Janai Bryan, LCSW-S
Licensed Clinical Social Worker License # 57155
650-454-6538

Name_____

Name_____

STANDARDS, POLICIES AND CONSENT FOR COUNSELING

(Read, initial and sign highlighted areas and return back to me via email)

Welcome in taking the first steps towards healing and restoration. Thank you for choosing me to walk alongside you on this journey. It is important to me to co-create a safe and working relationship with you. The relationship we establish is an essential component for the counseling process.

The following information is provided to inform you of my basic policies and procedures. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations.

While this documents is long and complex, it is very important that you understand. When you sign this document, it will represent an agreement between us. We can discuss any questions you have when you sign it or at any time in the future.

STANDARDS AND POLICIES

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety necessary to take risks and have the support to become empowered to change. As a client, you have certain rights that are important for you to know about because this is your therapy which concerns your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities.

SERVICES

My training and experience allows me to provide individual and couples therapy for personal development and treatment of a variety of issues of an emotional, psychological, and spiritual nature. I also have training to treat trauma including EMDR (Eye Movement Desensitization Reprocessing), and Somatic Therapy. If a need for medical treatment is indicated, I can help identify and refer you to a psychiatrist or other medical professionals for evaluation and medical care.

THE PROCESS OF THERAPEUTIC COUNSELING

Participation in therapy can result in a number of benefits to you, including improving interpersonal and spiritual relationships and resolution of specific concerns or symptoms that led you to seek therapy. Although there are no promises or guarantees of what you will experience or what benefits you will receive, counseling has been shown to provide solutions to specific problems, reduce feelings of distress, and improve the quality of

relationships. Part of this experience can also be an increased awareness of feelings like anger, hurt, sadness, guilt, shame and other emotions or memories of unpleasant events. I will help you process your important experiences and emotions. Your therapy is most likely to be beneficial through your active involvement, sincere honesty and your commitment to working on the important relationships in your life. Working toward progress, growth and healing requires a collaborative effort on your part both within and outside of sessions.

CONFIDENTIALITY FOR COUNSELING

Our therapeutic relationship and the content of our sessions is held in the strictest confidence. I will not knowingly acknowledge the relationship and/or any communication concerning you without your express written permission, except in the following circumstances, as required by law.

Please Initial Below:

_____ 1) When there is reasonable suspicion that abuse or neglect of a child, elderly or disabled person has occurred, I am required to file a report with the proper authorities in a timely manner.

_____ 2) When it is reasonable to believe that a client presents a danger to self or others, I may contact medical or law enforcement authorities. In addition, by your initials and signature, you further authorize me to disclose information deemed necessary to a spouse, parent or guardian, and/or to the intended victim.

_____ 3) If my records are subpoenaed by any person or entity, I will contact the you to make you aware of the subpoena and allow you the chance to challenge it through your own legal counsel. With your signature below, you expressly authorize me to comply with any legally issued subpoena and provide records or testimony without the need for a separate authorization or release.

_____ 4) When I am court ordered to testify or provide records to any person or entity.

_____ 5) When the records are requested by any state or federal agency.
_____ 6) Any other circumstance as outlined in the Notice of Privacy Practices

If you and I see each other in a setting other than our sessions, be it public, business or social, I will not speak to you or acknowledge that I know you. It will be your choice to either acknowledge me or not. If you decide to initiate a greeting, I will respond. If you do not, I will not verbally or non-verbally signal you in order to maintain your confidentiality. Your signature below indicates that you have been advised of this policy and you agree to abide by it.

LIMITATIONS OF THERAPY

As a mental health professional, I cannot offer a diagnosis for medical conditions, although I may recommend a medical exam to rule out possible physical issues/problems as a

cause of any mental health symptoms. If you have a known medical condition, please let me know. With your permission, I will work closely with your physician to ensure the compatibility of your treatment. In addition, I cannot prescribe medication. If it is determined that a medical evaluation is appropriate, I may refer you to a psychiatrist who can fully make a determination for medication as a necessary part of treatment. I will not make recommendations regarding custody, visitation or parental access to children or any matters pertaining to the best interest of the child in Suits affecting the Parent Child Relationship (S PCR), adoption or termination proceedings.

STANDARD FEES

I am Licensed Clinical Social Worker of 20+ years and trained in EMDR, Interpersonal Neurobiology (IPNB), Somatic, Internal Family System (IFS), Coherence Therapy and inner healing modalities such as SOZO and Immanuel Approach. My fees are as follows:

$165 per 55 minute session - $175 per 55 minute session **starting 1/01/2023** and prorated for each addition 25 minutes.

Phone Consultation Costs

Telephone consultation fees are charged on a prorated basis in 15-minute increments.

Fees for Depositions and Court Testimony

I prefer to remain uninvolved in clients legal matters, as it often compromises the therapeutic relationship and necessitates referring you, the client, to a new therapist. Fees for depositions and court testimony; including preparation time, point to point travel time, and actual time on location to attend a hearing, give a deposition or testify, as well as the costs of complying with a subpoena for records or testimony regardless of which party issued the subpoena will be billed at the rate of per hour. By your signature below, you agree to pay the rate of per hour for my time, and you agree to pay the itemized charges upon receipt of an invoice.

DURATION AND CHARGES FOR SERVICES RENDERED

The length of therapy is dependent on many factors, including the type and severity of the presented issues. The first few sessions of our work typically involves gathering data and assessment so as to develop a plan for your therapeutic treatment. My fees are consistent with norms for professional counseling in the Austin, Texas area.

REQUEST FOR CLIENT RECORDS

You have the right to review or receive a summary of your records at any time, except in limited legal circumstances or situations when such release might be harmful to you or others. All requests for records must be made in writing. I am required by law to provide records to you within fifteen (15) days of receiving a written request in non-emergency situations.

APPOINTMENTS AND CANCELLATIONS

We will schedule your next appointment at the end of each session. It is the responsibility of the client to remember appointments and allow for traffic delays, work demands and other personal conflicts. Arriving late, missing appointments or late appointment cancellations hinder our ability to provide proper care to you and other clients. I will make every reasonable effort to accommodate changes in your schedule as long as you notify me 24-hours in advance. Appointments canceled less than 24-hours in advance are subject to full charge. Life threatening emergencies, serious illnesses will be considered grounds for waiving such charges at my discretion.

PAYMENT AND INSURANCE

Payment is due at the end of your session unless other arrangements have been made in advance. I accept checks, credit/debit cards or cash (please bring correct change or the difference will be credited to your account). A fee of $25 will be charged for returned checks.

I am considered Out of Network for all insurance and do not file insurance claims for clients. Clients should call their own insurance company to see if they will pay reimbursement for out of network psychotherapy and what the procedure is for the client to file. Your health insurance carrier may require the disclosure of confidential information in order to process your claims. Only information required for billing and authorization will be disclosed. This does, however, require disclosure of diagnostic codes. I will provide the client with these necessary codes to assist them in filing insurance claims. Clients pay in full and they receive a Statement of Services that includes all necessary information so that they can submit to their insurance company for reimbursement. I cannot guarantee insurance reimbursement and it is the responsibility of the client to call their insurance company prior to future counseling appointments.

POLICY ON SOCIAL NETWORKING AND ELECTRONIC COMMUNICATIONS

I am committed to following state and federal confidentiality guidelines for protection of the privacy of client sessions and records. To provide for protection of your privacy, a confidential voice mailbox is available for leaving messages. Should you choose to send an email, I cannot provide or guarantee the protection of the information in an email or text. By signing below, you are acknowledging that you have been informed that if you choose to send an email or text, I cannot ensure confidentiality.

I have a FaceBook Business page and an Instagram account where I post about upcoming workshops, retreats and courses. Please feel free to follow these posts, however I will not engage in any form of therapeutic conversation or acknowledge you as a client. My personal social networking sites are private. Please do not send friend requests or otherwise communicate with me through any interactive or social networking websites. Our primary source of communication is through our sessions. Emails are ok to send and texts are primarily used for scheduling purposes only. Although I do have a system to keep your name confidential, I can not ensure complete confidentiality through emails and text.

EMERGENCIES

I do not provide 24-hour availability of services. If you are experiencing an emergency or crisis after regular business hours, you or someone you trust should call 911, your nearest emergency center, or your medical doctor. If during the course of your counseling experience I assess that you are at risk for harming yourself or others, I may take steps to contact emergency personnel to advocate for your care and safety or the protection of others. Please do not use email, fax or text to communicate emergencies.

TERMINATION OF THERAPY

Together, we will determine when it is appropriate for therapy to end. While you are free to end at any time, it can be more beneficial for you when the end of therapy is intentional. You will have a role in determining when you have accomplished the stated therapeutic goals. In addition, I am ethically bound to terminate therapy if I determine that you are not benefitting from our work together, if I determines that your therapeutic needs are beyond the scope of my training, or if there is a conflict that makes further treatment inadvisable. Should that occur, I will refer you to other therapists who have specialized training or whose treatment might benefit you.

CONTACTS FOR COMPLAINTS OR CONCERNS

If you have any complaints and concerns, I am open to hear them and attempt to resolve them. You may also file a complaint with the Social Work Licensing Board. The Texas Behavioral Health Executive Council regulates the practice of Licensed Clinical Social Workers. You may call the toll-free complaint hot line (1-800-821-3205) to request a complaint form or obtain more information. If you have a complaint concerning the HIPAA Privacy Regulations, you may contact the U. S. Department of Health and Human Services, Office for Civil Rights, at OCRMail@hhs.gov.

INFORMED CONSENT FOR TREATMENT AND SERVICES

Please Initial:

_____I understand the nature of the proposed therapy and I give my informed consent for therapy.

_____I understand the fees for the services to be provided.

_____I understand the limits of confidentiality and have been given the opportunity to ask questions.

_____I understand that the counseling session may vary in length, according to the mutually agreed treatment plan.

_____I agree to give 24 hours advanced notice if I must cancel or reschedule an appointment.

_____ I agree to pay for any missed appointments as set forth in this agreement.

_____I understand that if I experience a medical or psychiatric emergency, I have been advised to dial 911 or go to nearest emergency room, and I agree to abide by these instructions.

I have read this entire agreement carefully. I understand the terms of this agreement and I agree to comply with them. I agree that this agreement will stay in effect until I revoke it in writing. I understand that any written revocation must be dated and include the date of this agreement. A copy of this agreement has the same force and effect as the original. I have received and read the HIPAA Notice of Privacy Practices.

Client Printed Name(s):

_____

Client Signature(s):

_____

Date: _____

NOTICE OF PRIVACY ACTS - signature required at the end of this section

This notice describes how your Personal Health Information (PHI) may be used and disclosed and how you can get access to this information, please review it carefully.
If you have any questions about this Notice of Privacy Practices, please contact me.

INTRODUCTION

I am required by law to maintain the privacy of Protected Health Information ("PHI"), to provide individuals with notice of legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition, and relates to the provision of health care or payment for the provision of health care for your past, present or future physical or mental health or condition and related healthcare services. This Notice of Privacy Practices ("Notice") describes how I may use and disclose PHI to carry out treatment, obtain payment or perform our health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you. I am required to follow the terms of this Notice currently in effect. I reserve the right to change the practices and this Notice and to make the new Notice effective for all PHI I maintain. Upon request, I will provide any revised Notice to you.

MY PLEDGE

The privacy of your personal health information (PHI) is important to me. I will not use or disclose PHI about you without your written authorization, except as described in this Notice. Our privacy practices must be followed by all of our employees, contractors, and staff.

HOW YOUR PHI MAY BE USED AND DISCLOSED

The following categories describe different ways that I may use and disclose your PHI. For each category of use or disclosure, an explanation of what is meant and some examples are provided. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose PHI will fall within one of the categories.

- **For Treatment**: I may use or disclose your PHI to provide and coordinate the mental health treatment and services you receive. For example, if your mental health care needs to be coordinated with the medical care provided to you by another physician, I may disclose your health information to a physician or other healthcare provider.. I will secure your written authorization to disclose this information in these situations.
- **For Payment**: I may use and disclose your PHI for various payment related functions so that I can bill for and obtain payment for the treatment and services I provide for you. For example, your PHI may be provided to an insurance company so that they can reimburse you for claims you submit. Also, your PHI may be provided to other third party payers.
- **For Healthcare Operations**: I may use and disclose your PHI for certain operational, administrative and quality assurance activities, in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, such as conducting training programs or surveys for feedback on courses.

- **For Special Purposes**: I am permitted under federal and applicable state law to use or disclose your PHI without your permission only when certain circumstances may arise, such as the following:
- I**ndividuals Involved in Your Care or Payment for Your Care**. With your authorization, I may disclose to a member of your family, a relative, a close friend or any other person you identify your PHI that directly relates to that person's involvement in your health care. If you do not authorize such a disclosure, I may disclose such information as necessary if I determine that it is in your best interest based on my professional judgment.
- **Disclosures to Parents or Legal Guardians**. I may release PHI to parents or legal guardians when I am permitted or required under federal and applicable state law.
- **Worker's Compensation**. I may disclose your PHI to the extent authorized by and necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- **Public Health**. I may disclose your PHI to federal, state, or local authorities, or other entities charged with preventing or controlling disease, injury, or disability for public health activities.
- **Health oversight activities.** I may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for my licensure and for government monitoring of the health care system, government programs, and compliance with federal and applicable state law.
- **Law Enforcement**. I may disclose your PHI for law enforcement purposes as required by law or in response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about a death resulting from criminal conduct; about crimes on the premises or against a member of our workforce; and in emergency circumstances, to report a crime, the location, victims, or the identity, description, or location of the perpetrator of a crime.
- **Judicial and administrative proceedings**. If you are involved in a lawsuit or a legal dispute, I may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **United States Department of Health and Human Services and/or Texas Board of Behavioral Health Executive Council**. Under federal law,I am required to disclose your PHI to either of these two government agencies to determine if I am in compliance with federal laws and regulations regarding the privacy of PHI.
- **Notification**. I may use or disclose your PHI to assist in a disaster relief effort so that your family, personal representative, or friends may be notified about your condition, status, and location.
- **To Avert a Serious Threat to Health or Safety.** I may use and disclose your PHI to appropriate authorities when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public. I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.
- **Military and Veterans**. If you are a member of the armed forces, I may release your PHI as required by military command authorities. I may also release PHI about foreign military personnel to the appropriate military authority.
- **National Security, Intelligence Activities and Protective Services for the President and Others.** I may disclose your PHI to authorized federal officials for intelligence, counterintelligence, provision of protection to the President, other authorized persons or foreign heads of state, and other national security activities authorized bylaw.
- **Appointment Reminders.** I disclose PHI when I provide you with appointment reminders (such as an email reminder or text messages). You have a right, to request restrictions or limitations on this PHI disclosed. You also have a right, to request that information be communicated with you in a certain way or at a certain location.
- **As required by law**. I must disclose your PHI when required to do so by applicable federal or state law.

Uses and Disclosures of Your PHI Requiring Your Authorization

I will obtain your written authorization before using or disclosing your PHI for the following purposes which are other than those described above (or as otherwise permitted or required by law):

- **Psychotherapy Notes**. I will not use or disclose psychotherapy notes without your written authorization, and only as permitted by law.
- **Marketing Health---Related Services**. I will not use or disclose your PHI for marketing communications without your written authorization, and only as permitted by law.

If you give us an authorization for use of your PHI for any purpose, you may revoke it by submitting a written notice to me via email. Your revocation will become effective upon the receipt of your written notice. If you revoke your authorization, I will no longer use or disclose health information about you for the reasons covered by the written authorization. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale of your PHI. I will not sell your PHI under any circumstances**.**

CHANGES TO THIS NOTICE

I reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I will reserve the right to make the changed Notice effective for all health information that is maintained, including health information I created or received before I made the changes. When I make a change in my privacy practices, I will change this Notice and make the new Notice available to you.

YOUR HEALTH INFORMATION PRIVACY RIGHTS

You have privacy rights under federal and state laws that protect your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think that your rights are being denied or your health information isn't being protected. I must comply with your rights as follows:

To Request Restrictions on Certain Uses and Disclosures of PHI. You have the right to request restrictions on our use or disclosure of your PHI by sending a written request to the Privacy Office. I am not required to agree to those restrictions. I cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business. I must agree to the request to restrict disclosure of PHI to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a health care item or service for which you, or another individual other than a health plan on behalf of you, has paid us in full.

To Request Confidential Communications. You have the right to request that PHI be communicated to you by alternative means or at alternative locations. For example, you can ask that you only be contacted at work or by mail. I will accommodate all reasonable requests.

To Access PHI. You have the right of access to inspect and obtain a copy of your PHI. You may not be able to obtain all of your information in a few special cases such as, if I determines that the information may endanger you or someone else. In most cases, your copies must be given to you within fifteen (15) days.

In accordance with Texas law, you have the right to obtain a copy of your PHI in electronic form for records that I maintain using an Electronic Health Records (EHR) system capable of fulfilling the request. Where applicable, I must provide those records to you or your legally authorized representative in electronic form within fifteen (15) days of receipt of your written request and a valid authorization for electronic disclosure of PHI.

To Obtain a Paper Copy of This Notice Upon Request. You may request a copy of the current Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy.

To Request an Amendment of PHI. If you feel that PHI I have about you is incorrect or incomplete, you may request an amendment to the information. Requests must identify: (i) which information you seek to amend, (ii) what corrections you would like to make, and (iii) why the information needs to be amended. I will respond to your request in writing within 60 days (with a possible 30a day extension). In our response, I will either: (i) agree to make the amendment, or (ii) inform you of our denial, explain our reason, and outline appeal procedures. If denied, you have the right to file a statement of disagreement with the decision. I will provide a rebuttal to your statement and maintain appropriate records of your disagreement and our rebuttal.

To Receive an Accounting of Disclosures. You have the right to request an accounting of your PHI disclosures for purposes other than treatment, payment or healthcare operations. Your request must state a time period. The time period for the accounting of disclosures must be limited to less than 6 years from the date of the request. I will respond in writing within 60 days of receipt of your request (with a possible 30 day extension). I will provide an accounting per 12 month period free of charge, but you may be charged for the cost of any subsequent accountings. I will notify you in advance of the cost involved, and you may choose to withdraw or modify your request at that time.

To Notification in the Event of a Breach. You have a right to be notified of an impermissible use or disclosure that compromises the security or privacy of your PHI. I will provide notice to you as soon as is reasonably possible and no later than sixty (60) calendar days after discovery of the breach and in accordance with federal and state law.

To File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our privacy official, listed below. You may also file a complaint directly with any or all of the following federal and state agencies: The Secretary of the Department of Health and Human Services, the Office of the Attorney General of Texas, or the Texas Behavioral Health Executive Council. I will provide you with the addresses to file your complaint with the Secretary, the Office of the Attorney General of Texas and/or the Texas Behavioral Health Executive Council upon request. You will not be penalized in any way for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of The Notice of Privacy Practices ("Notice"), which describes how my health information may be used and shared. I understand that

My signature below acknowledges that I have been given a copy of the Notice of Privacy Practices.

Client Printed Name(s):

_____

Client Signature(s):

_____

Date: _____