[redacted]
Licensed Professional Counselor
Mailing Address:
[redacted]
Email: [redacted]

Disclosure of Information, Policies, and Client Agreement

PROVISION OF THE FOLLOWING INFORMATION AND WRITTEN ACKNOWLEDGMENT OF ITS RECEIPT ARE REQUIRED PRIOR TO ONSET OF SERVICES. PLEASE READ IT CAREFULLY. I WELCOME THE OPPORTUNITY TO DISCUSS ANY QUESTIONS OR CONCERNS YOU MAY HAVE REGARDING THIS AGREEMENT OR MY SERVICES.

This disclosure statement contains the policies and procedures of services provided by Amanda Chiavini and is HIPAA compliant. No medical or psychotherapeutic information, or any other information related to your privacy, will be revealed without your permission unless mandated by Tennessee law. You, as a client, may revoke your consent to treatment, release of confidential information, or disclosure in writing at any time during psychotherapy.

MY TRAINING AND APPROACH TO PSYCHOTHERAPY

I have a Masters of Education in Human Development Counseling (2008) from Vanderbilt University, with an emphasis in community counseling. I have worked with adults, seniors, and families in hospitals and nursing care facilities. I am specialized in end of life issues, terminal illness, caregiving, bereavement, grief and loss. If at any time you present an issue outside of my areas of competence, I will provide you with the names of other counselors that can help you with those issues or obtain consultation with a counselor that specializes in that area during our work together.

I work primarily from a humanistic approach, although narrative, remembrance, and cognitive behavioral therapies also influence my approach. I regard both current issues as well as historical information, especially family of origin history, as important in treatment planning. I work with thoughts, feelings and behaviors in doing this work. Relationship issues (with partners, children, parents, siblings, or friends) are given attention. I take an active role in psychotherapy by sharing observations, giving feedback, supporting and challenging behaviors or ideas, and assigning homework when I believe it will be useful.

Good!

Spirituality and religious beliefs may play an important role when working with end of life issues. I respect your religious and spiritual beliefs and differences. I feel very comfortable if you choose to include these in your therapy session. I also respect your right not to include this aspect of your life in your session. Please feel free to discuss this subject with me.

Each course of treatment is unique to those who participate in it. Thus, your experience in psychotherapy is a blend of what you and I do together. Although many people find psychotherapy helpful, it requires a good deal of work on the part of the client. It is a process that requires self-reflection and commitment. There may be times when we work on subjects that are painful for you to discuss. The reactions that you have within the therapeutic relationship are important to our work and I welcome your feedback and suggestions throughout the process.

Risks

CLIENT RIGHTS

Termination: You have the right to decide whether or not to work with me as your therapist. If you wish, I can provide you with the names of other qualified therapists. You have the right to end therapy at any time for any reason without any legal or moral obligation. You also have the right at any time to ask questions about the course of therapy and my particular methods of treatment, please do not hesitate to ask.

Therapeutic relationship: The therapeutic relationship is unique in its level of intimacy and trust. We will work together to build that relationship. However, in a professional relationship (such as psychotherapy), sexual intimacy between a client and therapist is never appropriate. You have the right to feel safe in the therapeutic relationship.

Records: A record of the mental health care provided to you is kept by me. You may ask to see and have a copy of that record. I will not disclose your record to others unless you direct me to do so, or unless the law authorizes or compels me to do so. Please let me know if you wish to see your record or have questions about it.

If I am seeing you in joint sessions with other family members, I will need the written agreement of all family members over the age of 13 years before I will be able to release any records to family members or unless compelled by law.

Confidentiality: The information shared during your counseling sessions is legally confidential, meaning that it will not be shared with any person outside of your therapeutic relationship without your consent, in the absence of an exception outlined below.

However, there are legal exceptions to the general rule of legal confidentiality. These legal exceptions include: intent to harm others or yourself; abuse or suspected abuse of children, and the abuse of the elderly or others unable to care for themselves; neglect or suspected neglect of children; subpoenaed testimony in criminal court cases and orders to violate privilege by judges in child-custody, divorce and other court cases. In the case of harm to yourself or someone else, I am legally obligated to report such information to the appropriate authorities. In the event of such reporting, I will release the least amount of information that is sufficient to protect yourself or others. If any of these legal exception arise within our therapy work, I will notify you and I will take the appropriate action.

In couples or family counseling, I hold a "NO SECRETS" policy. All members of the couple or family system are treated equally and "secrets" are not kept that require differential or discriminatory treatment of family members. Therefore, any information shared in individual therapy MUST be also shared in couple or family therapy to insure this "NO SECRETS" policy. Signing this disclosure statement affirms permission to share this confidential information.

In the case of emergency that affects my ability to continue services, I have arranged for a colleague of mine, [redacted], M. Ed., LPC, to receive a copy of my psychotherapy notes and your contact information. You will have the option to continue your services with her or be provided with appropriate referral information for other therapists available.

In order to maintain your privacy, I need to know how you would like to be contacted: (Please circle appropriate response)

Home Phone Yes No If yes, would you like me to leave a message? Yes No

Work Phone Yes No If yes, would you like me to leave a message? Yes No

Would you like to receive any correspondence through the mail? Yes No

FEES AND FINANCIAL INFORMATION

Fee Rate: The standard fee is $85 per 50 minute session.

Cancellation and Missed Appointment Policy: You are asked to cancel any appointments at least 24 hours in advance. If you are unable to cancel the appointment 24 hours ahead I will charge **$50 for late cancellation** unless we can mutually agree on an appointment during the same week. If you miss an appointment without notifying me I will charge my full fee. It is important for you, the client, to recognize that when you make an appointment, I am reserving that time for you. If you are late, that cuts down on your therapy time. If you miss an appointment, that is time that could have been scheduled for another client. Therefore it is necessary for me to charge for appointments where I have not been given 24 hours cancellation notice. If you do need to cancel, I appreciate as much notice as possible so that someone else who may be waiting for a cancellation can arrange to come in.

Payment Options: I accept payment for services from insurance companies, HMO, third party payors, or private pay by the client. If you choose to use an insurance company for payment, please understand that they frequently require diagnosis codes and reports of the content of our therapy sessions. I have no control over what your insurance company requires as far as counseling records or chooses to do with this information after I submit records or reports. I encourage you to contact your insurance company if you have questions about what records they may or not request of me and what implications they may have for your future health care needs.

AS A PSYCHOTHERAPY CLIENT I UNDERSTAND THAT:

1) I understand that there may be times when [redacted] may need to consult with a colleague or another professional, like an attorney, about issues raised by me in therapy. My confidentiality is still protected during consultation by [redacted] and the professional consulted. Signing this disclosure statement gives [redacted] permission to consult as needed to provide professional services to me as a client.

2) I understand that [redacted] provides non-emergency psychotherapeutic services by scheduled appointment. If [redacted] believes my psychotherapeutic issues are above her or level of competence, or outside her scope of practice, she is legally required to refer, terminate, or consult. If, for any reason, I am unable to contact [redacted] by telephone, (615) [redacted], and I am having a true emergency, I will call 911, the Crisis Hotline (TN Suicide Prevention Network Crisis Line (615) 244-7444 or TN Statewide Hotline 1-800-372-0693), or check myself into the nearest hospital emergency room.

3) I understand that there are limits to legal confidentiality. These legal exceptions include: intent to harm others or myself; abuse or suspected abuse of children, and the abuse of the elderly or others unable to care for themselves; neglect or suspected neglect of children; subpoenaed testimony in criminal court cases and orders to violate privilege by judges in child-custody, divorce and other court cases. I understand that if I have any questions or would like additional information, I may feel free to ask during the initial session and any time during the psychotherapy process.

4) I understand that I am legally responsible for payment for my psychotherapy services, if, for any reason, my insurance company, HMO, third-party payor, etc. does not compensate [redacted] I also understand that signing this form gives permission to [redacted] to

communicate with my insurance company, HMO, third-party payor or anyone connected to my psychotherapy funding source.

5) I understand that this form is compliant with HIPAA regulations and no medical or no psychotherapeutic information, or other information related to my privacy, will be released without permission unless mandated by Tennessee law. Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked one year after the signing date.

I have read the preceding information and understand my rights as a client. By signing below I acknowledge my understanding and agree to all the terms discussed in this disclosure statement. This disclosure statement will be automatically revoked one year after signing in compliance with HIPAA guidelines.

Client Signature	Date
[redacted] M. Ed., LPC	Date