reasonable belief that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also inform the appropriate law enforcement and ask them to protect that person.

    **In any of these previous three situations, I will reveal only the information necessary to protect you or the person in danger. I will not divulge everything you have told me.

    d. I may sometimes consult with another professional about your treatment. All counselors are required by law and professional ethics to keep your information confidential. These case consultations/supervision sessions are helpful to both you and me in determining that I am providing you with the best treatment possible. In addition, when I am out of town or unavailable, another counselor will be on-hand to assist my clients. I must provide him or her with information about any clients that might call.

    e. A court order issued by a judge may require the release of information contained in records and/or require a counselor to testify in a court hearing. Please note that I will attempt to gain your consent before commencing communication with a third party.

3. I will always act so as to protect your privacy, even if you provide written authorization to me to share information about you. I will only ever share the minimal information necessary for the situation.

4. Whenever I transmit any of your Protected Health Information (PHI) or other information about you electronically (for example, sending bills or replying to an email from you), it will be done with special safeguards to insure confidentiality.

    a. If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential.

b. A more secure patient portal is provided to you at no additional cost with which you may communicate with me as appropriate.

c. You will only receive "Session Reminders" in a manner you choose and agree to receive, either through email, text, or phone call.

5. There may be times that I have an office manager to complete billing and scheduling tasks for my clients. You will be notified if I have an office manager completing these tasks while I am working with you. The office manager would have limited access to some of your PHI that is necessary to complete these tasks. The office manager will not have access to clinical documents that are not directly required to complete billing/scheduling tasks.

FINANCIAL AGREEMENT

My fees follow established community guidelines and standards of reasonable value. For the initial 90-min session which includes a diagnostic interview, the fee is $180. Following the initial session, the fee starting July 23 is $150 for a 60-min individual session, $120 for a 45-min individual session, and $90 for a 30-min individual session. The fee for a 90-min group session is $40.

Your fee may be a contracted rate with your insurance provider. Please check with your insurance company as to your portion of the fee (i.e. co-pays, deductibles, percentage covered). While I will bill your insurance for you, you are responsible for knowing the limits of your insurance. Private Pay clients may receive a discount up to 30% on the initial session fee, after which individual-session rates can be reduced up to 20% for follow-up sessions.

In the event of an insurance denial of payment, you are financially responsible for the full fee of your sessions.

The full co-pay or fee of $50 or less is due at the start of the session. A minimum of $50 of your co-pay or fee, if more than $50, is due at the start of the session. Payment may be made in cash, check, or credit card. There will be a $25 Returned Check fee for all returned (bounced) checks. If you choose to pay less than 100% of your co-pay or fee at the start of sessions, patient statements are mailed at the beginning of each month and payment is due 30 days later, as indicated by the due date on the statement. If you are unable to pay the fees in full by the due date, we can arrange a payment plan upon your request. **Clients are now required to provide a valid credit card at the time of their initial session for the office to keep in their electronic file.** Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired.

If no payment has been received within 60 days of receipt of patient statement (or 30 days past due), a payment will be automatically charged to the credit card on file. Cards will not be charged without prior notification, and an opportunity to provide alternative payment or set up a payment plan will be offered at that time. Any services left unpaid for 60 days past the due date as shown on your statement, or fees owed that total more than $400, will result in a hold for treatment. Once all services have been paid or a payment plan has been signed, treatment will resume. If a 60 day lapse in payment occurs more than once, we will need to discuss terminating treatment and I will refer you to another provider as needed. If your account has not been paid for more than 90 days past the statement due date, arrangements for payment have not been agreed upon, and the credit card you provide is not valid, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. It is my legal right to disclose this information in the event that I need to collect overdue payment.

For any out-of-session time exceeding 15 minutes per week that I spend responding to your non-emergent phone calls, emails, or in consultation with other providers *that you request*, a fee will be applied to your bill as follows: $40 for 20 minutes, $80 for 40 minutes, $120 for 60 minutes, and an additional $50 for every 20 minutes following the first hour. Insurance companies will not cover these charges. Time that I spend preparing for or traveling to court-related tasks on your case is billed at 200% my normal hourly rate, or $300/hour.

Following the third Late Cancellation within a 90 day period a warning letter will be sent out. Following the second No Show within a 90 day period a warning letter will be sent out. Please see Attendance Policy for definitions. After receiving the warning letter, you will be charged $50 for any Late Cancellation or No Show thereafter. Insurance companies will not cover this charge and it must be paid in full before another session will be scheduled.

My rates are subject to change. You will be notified of changes at least 6 weeks before the changes take effect.

ATTENDANCE POLICY

Engaging and participating in regular treatment will increase the likelihood of experiencing positive results. We will work together to determine the appropriate frequency of your sessions. All clients, whether receiving individual or group services, must first have an initial session with the diagnostic interview before further services may begin.

Your appointment time has been designated for you. If you are late for your session, we will still end on time. If you are more than 20 minutes late, the session will be cancelled and will be considered a No Show. If you cannot attend your appointment, you must cancel at least 24-hours in advance. Cancellations that occur after the 24-hours will be considered Late Cancellations. Cancelling or No Showing more than 3 times in 2 months will result in the need for termination of services. To cancel a session or inform me that you may be late, please call (531) 289- 8246.

If a session has not been scheduled and I have not received contact from you in 3 months, I will assume you are no longer interested in services and close your file. You may return for services and re-open your file in the future if we both feel this is appropriate.

Definitions:

Cancellation: Cancellation of a session more than 24 hours in advance.
Late Cancellation: Cancellation of a session less than 24 hours in advance.
No Show: Not cancelling a session and not coming to session as scheduled, or arriving to appointment more than 20 minutes late.

TERMINATION POLICY

The termination of therapy may be necessary for various numbers of reasons. Most often, termination of services is mutually agreed upon and planned for by both parties. Both parties reserve the right to deny, delay, defer, or discontinue services for any reason.

Termination becomes necessary if I no longer possess the necessary competence to assist you (either due to your changing treatment needs or due to problems of professional competence relevant to stress, distress, burnout, illness, etc.) and/or because I believe that continued treatment would likely be harmful to you. I may also terminate services if I feel threatened or otherwise endangered, if the payment of fees is not upheld as described in the Financial Agreement, or if sessions are not scheduled or attended as agreed upon in the Attendance Policy.

If treatment is terminated for any reason and a client desires to return to services, the initial session may or may not be required by the individual's insurance company within the first 12 months. Following 12 months after termination, if the client desires to return to services a new initial session will be required.

CONTACTING ME

As I spend much of my day in sessions, I may not be immediately available. When I am unavailable, you may leave a message on my confidential voicemail. I monitor voicemail frequently and will make every effort to return your call within the same business day. If this is not possible, then I will respond within the next business day. **If you are experiencing an emergency, do not wait for my response as I cannot guarantee how quickly I will respond to voicemail or email. See below for what to do in times of emergency.** If you

may be difficult to reach, please provide me with times you are available. Over extended periods of time that I am out of the office, I will provide you with contact information for a colleague that you may contact as needed. You may also contact me as appropriate and within reason through email or the patient portal that I monitor and respond to regularly. Please see above information about my electronic communication practices.

EMERGENCIES

In the event of a psychological emergency, call 911 or go to your nearest hospital ER. You may also call the National Suicide Prevention Lifeline at 1-800-273-8255. If we have an established safety plan, follow that safety plan.

STATEMENT OF UNDERSTANDING

Therapy involves sharing sensitive, personal, and private information that may at times be distressing. During the course of therapy, there may be periods of increased anxiety or confusion. This can be a natural part of the healing and change process. I am available to support you throughout this process. The outcome of counseling is generally positive; however, the level of satisfaction for any individual cannot be guaranteed.

I have read the enclosed policies and procedures, asked any questions that I needed to, and understand the terms of this consent. I understand my rights and responsibilities as a client and my counselor's responsibilities to me. I agree to these conditions and consent to treatment.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Counselor Date

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COUNSELING

Debit/ Credit Card Information

Please list your debit/ credit card information below:

Patient Name: _____ DOB: _____

Printed Name (As it appears on card): _____

Card Number: _____

Expiration Date: _____ Security Code: _____

***This form will be shredded as soon as your information is input into my secure system. The information will be saved within the system, but I will be unable to see your credit card's full number nor security code (CVV).**

RIVER CAIRN COUNSELING

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

I. Uses and Disclosures of your PHI for Treatment, Payment, and Health Care Operations

For Treatment. I may use and disclose your PHI for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with my clinical supervisor or other treatment team members, such as your family physician or psychiatrist. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. Health Care Operations refers to activities related to the performance and operation of my practice. I may use or disclose, as needed, your PHI in order to support business activities including, but not limited to, quality assessment, employee review, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

II. Uses and Disclosures Requiring Authorization

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that I have already made a use or disclosure based upon your authorization.

The following uses and disclosures will be made only with your written authorization:

- **a)** Most uses and disclosures of psychotherapy notes, which are separated from the rest of your medical record;
- **b)** Most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications;
- **c)** Other uses and disclosures not described in this Notice of Privacy Practices.

Verbal Permission. I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

Required by Law. Under the law, we must disclose your PHI to you upon your request.

III. Uses and Disclosures Without Consent nor Authorization

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is my practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. In cases that I have reasonable cause to believe that a child is being or has been subjected to abuse or neglect, or if I observe a child being subjected to conditions that may result in abuse or neglect, I am required to report this and may disclose your PHI to the proper law enforcement agency in your jurisdiction or to the Nebraska Department of Health and Human Services.

Adult and Domestic Abuse. In cases that I have reasonable cause to believe that a vulnerable adult is being or has been subjected to abuse or neglect, or if I observe a vulnerable adult being subjected to conditions that may result in abuse or neglect, I am required to report this and may disclose your PHI to the proper law enforcement agency in your jurisdiction or to the Nebraska Department of Health and Human Services.

A "vulnerable adult" is a person aged eighteen years or older for whom a guardian has been appointed under the Nebraska Probate Code, or whom has a substantial mental or functional impairment.

Judicial and Administrative Proceedings. I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Public Safety. I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Family Involvement in Care. I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Public Health. If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Health Oversight. If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Required by Law. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

IV. Your Rights Regarding Your PHI

You have the following rights regarding PHI that I maintain about you. To exercise any of these rights, please submit your request in writing to me/my office.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. You may request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI that I have about you is incorrect or incomplete, you may ask me to amend the information, although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for

purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending an electronic copy to you through the electronic communication mode that you select, or sending a copy to you in the mail upon request.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me at 5539 S. 27, Suite 104 in Lincoln, NE 68512 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201. **I will not retaliate against you for filing a complaint.**

The effective date of this Notice is February 1, 2017.

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of River Cairn Counseling's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact River Cairn Counseling at:

Phone: (531) 289-8246

Email: Christina@rivercairncounseling.com

Address: 5539 S. 27, Suite 104, Lincoln, NE 68512

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Counselor **Date**

RIVER CAIRN
COUNSELING

Informed Consent

Welcome to my private practice. Counseling is a relationship that works, in part, because of clearly defined rights and responsibilities held by each person. This document frames those rights and responsibilities, and includes important information about my professional services and business policies. You have certain rights that are important for you to know about because this is your therapy, whose goal is your own personal well-being. There are also certain limitations to those rights that you should be aware of.

CONFIDENTIALITY STATEMENT:

1. You are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA), as outlined with further detail in the **Notice of Privacy Practices**. This means that I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without written permission. You may give written consent for me to share information with whomever you choose, and you can change your mind and revoke that permission at any time.

2. The following are the legal exceptions to your right to confidentiality:

    a. If I have reasonable belief that you are in imminent danger of harming yourself, I may legally break confidentiality and contact law enforcement. Under the provisions of the Health Care Information Act of 1992, only in emergency situations I may also legally speak to another health care provider or a member of your family about you without your prior consent. However, when possible I will explore all other options with you before taking these steps.

    b. If I have reasonable belief that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform the appropriate law enforcement or the Department of Health and Human Services within 48 hours.

    c. If I have reasonable belief that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also inform the appropriate law enforcement and ask them to protect that person.

**In any of these previous three situations, I will reveal only the information necessary to protect you or the person in danger. I will not divulge everything you have told me.

d. I may sometimes consult with another professional about your treatment. All counselors are required by law and professional ethics to keep your information confidential. These case consultations/supervision sessions are helpful to both you and me in determining that I am providing you with the best treatment possible. In addition, when I am out of town or unavailable, another counselor will be on-hand to assist my clients. I must provide him or her with information about any clients that might call.

e. A court order issued by a judge may require the release of information contained in records and/or require a counselor to testify in a court hearing. Please note that I will attempt to gain your consent before commencing communication with a third party.

3. I will always act so as to protect your privacy, even if you provide written authorization to me to share information about you. I will only ever share the minimal information necessary for the situation.

4. Whenever I transmit any of your Protected Health Information (PHI) or other information about you electronically (for example, sending bills or replying to an email from you), it will be done with special safeguards to insure confidentiality.

   a. If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential.

   b. A more secure patient portal is provided to you at no additional cost with which you may communicate with me as appropriate.

   c. You will only receive "Session Reminders" in a manner you choose and agree to receive, either through email, text, or phone call.

FINANCIAL AGREEMENT

My fees follow established community guidelines and standards of reasonable value. For the initial 90-min session which includes a diagnostic interview, the fee is $180. Following the initial session, the fee is $140 for a 60-min individual session, $110 for a 45-min individual session, and $80 for a 30-min individual session. The fee for a 90-min group session is $35.

Your fee may be a contracted rate with your insurance provider. Please check with your insurance company as to your portion of the fee (i.e. co-pays, deductibles, percentage covered). While I will bill your insurance for you, you are responsible for knowing the limits of your insurance. If you have any questions regarding your statement, please contact me at (531) 289-8246 or through your patient portal.

In the event of an insurance denial of payment, you are financially responsible for the full fee of your sessions.

Your co-pay or fee is due at the start of the session. Payment should be made in cash or check and you will be provided a receipt. There will be a $25 Returned Check fee for all returned (bounced) checks. I do not accept any other forms of payment at this time.

Private Pay clients are required to pay for services in full before the session may begin. If services are unable to be paid, the session will be cancelled. Private Pay clients are responsible for the initial session fee of $180, after which individual-session rates will be reduced by 20% for follow-up sessions.

Your appointment time has been designated for you. If you are late for your session, we will still end on time and your regular session fee will apply. Following the second Late Cancellation a warning letter will be sent out. Following the first No Show a warning letter will be sent out. Please see Attendance Policy for definitions. After receiving the warning letter, you will be charged $50 for any Late Cancellation or No Show. Insurance companies will not cover this charge and it must be paid in full before another session will be scheduled. To cancel a session or inform me that you may be late, please call (531) 289- 8246.

For any out-of-session time exceeding 15 minutes per week that I spend responding to your non-emergent phone calls, emails, or in consultation with other providers *that you request*, a fee will be applied to your bill as follows: $40 for 20 minutes, $80 for 40 minutes, $120 for 60 minutes, and an additional $50 for every 20 minutes following the first hour. Insurance companies will not cover these charges.

Any services left unpaid for 1 month (30 days) following a session, or fees owed that total more than $150, will result in a hold for treatment. Once all services have been paid treatment will resume. If a 1 month lapse in payment occurs more than once, we will need to discuss terminating treatment and I will refer you to another provider as needed.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is

necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. It is my legal right to disclose this information in the event that I need to collect overdue payment.

My rates are subject to change. You will be notified of the rate change at least 6 weeks before the change takes effect.

ATTENDANCE POLICY

Engaging and participating in regular treatment will increase the likelihood of experiencing positive results. We will work together to determine the appropriate frequency of your sessions. All clients, whether receiving individual or group services, must first have an initial session with the diagnostic interview before further services may begin.

Your appointment time has been designated for you. If you are late for your session, we will still end on time. If you are more than 20 minutes late, the session will be cancelled and will be considered a No Show. If you cannot attend your appointment, you must cancel at least 24-hours in advance. Cancellations that occur after the 24-hours will be considered Late Cancellations. Cancelling or No Showing more than 3 times in 2 months will result in the need for termination of services.

If a session has not been scheduled and I have not received contact from you in 2 months, I will mail a 2-week notice for the termination of services. After two weeks, if I still have not heard from you, I will assume you are no longer interested in services and close your file. You may return for services and re-open your file in the future if we both feel this is appropriate.

Definitions:

Cancellation: Cancellation of a session more than 24 hours in advance.

Late Cancellation: Cancellation of a session less than 24 hours in advance.

No Show: Not cancelling a session and not coming to session as scheduled, or arriving to appointment more than 20 minutes late.

TERMINATION POLICY

The termination of therapy may be necessary for various numbers of reasons. Most often, termination of services is mutually agreed upon and planned for by both parties. Both parties reserve the right to deny, delay, defer, or discontinue services for any reason.

Termination becomes necessary if I no longer possess the necessary competence to assist you (either due to your changing treatment needs or due to problems of professional competence relevant to stress, distress, burnout, illness, etc.) and/or because I believe that continued treatment would likely be harmful to you. I may also terminate services if I feel threatened or otherwise endangered, if the payment of fees is not upheld as described in the Financial Agreement, or if sessions are not scheduled or attended as agreed upon in the Attendance Policy.

If treatment is terminated for any reason and a client desires to return to services, the initial session may or may not be required by the individual's insurance company within the first 6 months. Following 6 months after termination, if the client desires to return to services a new initial session will be required.

CONTACTING ME

As I spend much of my day in sessions, I may not be immediately available. When I am unavailable, you may leave a message on my confidential voicemail. I monitor voicemail frequently and will make every effort to return your call within the same business day. If this is not possible, then I will respond within the next business day. **If you are experiencing an emergency, do not wait for my response as I cannot guarantee how quickly I will respond to voicemail or email. See below for what to do in times of emergency.** If you may be difficult to reach, please provide me with times you are available. Over extended periods of time that I am out of the office, I will provide you with contact information for a colleague that you may contact as needed. You may also contact me as appropriate and within reason through email or the patient portal that I monitor and respond to regularly. Please see above information about my electronic communication practices.

EMERGENCIES

In the event of a psychological emergency, call 911 or go to your nearest hospital ER. You may also call the National Suicide Prevention Lifeline at 1-800-273-8255. If we have an established safety plan, follow that safety plan.

STATEMENT OF UNDERSTANDING

Therapy involves sharing sensitive, personal, and private information that may at times be distressing. During the course of therapy, there may be periods of increased anxiety or confusion. This can be a natural part of the healing and change process. I am available to support you throughout this process. The outcome of counseling is generally positive; however, the level of satisfaction for any individual cannot be guaranteed.

I have read the enclosed policies and procedures, asked any questions that I needed to, and understand the terms of this consent. I understand my rights and responsibilities as a client and my counselor's responsibilities to me. I agree to these conditions and consent to treatment.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Counselor Date

RIVER CAIRN
COUNSELING

Adolescent Informed Consent

The purpose of meeting with a counselor is to get help with problems that are bothering you, or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this plan in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself. This may include, only if absolutely necessary, contacting the nearest Emergency Room or law enforcement.

- You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, law enforcement, and I must inform the person who you intend to harm.

- You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- You tell me you, another minor, or a vulnerable adult are being abused (physically, sexually, or emotionally), or that abuse has occurred in the past. In this situation, I am required by law to report the abuse to the Nebraska Department of Health and Human Services. If through professional judgment I determine that the abuse is a current

emergency, I am also required to contact law enforcement and ensure the safety of everyone involved.

- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. **If I feel that you are in such danger, I will communicate this information to your parent or guardian.**

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

Even if I have agreed to keep information confidential, I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/ guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your

school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor or other medical professional and I may need to work together; for example, if you need to take medication in addition to seeing a counselor. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Consent to Treatment:

In the state of Nebraska, an adolescent is considered a minor until the age of 19. Mental health treatment requires the consent of a minor's parent or guardian. The only exceptions to providing treatment without parental or guardian consent include: if the minor is married or emancipated.

RIVER CAIRN
COUNSELING

Adolescent Consent & Parent Agreement to Respect Privacy

Adolescent client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your counselor at any time.

_____

Signature of Client (Minor) Date

Parent/Guardian:

Initial each line and sign below indicating your agreement to respect your adolescent's privacy:

_____ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/ or may be asked to participate in therapy sessions as needed.

_____ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree not to request these records, unless absolutely necessary, in order to respect the confidentiality of my adolescent's treatment.

_____ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/ supervisor.

_____

Signature of Parent, Guardian or Personal Representative Date

_____

Signature of Parent, Guardian or Personal Representative Date

_____

Signature of Counselor Date

Mental Health Treatment
Release of Information

I, _____ [Client name], whose Date of Birth is _____,

authorize River Cairn Counseling to ☐ disclose to and/or ☐ obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed
(Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes*
_____ Other_____
_____ Other_____

(*Cannot be combined with any other disclosure)

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to River Cairn Counseling at 5539 S. 27, Suite 104, Lincoln, NE 68512. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date (No more than 1 year from today's date): _____ or as otherwise indicated: _____
_____

Conditions

I further understand that River Cairn Counseling will not condition my treatment on whether I give authorization for the requested disclosure, except for if the purpose of the treatment is solely to create protected health information (PHI) for disclosure to a third party (e.g., a fitness for duty evaluation). However, it has been explained to me that failure to sign this authorization may have the following consequences:

_____

_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the PHI that is disclosed pursuant to this authorization may be redisclosed by the recipient. I understand that River Cairn Counseling is not responsible for the redisclosure of PHI by the recipient.

I will be given an electronic copy of this authorization for my records. If I would like a physical copy, I will provide written request to River Cairn Counseling at 5539 S. 27, Suite 104, Lincoln, NE 68512.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Counselor Date

Authorization for Electronic Communication

As a convenience to me, I hereby request that River Cairn Counseling communicate with me regarding my treatment by River Cairn Counseling via electronic communications. I understand that this means River Cairn Counseling will transmit my protected health information (PHI) such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any PHI transmitted via electronic communications pursuant to this authorization may not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, River Cairn Counseling shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information between River Cairn Counseling and myself.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize River Cairn Counseling to communicate electronically with me, which will include the transmission of my PHI electronically. I understand that in the event I no longer wish to receive electronic communications from River Cairn Counseling, I may revoke this authorization by providing written notice to River Cairn Counseling at 5539 S. 27, Suite 104, Lincoln, NE 68512.

I agree that River Cairn Counseling may communicate with me electronically unless and until I revoke this authorization by submitting notice to River Cairn Counseling in writing. This authorization does not allow for electronic transmission of my PHI to third parties and I understand I must execute a separate authorization for my PHI to be disclosed to third parties.

I hereby authorize the transmission of my PHI electronically as described above.

_____

Client Name

_____ _____

Signature of Client Date

RIVER CAIRN
COUNSELING

Social Media Policy

Confidentiality and clearly defined boundaries are necessary for the process of therapy to maintain authenticity and effectiveness. As technology advances and social media becomes more prominent in our culture, special caution must be taken to protect the therapeutic relationship between counselors and their clients over the internet. The Social Media Policy details how you may expect me to respond to possible internet interactions we may have.

River Cairn Counseling Website

I maintain a professional website which includes a blog and opt-in newsletters. As a client, you are not required to follow, read, nor comment on my blogs. You are also not required to opt-in to receiving newsletters. Please be aware that if you use an easily recognizable name and choose to comment on a blog, I will need to "approve" the comment before it is posted for the general public to see. Before I approve any comment you make, we will review the purpose and intent of the comment in your next session. If your name is not distinguishable enough for me to determine it is you, then the comment will be approved if appropriate. If you discontinue services with River Cairn Counseling, we will discuss whether future comments you might make will be approved or not. Please also be aware that if I approve a comment, any response I provide to the comment will be generic in nature.

Comments that will not be approved include:

- Comments with inappropriate language
- Comments that identify you as a current/ past client of mine
- Comments that include personal and/or identifying information about yourself, such as phone numbers, addresses, etc.

Facebook

I maintain a professional Facebook page for the River Cairn Counseling business. You are in no way obligated or expected to follow River Cairn Counseling on Facebook, but you are welcome to read or share posts that I make on the page if you desire. If you make any comments on the page, I reserve the right to remove those comments as deemed appropriate. Please be aware that engaging on the River Cairn Counseling page of Facebook increases the possibly of your confidentiality being compromised. Any activity you contribute to the page will also be

discussed in our next session. Please note that if you also maintain a page on Facebook, I will not Like the page or follow the page. Doing so will complicate our working, professional, and therapeutic relationship.

Friending

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.

Following

Just as I have no expectations of you to follow the Facebook page, I also do not expect you to follow River Cairn Counseling's Twitter or Pinterest boards. If you choose to follow River Cairn Counseling on Twitter or Pinterest, the same general guidelines as those described under the Facebook section will be maintained. Keep in mind that any online activity can potentially compromise your confidentiality and privacy. If you choose to follow on Twitter or Pinterest, it may be in your best interest to use a name that is not easily identifiable. If I notice that you are following River Cairn Counseling on any of these sites, we will briefly discuss it and its potential impact on our working relationship in our next session. Please note in advance that I will not reciprocate the follow, as I feel this would be compromising to our relationship. In general, I only follow other professionals, organizations, and leaders in the field.

Communication

Please do not use any social networking site or the River Cairn Counseling website as a means to communicate with me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/counselor relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me, call me at (531) 289-8246 or send me a message through your secure Patient Portal. If you are experiencing an emergency, call 911 or go to the nearest ER.

Search Engines

It is not a regular part of my practice to search for clients on Google, Facebook, or any search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Business Review Sites

You may find River Cairn Counseling or my own name on sites such as Yelp, Healthgrades, Psychology Today, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites, whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

Location-Based Services

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on sites. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis.

Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone.

Email

I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record. I encourage you to set up and use your secure patient portal with Valant to communicate non-emergency information to me.

Conclusion

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions over the internet, please bring them to my attention and we will discuss them in therapy.

** Portions of this Social Media Policy were provided by Dr. Keely Kolmes.**