

THE CENTER FOR COUNSELING ARTS

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PITTSBURGH, PENNSYLVANIA, 15221

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THECENTERFORCOUNSELINGARTS.COM

WHERE THE QUALITY OF CARE MATTERS & COUNSELING IS AN ART



THE CENTER FOR COUNSELING ARTS WELCOME PACKET

Welcome to the Center for Counseling Arts, where we are committed to helping you explore solutions and promise the highest quality of care.

Our mission is to provide a safe space, empower with self-knowledge, reveal insights, uncover healing energy and partner with you on the journey.

This packet contains five sections, and may also be submitted online on our website (<https://thecenterforcounselingarts.com/welcomepacket>), or printed and brought to the office, or completed at your first appointment.

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POLICIES & PROCEDURES: ABOUT THE FIRST APPOINTMENT

At the evaluation session:

The therapist will

- A. Assess the necessity for therapy.
- B. Discuss your presenting issues/concerns.
- C. Review your mental health history.
- D. Discuss the limits of confidentiality.

The client will

- A. Complete an Intake Form and any pertinent Insurance Forms if not completed online.
- B. Sign a copy of Client's Rights and Responsibilities Statement if not signed online.
- C. Sign a consent for treatment if not completed online.

Referrals:

Your therapist may make referrals to a psychiatrist, support group, or community programs. If, for any reason, your issues are outside the level of competence of your therapist, an appropriate referral will be made.

Clinical Emergency:

If in a true medical emergency situation call 911 or go to your local hospital. If you have an urgent situation first try to contacting your therapist. You may also call the WPIC Resolve Crisis Network at 1-888-796-8226. If you are unable to reach your therapist at the office number, please call the personal phone number they have provided. If you are an imminent danger to yourself or someone else as

a result of mental illness it may be necessary to institute commitment procedures. You may also go to the hospital voluntarily. If you threaten to do physical harm to another individual the intended victim may be warned by your clinician.

Injuries and Medical Emergencies

If a minor injury occurs, A First Aid Kit with gloves is available. Universal precautions should be followed. For medical emergencies call 911 or go to your local hospital.

Evacuation Plan

The plan is located in our office.

Cultural Awareness

You will be treated with dignity and respect.

You will be treated without discrimination based on cultural diversity, race, religion, gender, ethnicity, age, sexual orientation, or special needs.

CLIENT'S RIGHTS & RESPONSIBILITIES:

Statement of Client's Rights:

- You have the right to be treated with dignity and respect.
- You have the right to fair treatment. This is regardless of race, gender, ethnicity, age, disability, or source of income.
- You have the right to have treatment and other member information kept private.
- Only in an emergency, or if required by law, can records be released without your permission.
- You have the right to information from staff/providers in a language that you can understand.
- You have the right to have an easy to understand explanation of your condition and treatment. You also have the right to share in the formulation of your plan of care.
- You have the right to know all about your treatment choices. This would mean no matter of cost or if they are covered or not.
- You have the right to information about providers.
- You have the right to know the clinical guidelines used in providing and/or managing your care.
- You have the right to know about the complaint, grievance, and appeal process.
- You have the right to know about State and Federal laws that relate to your rights and responsibilities.
- You have the responsibility to give providers information they need. This is so they can deliver the best possible care.
- You have the responsibility to let your provider know when the treatment plan is no longer working for you.

- You have the responsibility to follow your medication plan. You must tell your provider about medication changes, including medications given to you by other providers.
- You have the responsibility to treat those giving you care with dignity and respect.
- You have the responsibility to keep your appointments. You should call your provider as soon as possible if you need to cancel visits.
- You have the responsibility to ask your providers questions about your care. This is so you can understand your care and your role in that care.
- You have the responsibility to let your provider know about problems with paying fees.
- You have the responsibility to follow the plans and instructions for your care. The care is to be agreed upon by you and the provider.

I read the above statement and understand a copy may always be downloaded on the website or provided at the office.

Signature: _____

Date: _____

HIPAA & PHI:

NOTICE OF PSYCHOTHERAPISTS' POLICIES & 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

The Center for Counseling Arts and / or Harlee A. Abromson, LCSW and Associates 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 identify you.
- “Treatment, Payment and Health Care Operations”
 - Treatment is when The Center for Counseling Arts and / or Harlee A. Abromson, LCSW and Associates 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 therapist.

- o Payment is when The Center for Counseling Arts and / or Harlee A. Abromson, LCSW and Associates obtain reimbursement for your healthcare. 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.
 - o Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination.
- “Use” applied only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

The Center for Counseling Arts and / or Harlee A. Abromson, LCSW and Associates 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 the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also obtain an authorization before releasing your psychotherapy notes.

“Psychotherapy notes” are notes made about our conversation during a private, group, joint or family counseling session, which we 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, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

The Center for Counseling Arts and / or Harlee A. Abromson, LCSW and Associates may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If we have reasonable cause, on the basis of our professional judgment, to suspect abuse of children with whom we come into contact in our professional capacity, we are required by law to report this to the Pennsylvania Department of Public Welfare
- Adult and Domestic Abuse: If we have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), we may report such to the local agency which provides protective services.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services we provide you or the records thereof, such information is privileged under state law and we 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 identifiable person or group of people, and we determine that you are likely to carry out the threat, we must take reasonable 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, we 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 Therapist's Duties

Patient's Rights:

- Right to Request Restrictions--You have the right to request restrictions on certain uses and disclosures of PHI about you. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations--You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations, (For example,

you may not want a family member to know that you are receiving counseling. Upon your request, we will send your bills to another address.)

- Right to Inspect and Copy--You have the right to inspect or obtain a copy (or both) of PHI in the mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. An appointment must be made to review your psychotherapy notes as they are not considered part of your PHI. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- Right to Amend--You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we 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, we 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 us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- The Center for Counseling Arts and / or Harlee A. Abromson, LCSW and Associates are 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.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you at our next therapy session.

V. Complaints

If you are concerned that The Center for Counseling Arts and / or Harlee A. Abromson, LCSW and Associates have violated your privacy rights, or you disagree with a decision made about access to your records, you may contact Lee Reichbaum, Ph.D., C.E.O., at (412)967-5660.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

The Center for Counseling Arts and / or Harlee A. Abromson, LCSW and Associates reserve the right to change the terms of the notice and to make the new notice provisions effective for all PHI maintained.

You will be provided a revised notice at your next therapy session following the revision.

I, _____, (*please PRINT name*) have read and understand the above Notice of Privacy Practices and agree to the terms therein.

Signature: _____

Date: _____

CANCELLATION POLICY:

I, the undersigned client, accept responsibility for keeping scheduled appointments.

Missed appointments impact: (1) staff time concerned with follow-up, including rescheduling, (2) lost office space allotted for counseling those in need, (3) the time of my therapist.

Therefore a 24 hour cancellation policy is in effect: if in need of rescheduling, I am asked to kindly call a day before my appointment. If an appointment is not cancelled within 24 hours of the scheduled time, a charge of \$50 may be issued.

Emergencies, unforeseen circumstances and weather conditions will be taken into account by my therapist, The Center for Counseling Arts and Harlee A. Abromson, LCSW and Associates.

I also understand my insurance company cannot be charged for this fee.

By signing this statement, I agree to the terms above.

Signature: _____

Date: _____

CONSENT & ACKNOWLEDGEMENT:

I, _____, (please PRINT name) agree to enter into outpatient psychotherapy, of my own volition with The Center for Counseling Arts. It is my responsibility to give accurate information with the understanding that all information about me will be kept confidential. I will participate in my treatment planning and goal setting, and I understand that I am responsible for following my treatment plan.

I accept responsibility for keeping scheduled appointments. I understand that a 24-hour cancellation notice is required unless waived by my insurance company to avoid being charged for the time set aside for the appointment. Unless other adjustments or agreements are made, payment in full is expected at the time of service and a statement will be received monthly. I agree to be responsible for any payment not paid by my insurance company, including deductibles and co-payments.

I acknowledge that I have received a copy of the Policy and Procedures, Clients Rights and Responsibilities Statement, and HIPAA Privacy Information.

I give permission to keep my signature on file to authorize The Center for Counseling Arts and/or Harlee A. Abromson, LCSW and Associates to electronically bill my health insurance provider.

Signature: _____

Date: _____

ADDRESS, PHONE NUMBER & NOTES

OUR OFFICE ADDRESS & WEBSITE

907 West Street, Second Floor

Pittsburgh, PA, 15221

For mail correspondence, please include Suite 223

www.thecenterforcounselingarts.com

OUR OFFICE PHONE NUMBER

412-241-8552

YOUR THERAPIST'S PHONE NUMBER