Welcome

Welcome to my office. The following information and agreement is with me, Jessica Tupa, LPCC. It contains important information about me, the services I offer, and policies and procedures of my practice. Please read it carefully and keep this copy for your records. We will go over this in our first appointment and you will have the opportunity to ask any questions you may have.

**Therapy Services**

Therapy is not easily described in general statements. It varies depending on personalities of the therapist and the patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems you hope to address. Therapy is not like a medical doctor visit. Instead, it calls for a very active effort both of our parts. In order for the therapy to be most successful, you will have to work on things we talk about during our sessions and at home. Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs and assessment of the problems you are experiencing. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. As therapy progresses the treatment plan may change. We will work together to determine how to effect the changes you are seeking to make for yourself.

**The Therapeutic Relationship**

Your relationship with me is a ***professional and therapeutic one.*** In order to preserve this relationship, it is important that I not have any other type of relationship with you during therapy. Personal and/or business relationships can undermine the effectiveness of the therapeutic relationship and can cause my professional judgment to be compromised and each situation must be carefully evaluated. We will discuss this if it is or becomes an issue. The Counselor, Social Worker & Marriage & Family Therapist (CSWMFT) Board advises that therapists should not be “friends” on various social networking sites (Facebook, Twitter, etc.) and ***I want to abide by that advice.*** By signing this agreement***,*** you acknowledge that you understand this and will not attempt to “friend” me.

**Appointments**

Appointments are scheduled via email at **jessica@tupaco.com**or via phone at **937.815.9369**. I normally conduct an intake evaluation that will take anywhere from 1 to 2 sessions and will last approximately 50 to 90 minutes. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. I will schedule 50-minute follow up sessions at a time and frequency we agree upon based on your treatment needs. In some circumstances a 90-minute follow up session may be more beneficial, which is something we will discuss together. The number of appointments depends on many factors and will be discussed with you during our sessions.

**Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours’ advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control).** I reserve our appointment time for you and it is often difficult to fill with new clients unless I have adequate notice. If too many appointments are being missed (whether cancelled 24 hours in advance or not) we may need to re-evaluate our fit in working together, and I reserve the right to terminate the therapy with you.

**Termination**

Termination can be a valuable part of the therapy process. Stopping therapy should not be done casually, although either of us may decide to end therapy if we believe it is in your best interest. If you wish to stop therapy at any time, I ask that you agree to meet for at least one additional session to review our work together and ensure you feel confident in your plans moving forward.

**Contacting Me**

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by my confidential voice mail system. I try to monitor this voice mail throughout the day, and will make every effort to return your call within that day if I am available, or asap the next day. If I do not answer, please leave a message as I will be periodically checking phone messages**. If you feel that you cannot wait till my return call, or if you need to speak to someone immediately, please contact your family physician, call the** **crisis line for Montgomery County, 937-224-4646**, **call 911, or go to your nearest emergency room.**

* If I go out of town, or cannot be available for some other reason over which I have control, we will discuss alternative resources and I will leave information on my office voice mail.

**Email*:*** The Health Insurance Portability and Accountability Act (HIPAA) of 1996 places severe limitations and restrictions on the electronic transfer of client information and records. With the exception of scheduling appointments, I would prefer that we have face-to-face or phone contact only. If you send me an e-mail I may not respond unless it is encrypted, as required by the CSWMFT Board rules, and you should understand that there is no guarantee of confidentiality when using the internet.

Professional Fees

* **Individual, Couple, and Family Therapy Sessions –** 50 to 60 minutes, $100.00; 60 to 90 minutes, $130.00
	+ I offer a sliding fee scale for clients who cannot afford to pay my full session fees. If these costs are too high for you, please let me know as soon as possible so we can discuss sliding fee options.
* **Missed Appointments** ***–*** The full session is charged for missed appointments (or when less than 24 hours’ notice is given)
* **Phone calls/Requested Treatment Summaries and Letters** - Phone calls lasting more than 5 minutes which are at your request, such as crisis or consultation with other professionals or family members, will be charged at the rate of $*100.00 for each 45 minutes involved****.*** The same rate will also be applied to time involved in preparing and writing requested treatment summaries, letters, or other requests.
* **Copies of Records *-*** If you are requesting copies of records for yourself or to be sent to other professionals, you will be billed a copying fee of $2.92 per page for the first ten pages, 61 cents per page for pages in excess of eleven through fifty, and 25 cents per page for pages fifty-one and higher, plus postage. This fee may be updated from time to time to conform to Ohio law.
* **Participation in Legal Proceedings *-*** Being a witness or expert in legal proceedings can have many risks to the therapeutic relationship. It is my policy to avoid being involved in legal proceedings if at all possible to protect the integrity and confidentiality of the therapist/client relationship and to avoid dual roles. If you become involved in a divorce or custody dispute, I will not provide evaluation or expert testimony regarding child custody issues in court as I will be in a treatment role with you. You will need to hire an independent mental health professional for any evaluation or testimony you require. If I become involved in legal proceedings that require my participation as a result of my treatment of you, whether or not you or another person involves me, you will be expected to pay for my professional time, including preparation and transportation costs. Because of the difficulty of legal involvement, I charge $150.00 per hour for preparation and attendance at any legal proceeding, including any related travel time or time waiting to testify. You will also be responsible for paying any legal fees I may incur with my practice attorney in connection with my participation.

**Billing, Payments, and Insurance Reimbursement**

In order for us to set treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment.

**For all clients*:***

Your full payment is due for each session at the time it is held, unless we agree otherwise. You may pay by cash or check or credit card. If your check does not clear, you will be responsible for the additional fee the bank charged. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment and you consent to my doing that. This may involve collection services.

**If you are having financial problems, please do not hesitate to discuss this with me so that we can avoid any of the above-mentioned problems. I am willing to discuss payment plans or other options that will be in your best interest in regards to balancing the need for treatment and your financial stability.**

**If you would like to seek reimbursement for my services from your insurance plan,** you will need to pay for my services in full at the beginning of each session. I would be happy to provide you with the necessary paperwork if you think your insurance plan has some out of network benefits. It is your responsibility, however, to get reimbursed for what you have paid for services.

Additional Information

**Minors**

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss the matter with you, if possible, and I will do my best to handle any objections you may have. There is an Ohio law which allows teens aged 14 years or older to avoid having their parents involved in their treatment (unless there is a substantial probability of harm to you or others), but then you and not your parents are responsible for the fee and the number of services that I may provide to you is limited.

**Information for Minors Whose Parents Are Divorced or Separated**

If you are under 18 years of age, I will need to have a copy of court documents or custody papers that prove legal guardianship. If there is a shared parenting or custody agreement, I will also need a copy of this so that I have full understanding of what the legal agreement is about receiving mental health services. If both parents are involved in parenting, it usually is most beneficial for both parents to be involved in therapy in some capacity. Decisions will always be based upon what is in the best interest of you, the client. Billing statements will only be sent to one guardian. It is the responsibility of the guardians to work out how treatment is being paid. The bill will be sent to the guardian who signed the treatment agreement and it is their responsibility to work out any problems with the other responsible party.

**In the Event of Incapacity or Death**

In the event that I, Jessica Tupa, become incapacitated or die, it will become necessary for another therapist to take possession of your file and records. By signing this informed consent to treatment form you are giving your consent to allow another licensed mental health professional selected by me to take possession of your file and records and provide you with copies upon request. I will only select a professional who I have the utmost confidence in their ability to be ethical and responsible with your records.

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to Protected Health Information (“PHI”). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy and security of PHI and to provide you with notice of our legal duties and privacy and security practices with respect to PHI.

I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website or in my office, or by sending a copy to you in the mail upon request.

**HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

* **For Treatment**:Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may discuss your situation and/or disclose PHI to any other consultant only with your consent, such as your primary care physician. 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, and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain a written authorization before releasing your psychotherapy notes. *“Psychotherapy notes”* are notes we 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. Note, psychotherapy notes may not be required to be released for eligibility or underwriting purposes

* **For Payment**: I make every attempt possible not to disclose your PHI for payment, however in some instances I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.
* **For Health Care Operations:** I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, PHI will be disclosed only with your authorization.
* **Required by Law:** Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.
* **Without Authorization**: Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:
	+ Required or allowed by law, such as (including but are not necessarily limited to): the reporting of child abuse or neglect, or mandatory government agency audits or investigations (such as the social work licensing board or the health department), or abuse involving the elderly or persons with developmental disabilities.
	+ If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release this information without written authorization from you or your personal or legally-appointed representative, or upon receipt of a court order. The privilege does not apply when you are being evaluated for a third party and you have provided an authorization to release the information to the third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
	+ If I believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and I believe you have the intent and ability to carry out the threat, then I may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis; 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional; 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s). I will inform you about these notices and obtain your written consent, if I deem it appropriate under the circumstances.
	+ If you file a worker’s compensation claim, I may be required to give your mental health information to relevant parties and officials.
	+ To defend against an action filed by you against me.
* **Verbal Permission:** I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.
* **With Authorization**: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Jessica Tupa, LPCC.

* **Right of Access to Inspect and Copy.** You have the right, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable fee for copies, as allowed under Ohio law.
* **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
* **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
* **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
* **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
* **Right to a Copy of this Notice.** You have the right to a copy of this notice.

**Complaints:** If you believe I have violated your privacy rights, you have the right to file a complaint in writing with Jessica Tupa, LPCC, at 2555 S. Dixie Suite 212, Kettering OH, 45409; Phone 937.815.9369or with Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601; Ph. (312) 886-2359; Fax (312) 886-1807; TDD (312) 353-5693.

I will not retaliate against you for filing a complaint. The effective date of this notice is May 1, 2018. If you need additional information regarding this Notice of Privacy Practices, please contact me.

Signature Page

## *Please place your initials on each line below, and your signature at the bottom of the page. Your signature below indicates that you acknowledge and agree to the following statements:*

* \_\_\_\_\_I HAVE RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICES AND HAVE BEEN PROVIDED AND OPPORTUNITY TO REVIEW IT. (Revised 5/1/18)
* \_\_\_\_\_I HAVE RECEIVED THE INFORMED CONSENT FOR TREATMENT DOCUMENT FOR JESSICA TUPA, LPCC, AND HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW IT AND ASK QUESTIONS ABOUT IT. MY SIGNATURE BELOW ACKNOWLEDGES THAT I UNDERSTAND ITS CONTENTS AND AGREE TO ABIDE BY THE TERMS IN THE AGREEMENT.
* \_\_\_\_\_ I GIVE MY CONSENT FOR MYSELF AND/OR MY MINOR CHILD TO RECEIVE PSYCHOTHERAPY SERVICES FROM JESSICA TUPA, LPCC. I ACKNOWLEDGE THAT THE RISKS AND BENEFITS OF EACH PROPOSED TREATMENT, OTHER ALTERNATIVES, AND NO TREATMENT HAVE BEEN EXPLAINED TO ME. I UNDERSTAND THAT THIS CONSENT IS FOR THE DURATION OF TREATMENT, UNLESS I CHOOSE TO REVOKE THIS CONSENT AT ANYTIME IN WRITING WITH SIGNATURE AND DATE INCLUDED.
* \_\_\_\_\_ I UNDERSTAND AND AGREE THAT I WILL PARTICIPATE IN THE PLANNING OF MY CARE, TREATMENT, OR SERVICES AND THAT I MAY STOP SUCH CARE, TREATMENT, OR SERVICES THAT I RECEIVE THROUGH JESSICA TUPA, LPCC, AT ANYTIME. I ALSO UNDERSTAND THAT THERE ARE NO GUARANTEES THAT TREATMENT WILL BE SUCCESSFUL.
* \_\_\_\_\_ SHOULD I REQUEST REIMBURSEMENT OF SERVICE FEES THROUGH MY INSURANCE COMPANY, I HEREBY AUTHORIZE THE RELEASE OF NECESSARY TREATMENT INFORMATION TO MY INSURANCE COMPANY FOR INSURANCE REIMBURSEMENT PURPOSES AND THE PAYMENT OF BENEFITS TO JESSICA TUPA, LPCC FOR HER PROFESSIONAL SERVICES.

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Client Name (please print) Date

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Client/Guardian Signature Date

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Relationship to Client

**Signature of Partner or Other Family Member(s) (If applicable):**

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Signature Date

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Jessica Tupa, LPCC Date