



Holistic Connections, LLC

Stacy Pettitt, LICSW #60663672

PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT

My Responsibilities to You as Your Therapist

I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not disclose to anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

The following are legal exceptions to your right to confidentiality

1. If I have good reason to believe that you will harm another person.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team.

II. Diagnosis

If a third party payor (insurance) is paying for your service, a diagnosis may be required as part of payment.

My Training and Approach to Therapy

I have a Master of Social Work earned in 2002 at Eastern Washington University. I am a licensed independent social worker (#60663762) in Washington State. My areas of special training and expertise include EMDR (eye, movement, desensitization and reprocessing), and trauma focused cognitive behavioral therapy. I have also worked extensively with people experiencing psychosis for the first time, multiple family psychoeducation as well as client centered care. I have extensive skills and experience in working in crisis mental health and currently hold a designation as a Designated Crisis Responder in Whitman County.

Your Responsibilities as a Therapy Client



Holistic Connections, LLC

Stacy Pettitt, LICSW #60663672

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last 50 min. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours notice, you must pay for that session at our next regularly scheduled meeting. First no show is billed at a rate of \$30, thereafter, the cost of the session will be billed at it's entirety.

You are responsible for paying for your session weekly unless we have made other firm arrangements in advance. My fee for an initial assessment is \$225.00 and ongoing 50 min sessions are billed at \$185.00. If we decide to meet for a longer session, I will bill you prorated on the hourly fee. If you have insurance, you will be required to pay your co pay at the time of service. If I am not credentialed with your insurance company, I am happy to provide you with "superbill" information for you to submit to your insurance agency for reimbursement. For paperwork requests, I charge the hourly rate prorated.

Telehealth

I use telehealth services when appropriate and agreed upon by the client. Currently I am using an online HIPPA compliant platform called Doxy.me. This is a confidential platform specifically designed for health care providers as well as HIPPA regulations. Doxy.me is a secure and encrypted Telehealth platform and does not record any communications between yourself and myself whether audio or video. The same limits and laws that were reviewed when you signed consent for treatment that include statements of intent for harm to yourself, others or abuse of children apply in Telehealth.

Although electronic means for counseling appointments is increasingly common, there are potential risks to using an online counseling platform:

- Internet services may malfunction or there may be technological challenges. Therefore, a telephone back-up may need to be used, which results in potential misunderstandings due to a lack of visual cues.
- Though every effort is made to ensure confidentiality, the limitations and risks in teleconferencing include public discovery, possibility of hackers, household noise or interruptions and other potential risks outside of our control.
- I will determine the appropriateness of whether to choose an audio/video session or audio only.
- Even with best practices using Telehealth, any information transmitted via the internet may not be 100% secure.

Client Consent to Psychotherapy

I have read this statement, and had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in insurance billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the fee of \$185.00 per session (if paying without insurance). I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Holistic Connections, LLC Stacy Pettitt, LICSW. I know I can end therapy at any time.

Signed: _____ Date: _____

Witness: _____ Date: _____