Stephanie A. DePalmer, M.Ed., LPC, NCC
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WELCOME!

Treatment Consent

Client name: ____ DOB: ______________

By my signature below, I am providing consent to treatment for myself, or for my child and I am expressing an understanding and an agreement of the details of this document.

I consent to treatment for myself, or for my child. I understand that counseling services offered by Stephanie DePalmer are voluntary, and I am entering treatment (or beginning treatment for my child) on my own free will. I understand that I may terminate treatment at any time.

I understand that psychotherapy is not easily described in general statements. It varies depending on the personalities of the counselor and the client, and the particular problems I bring forward. I understand that there are many different methods that the therapist may use to deal with the problems that I wish to address. Psychotherapy is not like a medical doctor visit. Instead it calls for a very active effort on my part. In order for my therapy to be most successful, I will have to work on things we talk about both during sessions and at home.

I understand that psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of my life, I may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, I understand that there are no guarantees of what I will experience.

Contact: I understand that Stephanie DePalmer is available by email and telephone. However, I understand that phone and email are not appropriate ways to gain “treatment,” and I will use these means of contact only for scheduling purposes and/or brief check-ins when needed. I understand that telephone and email are not entirely secure and confidential. I understand that the clinician office hours vary, and while she may be in the office, she will not answer the phone when she is with clients. When she is unavailable, her phone is answered by a confidential voice-mail. I realize that she will make every effort to return my phone call in a timely manner, with the exceptions of weekends and holidays. If I am difficult to reach, I will provide some times when I am most available.

I understand that if I am in an emergency and Stephanie DePalmer is unable to be reached and I feel I cannot wait for a returned phone call I will contact my family physician or the nearest emergency room, or I will call 911. If Stephanie DePalmer will be unavailable for an extended period of time she will provide me with avenues for support if necessary during her absence.

Emergencies: In an emergency situation in which one's physical safety is in danger or there is a need for hospitalization, I will contact 911 or Crisis Intervention for my specific county. These numbers are listed below:

Cumberland County: 717-763-2222	Carlisle Area: 717-243-6005
Dauphin County: 717-232-7511	Lebanon County: 717-274-3363
Lancaster County: 717-394-2631	York County: 1-800-673-2496

Professional Records: I understand that the law and standards of the profession require Stephanie DePalmer to keep treatment records. I am entitled to receive a copy of my records, or a summary of these records. Because these are professional records, they have the potential to be misinterpreted and/or upsetting to untrained readers. If I wish to see my records, I can review them with Stephanie DePalmer so that we can discuss their contents. I understand that I will be charged an appropriate fee for any professional time spent responding to information requests.

Minors: I understand that for clients who are under the age of 14, the law may provide parents the right to examine treatment records. It is Stephanie DePalmer's policy to request agreement from parents that they agree to give up access to my records. If my parents agree, my therapist will provide them only with general information about our work together, unless the clinician feels there is a high risk that I will harm myself or someone else. In this case, she will notify my parents of her concern. Prior to giving them any information, we will discuss the matter together, if possible, and do our best to handle any objections I might have with what we are prepared to discuss.

Confidentiality: In general, the privacy of all communications between a client and a therapist is protected by law. I understand that information given to my provider will not be shared with any source outside of my insurance company (if applicable) without my expressed written permission. My clinician can only release information about our work to others with my written permission. However, there are a few exceptions:

In most legal proceedings, I have the right to prevent Stephanie DePalmer from providing any information about my treatment. In some proceedings involving child custody and those in which my emotional condition is an important issue, a judge may order my therapist's testimony if s/he determines the issues demand it.

There are some situations in which Stephanie DePalmer is legally obligated to act to protect others from harm, even if she has to reveal some information about a client's treatment. For example, if she believes a child is being abused, she must file a report with the appropriate state agency.

If she believes that a client is threatening serious bodily harm to another, she is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm herself/himself, she may be obligated to seek hospitalization for her/him or to contact family members or others who can help provide protection.

These situations rarely occur in Stephanie DePalmer's practice. If a similar situation occurs, she will make every effort to fully discuss it with you before taking any action.

Consultation and Coordination: Stephanie DePalmer will occasionally find it helpful to consult with other mental health or medical professionals about a case. During a consultation, she makes every effort to avoid revealing the identity of her clients. The consultant is also legally bound to keep the

information confidential. My clinician will not be required to tell me about these consultations unless she feels it is important in our work together.

I understand that, with my consent, Stephanie DePalmer may provide brief summary updates periodically to my Primary Care Physician.

If there are other concerns that come up for me, I agree to speak with Stephanie DePalmer directly, as she welcomes open communication in order to meet the unique needs of each individual.

Fee for Services:

Payment of fee or accepted co-payment/co-insurance is expected at time of visit. Cash, check, or major credit cards are accepted. Charges may apply for services other than direct client care (e.g. requests for reports, telephone consults, and photocopies). Stephanie DePalmer may file claims for the insurance company, Highmark Blue Shield.

Every effort is made to resolve outstanding charges mutually with clients. However, delinquent, unpaid outstanding balances which are considered to be your responsibility may be referred to a Collection Agency and subject to additional fees.

An office support person will be available to do insurance billing and to answer billing concerns. This person will not be available for routine inquiries.

☐ I have read the three pages of this document and understand the above information.

____ _______________
Client Signature (age 14 and over) Date

____ _______________
Parent/Legal Guardian Signature (for clients under age 14) Date

HIPAA COMPLIANCE NOTICE

New Federal Law Health Insurance Portability and Accountability Act (HIPAA) for Protecting Client Behavioral Health Information

THIS NOTICE DESCRIBES HOW BEHAVORIAL HEALTH INFROMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes without your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"

– *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
– *Payment* is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
– *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my practice such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

***I may use or disclose PHI without your consent or authorization in the following circumstances*:**

- *Child Abuse* – We are required to report PHI to the appropriate authorities when I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.

- *Adult and Domestic Abuse* – If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- *Health Oversight Activities* – If various Pennsylvania Boards overseeing mental health services are conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena from a Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.
- *Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient/Client's Rights and Therapist's Duties

Patient/Client's Rights:

As with any services that are provided by professionals, you have client rights that you should be fully aware of and understand. These client rights are outlined below. If you have any questions about these client rights, they should be fully discussed with your counselor.

Right to communicate

- Every client has the right to receive an orientation to my counseling services, which includes the responsibilities of the counselor and client, what services will be provided, and what they will cost.
- Every client has the right to an individual treatment plan to meet your mental health needs that are in accordance with state and federal laws.
- Every client has the right to communicate freely and privately with others, including his/her counselor.
- Every client is encouraged to freely communicate their needs and opinions regarding their treatment and the operation of the private practice.

Right to confidentiality

- Every client has the right to expect that all records concerning his/her treatment shall be kept confidential and shall only be released by the written permission of the client except in the circumstances outline on the consent to treat form.
- Every client has the right to have their issues heard within a confidential relationship and to leave treatment should they feel treatment is not safe or useful.
- Every client has the right to examine his/her personal records, subject to the limitations as discussed with your counselor.
- Every client has the right to receive a copy of any consent form that he/she has signed.
- Every client has the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, thus in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to request restrictions

- Every client has the right to request restrictions on certain uses and disclosures of protected health information (PHI). However, I am not required to agree to a restriction that you request.

Right to a humane physical and psychological environment

- Every client has the right to treatment in a setting, which preserves and promotes physical and psychological dignity
- Every client has the right to be treated humanely, respectfully, and with consideration by all staff members

Right to treatment

- Every client has the right to expect scheduled treatment sessions to begin on time and to be notified within a reasonable period of time if the therapist needs to cancel or reschedule your appointment.
- Every client has the right to be treated as an individual and evaluated according to his/her individual needs.
- Every client has the right to receive treatment designed to aid and promote recovery. The client has the right to collaborate in the development in the of his/her treatment.
- This treatment shall be in the least restrictive setting to provide adequate treatment.
- Every client has the right to expect that he/she will be treated by a competent counselor.
- Every client has the right to refuse any treatment or procedure offered by the counselor. Staff shall inform the client that he/she may be discharged or referred for refusal to fully participate in treatment.
- Every client has the right to be discharged as soon as treatment is no longer necessary. Every client shall assist in planning activities following discharge that provide continued recovery and emotional health.
- Every client has the right to examine and receive an explanation of his/her balance due statement.
- Every client has the right to request reconsideration of any decision to terminate his/her treatment.

Right to religious freedom

- Every client has the right to follow and practice his/her religion. Substantiated ethical convictions held independently of a belief in any religion shall be accorded the same respect as a religious belief.

Nondiscrimination

- Admissions, the provision of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, marital status, sexual orientation, ethnicity, national origin, age, sex, or Limited English Proficiency. Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. Accessibility for language needs will be provided where reasonably feasible and available. A referral to another provider to overcome language barriers may be necessary and in the best interest of the client.
- Every client shall retain all civil rights and liberties except as provided by law. No client shall be deprived of any civil rights solely by reason of being a client.

Therapist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will post a notice that they have been changed. A copy of these changes will be made available to you upon your request.

V. Complaints

Grievance and appeal procedures

- Any client has the right to present a grievance and/or initiate a complaint orally or in writing, concerning the quality of the services and treatment. The client may deliver the complaint to the counselor and/or governing agencies and be assured that this will no way negatively impact their care.

If you are concerned that I have violated your privacy rights, or you disagree with a decision I have made about access to your records, you may contact me at any time. Any client may also send a written complaint to any of the following:

Stephanie DePalmer, M.Ed., LPC, NCC
20 Erford Road, Suite 101
Lemoyne, PA, 17043
Email: stephdepalmer@gmail.com

Bureau of Equal Opportunity
Room 223 Health and Welfare Building
PO Box 2673
Harrisburg, PA 17105

U.S. Dept. of Health & Human SVCS
Suite 372, Public Ledger Bldg.
150 S. Independence Mall West
Philadelphia, PA 19106-9111
PA Human Relations Commission
Harrisburg Regional Office
Riverfront Office Center
1101 S. Front St., 5th Floor
Harrisburg, PA 17104

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003

It is my practice to disclose the minimal amount of information from your record that is necessary to meet the purpose of the situation at hand.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. A notice will be posted on the bulletin board if there is a change. In compliance with 2013 changes to the HIPAA Privacy Rules, the following addendum to the Privacy Policy is effective as of September 23, 2013.

If there is a breach of your confidentiality, then I must inform you as well as Health and Human Services. A breach means that information has been released without authorization or without legal authority unless I, Stephanie DePalmer, M.Ed., LPC, NCC, can show that there was a low risk that the PHI has been compromised because the unauthorized person did not view the PHI or it was de-identified.

If you are self-pay, then you may restrict the information sent to insurance companies. Most uses and disclosures of psychotherapy notes and of protected health information for marketing purposes and the sale of protected health information require an authorization. Other uses and disclosures not described in the notice will be made only with your written authorization. You must sign an authorization (release of information form) for releases unless it is for purposes already mentioned in this Privacy Notice (such as mandated reporting of child abuse, reporting of elder abuse, reporting of impaired drivers, etc.).

You have a right to receive a copy of your Protected Health Information in an electronic format or (through a written authorization) you have the right to designate a third party who may receive such information.

By signing below, you agree that you have read and understand the above HIPPA Compliance Notice and that you have also received a copy of this notice for your records.

Signature: ____ Date: _______________________

Client Responsibilities

As with any services that are rendered by professionals, you have client responsibilities that you should thoroughly understand. If you have any questions about these client responsibilities, these should be fully discussed with your counselor. The following are your responsibilities as a client:

- Give your counselor the information they need to provide you with appropriate care.
- Follow your counselor's recommended plans and instructions for care. Participate in the treatment process with a focus on goal-setting and by the development of a mutually agreed-upon treatment plan.
- Inform your counselor of any changes in your health insurance coverage, home address or telephone number.
- Keep scheduled appointments and be sure to give at least 24-hour advance notice if you must cancel an appointment.
- Assist us in obtaining any necessary pre-authorization for treatment from your insurance carrier.
- Make payment for all insurance co-payments and deductibles at the time of service.
- Pay for the cost of your treatment. We will be glad to assist you in obtaining proper payment from your insurance carrier.

By signing below, you agree that you have read and understand the above client rights and responsibility information. You also agree that anything that you did not understand about these rights and responsibilities as a client have been explained to you adequately by your therapist.

____ _______________

Client (if over the age of 14) or Parent\Guardian Signature Date

Assistance Between Visits

Currently, I provide counseling services by appointment during evening hours on Wednesdays. Due to being a sole practitioner, I am unable to provide 24-hour, 7 days a week crisis services to clients. In the event you experience a crisis, please contact:

Crisis Intervention
Camp Hill Area/Cumberland County: 717-763-2222
Carlisle Area: 717-243-6005
Dauphin County: 717-232-7511
Lebanon County: 717-274-3363
Lancaster County: 717-394-2631
York County: 1-800-673-2496
All Other Areas: 866-350-HELP or 911

Global Crisis Text Line: Text "PA" to 741-741
National Suicide Prevention Hotline: 1-800-273-TALK

Walk-in service locations:
Holy Spirit Hospital: Emergency Room
503 N. 21st Street, Camp Hill, PA 17011

Use of Email and/or Text Messaging

Email and text messaging have become convenient forms of communication. However, electronic forms of communication are not completely confidential. I am the only one who reads and responds to emails and text messages. Please note, email and text messaging will only be used for the purposes of scheduling/re-scheduling appointments or answering simple questions about billing, co-pays, hours of operation, etc. Therapy-type questions or comments (such as "do you think...?" or "should I do...?" etc.) should be addressed during the therapy session. In the event of a crisis situation, please contact one of the crisis intervention services listed above at the number listed above or go to the nearest emergency room.

Grievance

A fair hearing will be available to any individual for whom services have been denied, reduced or terminated, or who is otherwise aggrieved. I will make every attempt to resolve any grievance and continue, within the limits of our policies, to provide care to promote the optimum mental health and well-being for the client.

If a client or family-member is dissatisfied with any aspect of service provided, the following steps should be taken:

1. Discuss the concerns with the counselor to pursue a resolution. I will respond as quickly as possible to your questions and concerns.
2. If, however, you are still not satisfied, please contact the following:

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building #32
P.O. Box 2675
Harrisburg, PA 17105-2675
717-787-6443

Financial Policy

Payments: My policy is to collect from the client any amounts not covered by the insurance company on the day the services are rendered. Please keep your account current by paying on the day of service any amount not covered by insurance. Currently, cash, check, or credit cards are accepted. Accounts that are not current will be billed and are due upon receipt. A service charge of 10% may be assessed on accounts that are 60 days past due. There may be a $10.00 handling fee for all returned checks. Delinquent, unpaid outstanding balances which are considered to be your responsibility may be referred to a Collection Agency and subject to additional fees.

Should a financial situation arise that hinders you from making your payments on time, I ask that you call my office to discuss the situation. If we are informed that there is a problem, I can do my best to work with you in keeping your account current.

Insurance: Please read your policy books and/or talk to your benefits coordinator to be fully aware of any limitations or exclusions. You are responsible for any charges the insurance does not pay.

Miscellaneous: From time to time there may be miscellaneous charges, i.e., letters to interested parties, telephone charges, court appearances, etc. These charges will normally not be paid by insurance and will be your responsibility.

No Show/ Late Cancellation: There is a $50.00 charge for missed appointments unless 24-hour notice is given, or it is a true emergency. Two late cancellations (less than 24-hour notice) or two no shows could result in your file being closed. **Cancellations can be made by calling 814-279-8274**.

Collections:

Should an account become 60 days past due it will be subject to my collections process.

I will handle session fees in the following manner:

______ I will pay in full each time

______ I will pay in full and seek reimbursement from my insurance company.

______ I will pay the insurance deductible and co-pay each time and assign insurance benefits to go directly to the provider.

______ I would like to discuss an extended payment plan.

BY SIGNING BELOW, YOU AGREE THAT YOU HAVE READ, UNDERSTAND, AND RECEIVED A COPY OF THIS FINANCIAL POLICY STATEMENT.

______________________________________ ______________________

Signature Date

Stephanie A. DePalmer, M.Ed., LPC, NCC
3461 Market Street, Suite 104, Camp Hill, PA 17055
Cell: 814-279-8274 Office: 717-730-8555
stephdepalmer@gmail.com Fax: 717-730-4566

Client Information:

Client Name: ____ Date of Birth: ________________

Gender: [ ] Male [ ] Female [ ] Non-binary Ethnicity: ____________________________

Home Address: ____

E-mail Address: ____

Home Phone Number: ____________________ May we leave a message? [ ] Yes [ ] No

Work Phone Number: ____________________ May we leave a message? [ ] Yes [ ] No

Mobile Phone Number: ___________________ May we leave a message? [ ] Yes [ ] No

Current employment status of client:

[ ] Employed Full-Time
[ ] Employed Part-time
[ ] Unemployed
[ ] Self-employed
[ ] Student
[ ] Other: _____________________

Marital status of client:

[ ] Single
[ ] Have a partner
[ ] Married, Length of time: ___________________
[ ] Separated, Length of time: ________________
[ ] Divorced, Length of time: _________________
[ ] Widowed, Length of time: _________________

If the above client is a minor, please complete the following (if applicable):

Name of Parent/Guardian: ____

Address of Parent/Guardian: ____

Email Address: ____

Home Phone: ______________________ May we leave a message? [ ] Yes [ ] No

Work Phone: _______________________ May we leave a message? [ ] Yes [ ] No

Mobile Phone: ______________________ May we leave a message? [ ] Yes [ ] No