CHOICES MENTAL HEALTH COUNSELING, PLLC
PO BOX 706 (6 PELTON STREET, SUITE #2), MONTICELLO, NEW YORK 12701

INFORMED CONSENT

Thank you for choosing **Choices Mental Health Counseling, PLLC** for counseling for you and your family. Individual, family, and couples sessions last 50 to 75 minutes. Most group counseling sessions are scheduled for 60 to 90 minutes, with occasional exceptions. Beginning therapy is a major decision and you may have questions. This document is intended to inform you of my office policies, State and Federal laws, and your rights as a patient If you ever have questions or concerns, please ask and I will try my best to give you all the information you need.

Informed consent is a practical means of honoring the more abstract concepts of the rights and dignity of the human person. The practice of informed consent actualizes and protects one of the most central values in modern bioethics: autonomy defined as the right and ability of the client to make her or his own medical decisions. Patients cannot exercise full and authentic self-determination or free will in medical or mental healthcare decision making without receiving adequate information from the professionals treating them.

INTRODUCTION

Choices Mental Health Counseling, PLLC is incorporated under the laws of New York State as a professional corporation organized to private clinical mental health and substance abuse counseling practice to the public. At this writing there is only one therapist on staff, namely Thomas Rue. For the purpose of this discussion, therefore, I will speak in the first person, as "I" - which I encourage you to do in counseling sessions, as well.

I practice cognitive behavioral therapy for most conditions in individual and group settings. Other theoretical treatment approaches and specific techniques are also used, depending on the person or condition. Treatment practice and philosophy will be discussed as we proceed. You are always free to ask ask any question you wish, or to question the purpose or necessity of anything that I may ask or recommend that you do.

Homework is an important part of the growth that you will make and may be given at each session attended. You may be asked to keep a personal journal and bring it to sessions, to write down your thoughts on specific topics, or try specific activities or behavior changes. Doing so will increase the likelihood you will benefit from therapy.

I completed a Bachelor of Arts Degree in Psychology from the College of New Jersey in 1983 and a Masters Degree in Counseling at Rider University in 1985. I have worked as a professional counselor since that time and am licensed by the State of New York as a Licensed Mental Health Counselor and as a Credentialed Alcoholism and Substance Abuse Counselor. I am also board-certified by the National Board for Certified Counselors as a Certified Clinical Mental Health Counselor and National Certified Counselor.

Higher education and specialized training that I have completed has included course-work and seminars on mental health, healthy and pathological aspects of psychology, addictions and recovery, family therapy, sexual health, social and intimate relationships, mindfulness, meditation, guided relaxation, psychology of women, men's issues, GLBT issues, feminist spirituality, cultural competency, recovery from sexual and physical trauma, personality, learning, family and couples therapy, blended family issues, parenting, adolescence, cults, gangs, preventing and living with STDs, HIV, AIDS and other blood-born illnesses, aging, quality of life during or after cancer treatment and oher chronic physical or mental disabilities, grieving the loss of loved ones, law and ethics in mental health practice. I regularly attend continuing education programs to learn new skills and stay current.

I have taught college classes in Humanistic Psychology, Self-Management, and Methodology of Behavioral Research for Sullivan County Community College, Marist College, and Mercy College. I hold a provisional certificate as a School Counselor in New York and Nevada. From the 1970s onward, I have volunteered many hours of *pro bono* community service, served on boards of directors for more than a dozen nonprofit organizations, and helped establish local charitable and human service organizations.

RISKS AND BENEFITS

Counseling may involve discussing relational, spiritual, psychological, and/or emotional issues that at times are distressing. Like any practice or procedure in health care, it has risks and benefits. Therapy often involves discussing unpleasant aspects of your life, and you may be reminded of uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness, or experience these feelings again. This is part of the process of healing and I will help you deal with those emotions.

Counseling and therapy have also been shown to lead to better relationships, identify solutions to solve or recover from specific problems, and significant reduction in feelings of emotional distress and physical pain. However, there is no guarantee of outcome. A large portion of ensuring progress, or preventing relapse, is in your hands.

At any point during the counseling relationship, I may find that is in your best interest to be referred to another professional. If you are involved in violence, substance abuse, or threatening behavior, I may discontinue your therapy and give you an appropriate referral. You have the right to discontinue counseling at any time.

Alternatives to care that I provide include inpatient or residential addiction or psychiatric treatment, group or individual counseling at a local publicly-funded clinic, or peer self-help programs that operate at no no cost. Feel free to discuss any of these alternatives or would like a referral. I do not give legal or medical advice. If you need a referral for help that is outside my scope of practice, I may offer it or you may ask.

Learning to "take a risk" and trust others by asking for, and receiving, social support is one of the benefits of group therapy. In a group setting, however, there is a risk that one patient may intentionally or unintentionally disclose what is said by another outside of group. For this reason, great emphasis is given to "group values and norms", high on the list of which is confidentiality. The same is true in couples counseling. Although the expectation of privacy is clearly communicated to all, the behavior of another person cannot be controlled.

COORDINATION OF TREAMENT

It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist or other health care providers. Depending on the nature of your condition and treatment, this may extend to all prescribers of medications. Depending on your legal status, it may also extend to your probation or parole officer, or the court. Your signed consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by means of written notice. However, a revocation is not valid to the extent that I have acted in reliance on such authorization. In cases involving the justice system, some consent forms may not be revoked.

If you prefer to decline consent, no information will be shared. However, if you exercise this choice there may be instances where I will be unable to meet your treatment needs and you will need to seek treatment elsewhere.

ANCILLARY SERVICES

I am Notary Public in New York State and provide free notary services in the office. Extra charges apply for laboratory work, reports, letters, travel time/expenses, home or hospital visits, court appearances, etc.

FINANCIAL/INSURANCE ISSUES

As a courtesy, I will bill your insurance company,or other third-party payer, provided I am in their network. If you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, I request that you pay the balance due at that time. If your balance exceeds $300.00, I will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). If account becomes overdue and turned over to a collection agency, the client or responsible party agrees to pay any collection fees to collect the debt owed. I ask that you authorize payment of insurance benefits directly to Choices Mental Health Counseling, PLLC.

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS

I/We consent that _____ *(name of minor)* may be treated as a client by Choices Mental Health Counseling, PLLC. At times it maybe necessary to schedule appointments during school hours. I ask for your cooperation to provide the most timely treatment for you and your children.

If the parents are legally separated or divorced a copy of the custody order is required to verify custody status.

No provision is made at my office for child care. If your child is not participating in a session, please make other arrangements for his or her care. Choices Counseling Services, PLLC is not responsible for any accidents or injuries to children who are unsupervised by their parents on the property.

POLICY ON CANCELLED OR MISSED APPOINTMENTS

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice. Otherwise, you will be billed at the hourly rate. I do my very best to keep on schedule and not have patients sitting in the waiting room. Please be considerate of my schedule and of other patients' time as well.

Notice of 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.

We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. This notice will also describe your rights and certain obligations I have regarding the use and disclosure of your health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

Your health information is personal. I am committed to protecting your health information. I create a record of the care and services you receive at this office. I need this record to provide you with quality care and comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your therapist or one of the office's employees.

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

The following describes the different ways that your protected health information (PHI) may be used or disclosed by this office. "PHI" refers to information in your health record that could identify you. For clarification, some examples are included. Not every possible use of disclosure is specifically mentioned.

For Treatment. "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 psychologist.

For Payment. "Payment" is when I obtain reimbursement for your healthcare. 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. I may also tell your health plan insurer about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover or continue to cover your treatment.

For Healthcare Operations. "Healthcare Operations" are activities that related to the performance and operation of our practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. I may use and disclose health information to provide you with appointment information. This may be done with voice mail, messages, post cards, and other mailings.

Use. "Use" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure. "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.

I may use or disclose PHI for purposes outside of treatment, payment, or 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 I am asked for information for purposes outside of treatment, payment or 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 privacy protection than ordinary 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, 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 reasonable cause to suspect child abuse or neglect, I must report this as required by law.

Health Oversight Activities. If I receive a subpoena or other lawful request from the NYS Department of Health, NYS Office of Professions, NYS Office of Mental Health, NYS Office of Alcoholism & Substance Abuse Services; or your insurance company, I must disclose relevant PHI pursuant to that subpoena or lawful request.

Judicial and Administrative Proceedings. If you are involved in a court proceeding and a request is made for information or records of your diagnosis and treatment, this information is privileged under state and federal law. I will not release information without your written authorization or a court order so directing me. This privilege does not apply when you are being evaluated for a third party or when the evaluation is court ordered. If you are involved in a lawsuit or a dispute, I may use your PHI to defend my practice or to respond to a court order.

Serious Threat to Health or Safety. If you make a threat of physical violence against a reasonably identifiable third person and you have apparent intent and ability to carry out that threat in the foreseeable future, I may disclose relevant PHI and take reasonable steps permitted by law to prevent the threatened harm. If I believe that there is an imminent risk that you will inflict serious physical harm on yourself or others, I may disclose information in order to protect you. One example might be if you arrived at my office under the influence of alcohol or other drugs and then tried to drive away.

Worker's Compensation. I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Therapist's Duties.

You have the following rights regarding PHI that this office maintains about you.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am 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 being seen. On your request, I will send your bills to another address.) To request confidential communications, you must complete our request form in writing and submit it to the Privacy Officer. I will accommodate all reasonable requests.

Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. To inspect and/or obtain a copy of your PHI, you must complete a request form and submit it to the Privacy Officer named below. If you request copies, I will charge you $0.25 per page. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend. You have the right to request an amendment to PHI if you believe it to be in error, for as long as the PHI is maintained in the record. To request an amendment, you must complete our request form and submit it in writing to the address shown below, stating a reason, explanation, or evidence that you believe supports your request. I may deny 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. On your request, I will discuss with you the details of the accounting process. To request this accounting on disclosures, you must complete a request form and submit it in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003.

Right to a Paper Copy. You have the right to obtain a paper copy of the Notice from me upon request.

Therapist's Duties: I am required by law to maintain privacy of PHI and notify you of my legal duties and 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.

V. Questions and Complaints.

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, please speak with me personally. If you believe your privacy rights have been violated and wish to file a complaint, you may address your written complaint to me at this address:

Privacy Officer:
Thomas S. Rue, M.A., LMHC, CASAC, CCMHC, NCC
Choices Mental Health Counseling, PLLC
PO Box 706 [located at 6 Pelton Street]
Monticello, New York 12701-0706
Phone: 845-323-9612 | Fax: 866-428-0282

If you are not satisfied, you may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I will provide you with the appropriate address upon request.

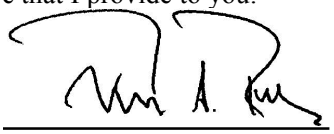
You have specific rights under the Privacy Rule. I will not retaliate against you or penalize you in any way for exercising your right to file a complaint.

Most issues of concern can be worked out between us. However, current or former patients may call the NYS Office of Mental Health's customer relations line, toll-free, at 800-597-8481; or the Client Advocacy Unit of the NYS Office of Alcoholism & Substance Abuse Services at 800-553-5790.

VI. Effective Date, Restrictions, and Changes to Privacy Policy.

This notice will go into effect on April 15, 2011. 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. If I revise our policies and procedures, I will post a copy of any revised Notice in this office.

Disclosures of your PHI not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide written consent to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, I will no longer use or disclose PHI about you for the reasons covered by your prior written authorization. Be aware that I am unable to take back any disclosures I have already made with your permission and that I am required to retain my records of care that I provide to you.



Dated: April 15, 2011
Monticello, New York

PATIENT'S ACKNOWLEDGMENT

By signing below, I acknowledge that I have have read and understand this Informed Consent and Notice of Privacy Practices. I understand that I may have a paper copy of this form, or download one in electronic form at choicescounselingservices.org or by e-mailing choices13@gmail.com.

If covered by insurance or other third-party payments, I hereby authorize payment of all medical benefits directly to Choices Mental Health Counseling, PLLC.

Patient's Signature	Date
Parent/Guardian's Signature (if under 18)	Date
Refusal to Sign Acknowledgement	Date
Notice of Privacy Practices was sent (name of patient)	Date

Initials: _____

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