Client Information Sheet

Women's Solutions, LLC
1 East Broad Street, Suite 130-1073, Bethlehem, PA 18018
610.866.6855 / wsolv@yahoo.com
Jackie L. Gower, M.Ed., LPC

Client Information:

Name _____
Address _____
City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____
EMAIL _____ Date of Birth _____

Current Medications _____
Previous Dates of Counseling _____

Person to Contact in the event of an Emergency _____
Phone ( ) _____ Relationship to Client _____

Reason for Seeking Counseling:

Person responsible for Payment (if other than yourself): ☐ Check if information is same as above
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone ( ) _____ Work Phone ( ) _____
Date of Birth: _____ Relationship to the Client: _____

Contact:

May I leave a message on your phone? ☐ Yes ☐ No
☐ Home: _____ ☐ Cell: _____ ☐Work: _____

May I email? ☐ Yes ☐ No
☐ Personal: _____ ☐ Work: _____

May I text message your cell phone? ☐ Yes ☐ No

I understand that I am responsible for any portion of my bill that insurance does not cover. This includes *DEDUCTIBLES* and *CO-PAYS*. I also understand that 24 hours' notice must be given for a missed appointment, or I will be charged the *No Show* fee of $75.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

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INFORMED CONSENT

Welcome to **Women's Solutions!** As a new client, I appreciate the opportunity to provide you with quality care. To make your session most helpful, this form clarifies what you might expect to receive from counseling and of my counseling policies.

What is counseling and how does it help? Counseling is designed to help solve problems and change patterns by making changes in feelings, thoughts, and behaviors. The relationship between us is the fundamental and essential ingredient to counseling. The initial focus of counseling is on understanding thoughts, emotions and behaviors, and the life situations that concern you. Counseling then offers you support, skills, and direction to make desired changes. We will determine your goals for counseling and the probable length within the first few sessions and will re-evaluate them often. Length of therapy varies. We agree to end counseling when we agree that your goals have been satisfactorily addressed or there is some other reason to end. *You have the right to end counseling at any time*. I would ask that you discuss your decision for at least one session before you finish.

There are benefits as well as risks to counseling. A positive counseling experience offers you the opportunity to learn about yourself, to develop skills, and to integrate both past and present life experiences leading to improved coping strategies and more satisfying relationships. The risks associated with counseling include the awareness of negative or uncomfortable feelings and situations, some of which may not be changed to your satisfaction. While counseling is expected to be helpful, there is no guarantee that counseling will be the best way to reach your desired goals. Every counseling experience is unique, and it is important that you feel free to discuss any concerns you have about the course of treatment. As a client, you have the right to seek a second opinion from another therapist.

In my experience, I have found three ways you can increase the benefit of our work together:

1. Be honest with yourself and your therapist.
2. Push yourself to talk about things you find the hardest to discuss. Issues kept hidden tend to grow in the dark. Bringing them out is a big step toward making them more manageable.
3. Between our sessions, do the work we agree you need to do. Changing one's thoughts, feelings and/or relationships requires practice. What you do in between our meetings is crucial in achieving your goals.

Confidentiality: The information you share is confidential. This means that all information about you cannot leave the office without your permission. Access to your case material or file is permissible only with your consent by signing a **Release of Information Form,** which is consistent with State and Federal regulations. The exceptions to confidentiality are as follows:

- ☑ As in all states, Pennsylvania has a mandatory child abuse law. This requires me to make a report to the Office of Children and Youth if I have reason to **suspect** child abuse and/or neglect.
- ☑ If there is clear intention on your part to do serious harm to yourself or someone else, I will share that information appropriately to prevent that harm from occurring.
- ☑ There have been instances where counseling records have been subpoenaed into court. I make every attempt not to release your records, but in the instance of a court subpoena, I would be held in contempt of court if I did not provide the records to the court.

Appointments and Fees: The first session is an information-gathering session, which will last 45-60 minutes. Subsequent counseling sessions will be 55-60 minutes. Shorter sessions, 30-minute or 45-minute can be available upon request. To minimize unexpected charges, below is a list of my fees. Initial session (90791) is $150.00; 55-minute sessions are $125.00; 45-minute sessions are $100; and 30-minute sessions are $75. All co-pays and deductibles are due at the time services are rendered.

Office Hours: Counseling sessions are by appointment only.

Insurance: If you plan to use insurance, **you are responsible** for learning about the specifics of your mental health coverage. I am an in-network provider on several local panels. Please check the website for more information. Any co-pays or coinsurance are due at the time services are rendered. Please verify whether a referral is needed. If you use insurance, I may be asked to release the following information: symptoms, diagnosis, treatment plan, and progress towards goals. You will be asked to sign a form granting permission to share this confidential information with your insurance company. PLEASE BE SURE YOUR PLAN COVERS TELETHERAPY.

Miscellaneous Fees: The following is a list of services that generates an additional fee, which will be your responsibility to pay since they are *not reimbursable* by insurance plans:

- Completion of documents (i.e.: disability, custody, DUI, etc.): **$25** [3 or more pages]
- Phone consultations (i.e.: attorneys, PO's, Custody Evaluators, etc.): **$25** per 15-minute increment
- Email consultations (i.e.: attorneys, PO's, doctors, schools, etc.): **$25** per email
- Attendance in court (i.e.: custody, disability, divorce, etc.): **$2500** (I will set aside an 8-hour day)
- Attendance at meetings (i.e.: schools, evaluations, disability, etc.): **$150** per hour

Missed Appointments and Cancellations: Cancellation of counseling sessions must be made 24 hours in advance to avoid being billed for that session. **I DO BILL FOR SESSIONS MISSED WITHOUT 24 HOURS NOTICE.** There are several reasons why this policy is strictly adhered to. 1) For counseling to work, regular appointments are necessary. 2) Frequently, others would like to use the time set aside for you should it become available; 24 hours gives people sufficient time to arrange to come in. *Exceptions:* when an illness or accident leads to a doctor or hospital visit. *The fee associated with missing an appointment or failing to cancel in time is $75.* Future sessions will not be scheduled until the No Show Fee has been paid.

Reaching Me by Phone/Email/Text: When you contact Women's Solutions, you will need to leave a message. I check these messages Monday through Friday between 8 AM and 6 PM. I do not check for messages in the evening (after 6 PM) or on weekends (from Friday 6 PM until Monday 8 AM). If you leave a message, please leave details as to where and when you can be reached. You will know in advance when I plan to be absent. When I am absent, I do not check messages.

Emergencies: I make every attempt to be available to clients during crisis times in their lives. Emergency or extra appointments can be made during regular office hours. In the case of a clinical emergency for which you need immediate assistance, please call Crisis Intervention (610.252.9060 or text 741741), dial 911 or go to your local emergency room.

Information about Credentials: I am a *Licensed Professional Counselors (LPC)*, having received my M.Ed. from Lehigh University. I am required to attend continuing education on a yearly basis to maintain skills and develop new skills. I belong to the American Psychological Association, as well as local organizations. If you have questions or concerns regarding my qualifications or modality of therapy, please contact the State of Pennsylvania Board of Licensed Social Workers, Marriage & Family Therapists and Professional Counselors {www.pa.state.org}.

Client Signature: _____ **Date:** _____

I have read the information presented in this disclosure statement. My signature indicates that I understand the information, agree with the conditions of counseling that are either stated or implied here, and agree to comply with them. I understand I have the right not to sign this form and can choose to discuss my concerns before counseling begins. I understand that once counseling begins, I still retain the right to withdraw my consent to participate in counseling at any time.

Therapist Signature: _____ **Date:** _____

HIPAA NOTICE

By signing below, I signify that I have read and received the HIPAA Regulations, and I understand my rights to medical and mental health confidentiality and privacy.

_____ _____

Client Signature Date

_____ _____

Parent Signature (If client is under 14 years of age) Date

_____ _____

Therapist Signature Date

HIPAA NOTICE

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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 IT CAREFULLY.

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

I may *use* or *disclose* your *protected health information* (PHI) for treatment, payment, and health care operations purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could define you.
- "*Treatment, Payment and Health Care Operations*"
    - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologists.
    - *Payment* is when I obtain reimbursement for your health care. Examples of payment are when I 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 office/group practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside my office/group 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, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and 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) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and 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**: If I have a reasonable cause, on the basis of my professional judgment, to suspect abuse of children with whom I come into contact in my professional capacity, I am required by law to report this to the Pennsylvania Department of Public Welfare.
- **Adult and Domestic Abuse**: If I have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.

HIPAA NOTICE

- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent, 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 express a serious threat, or intent to kill or seriously injure an identified or readily identified person or group of people, and I determine that you are likely to carry out the threat, I must take responsible measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.
- **Worker's Compensation**: If you file a Worker's Compensation claim, I will be required to file periodic reports with your employer, which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to receive Confidential Communications by Alternatives Means and at Alternative Locations:* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. Foe example – you may not want a family member to know you are seeing me. Upon your request I will send bills or other pertinent information to another address.
- *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI in my mental health record 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, but in some cases, you may have the decision reviewed. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting:* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy:* You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologists Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my 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 notify you in person or by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact a HIPAA coordinator. You may send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on April 14, 2003.

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. I will provide you with a revised notice in person or by mail.

Release of Confidential Information

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I, _____, understand that to use insurance to cover part or all of my treatment, my insurance company will require *Women's Solutions, LLC* to release confidential information about my treatment. I understand that this information may include, but is not limited to: symptoms, diagnoses, treatment plan, dates of service and progress toward goals.

With this knowledge, I hereby authorize *Women's Solutions, LLC* to release and exchange information with:

Name of Insurance Company: _____

Address: _____

_____

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

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INFORMED CONSENT for TELETHERAPY

I, _____ am choosing to facilitate my counseling / therapy sessions via the internet using Clocktree (www.clocktree.com) with Jackie L Gower, LPC.
By choosing this option I understand that:

- Clocktree is an online communication tool allowing face-to-face video, voice, or text-based chat dialogue. Clocktree video is encrypted using the same standards utilized by the US government to protect sensitive information.
- Clocktree software must be downloaded onto a computer / tablet / phone and an account must be created.
- Appointments will be made via the Clocktree program or via email (wsolv@yahoo.com).
- Please be prepared 5 minutes prior to your appointment. Please be alone in a private setting whenever possible. Clocktree will call you and the therapist at the scheduled time.
- For best picture and audio quality, please use a hardwired connection (via LAN cable) whenever possible. Headphones or ear buds add additional security.

I also understand the following limitations of using video applications for therapy sessions:

- Any internet-based communication is not 100% guaranteed to be secure / confidential. I agree that Jackie L Gower, LPC, will not be held responsible if any outside party gains access to personal or confidential information by bypassing the program security measures.
- In a crisis or emergency situation that needs immediate attention, whereby I am considering seriously harming myself or someone else, I will call the National Suicide Hotline (1-800-784-2433); call 911; call Crisis (610-252-9060 NC / 610-782-3127 LC); text Crisis (741 741); or go directly to the closest Emergency Room.
- Confidentiality should be treated like an in-office session: no outside distractions, turn off the volume on your cell phone, close other computer programs, and be on time for the session.
- Technical problem could occur. If the video is disrupted, the therapist will reconnect the session; call your cell using FaceTime; or call you for a phone session. If a reconnection cannot occur, the session will be rescheduled through email.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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INFORMED CONSENT for TELETHERAPY - Phone

I, _____ am choosing to facilitate my counseling / therapy sessions via telephone sessions with Jackie L Gower, LPC.
By choosing this option I understand that:

- Phone sessions can be a non-secure communication tool allowing us to continue therapy.
- Appointments will be made via email (wsolv@yahoo.com).
- Please be prepared 5 minutes prior to your appointment. Please be alone in a private setting whenever possible. I will call you at the scheduled time.
- For best audio quality, please have your phone fully charged. Headphones or ear buds add additional security.

I also understand the following limitations of using Telephone communications for therapy sessions:

- Any telephone communication is not 100% guaranteed to be secure / confidential. I agree that Jackie L Gower, LPC, will not be held responsible if any outside party gains access to personal or confidential information by bypassing security measures.
- In a crisis or emergency situation that needs immediate attention, whereby I am considering seriously harming myself or someone else, I will call the National Suicide Hotline (1-800-784-2433); call 911; call Crisis (610-252-9060 NC / 610-782-3127 LC); text Crisis (741 741); or go directly to the closest Emergency Room.
- Confidentiality should be treated like an in-office session: no outside distractions, turn off the notifications on your cell phone, and be on time for the session.
- Technical problem could occur. If the audio is disrupted, the therapist will attempt to call back. If a reconnection cannot occur, the session will be rescheduled through email.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CONSENT TO RELEASE
CONFIDENTIAL PATIENT INFORMATION

The undersigned hereby ☐ **authorizes** ☐ **requests** Women's Solutions LLC to **release to / obtain from**:

_____

_____

_____

_____

Phone: _____ Fax: _____

my medical record information relating to:

- ☐ diagnosis of/and treatment for medical conditions
- ☐ diagnosis of/and treatment for alcoholism / drug use
- ☐ diagnosis and/or treatment concerning mental health / rehabilitation
- ☐ diagnosis and/or treatment of AIDS/HIV testing/status

from the dates(s) of _____ through _____

Confidential HIV-related information is protected under PA law. The Confidentiality of HIV-related Information Act (35 P.S. 7607) requires written consent of the person to whom it pertains or is otherwise permitted by the ACT.

Drug / alcohol / mental health information is protected under Federal Confidentiality Law. Federal Regulations (42CRF Part 2) prohibit further disclosure of drug abuse patient records without written consent of the person to whom it pertains or is otherwise permitted by such regulation.

This consent may be revoked at any time **after** written notification is received, except to the extent that action has been taken, in reliance on this Consent. The Consent will automatically expire without the express revocation sixty (60) days from the date of my signature.

_____ _____

Client's Name (PLEASE PRINT) Date of Signature

_____ _____

Client's Signature Client's Date of Birth

_____ _____

Client's Street Address Client's Social Security Number

_____ _____

City State Zip Signature of Witness

If the client is a minor, is mentally or physically disabled, or is deceased, the legally responsible party should sign and date this consent.

_____ _____

Signature of Parent / Legal Guardian Date

☐ Client **Accepted** Copy ☐ Client **Refused** Copy