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**COUNSELING GUIDELINES, RIGHTS, AND RESPONSIBILITIES**

Welcome to *Nature & Nurture Holistics*. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

I have a dual Masters of Science in Holistic Nutrition and Clinical Health Psychology from Bastyr University in Kenmore, Washington. I have a Bachelor of Science in Nutrition and Dietetics also from Bastyr and a Therapeutic Bodywork Certificate from Massachusetts Bay Community College in Framingham Massachusetts. I am a Licensed Professional Mental Health Counselor Associate (LMHCA) supervised by Dr. Bonnie Bhatti, Certified Nutritionist (CN), and Licensed Massage Practitioner (LMP) with the State of Washington. I abide by the American Counseling Association (ACA), Academy of Nutrition and Dietetics (ADA) and the Associated Bodywork and Massage Professional (ABMP) Code of Ethics. As a practitioner, I am committed to serving client by partnering with them in moving towards healthy change, development, and growth. This will involve exploring thoughts, feelings, and behaviors and taking action to achieve positive change.

**THERAPEUTIC PHILOSOPHY**

My intention and belief is that you should feel comfortable with the practitioner you chose, and hopeful about the therapy. Please see the tabs ***Elements of Good Therapy, Signs of Healthy therapy, and Warning Signs in Therapy*** at www.goodtherapy.org which will give you more information regarding these topics. When you feel empowered in the collaborative process, therapy is more likely to be helpful for you.

My therapeutic approach is intuitive, collaborative, client centered, and compassionate. I incorporate a variety of evidence based treatment modalities tailored to meet your unique therapeutic needs through the lens of connecting the Mind, Body, and Spirit. The types of healing modalities that I offer include Body Centered Therapy (BCT) including Focusing Work, Therapeutic Body Work and Massage, Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), Narrative Therapy, Mindfulness Based Techniques, and Nutrition Consultation. I view therapy as a partnership between counselor and client. During this collaborative journey, I will provide you with a safe and confidential environment to explore difficult life issues. I offer an empowering non-judgmental approach to help clients begin the transformation process toward healing and growth.

Our first few sessions will involve evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include if you decide to continue with your healing path with me, such as our goals, the methods we will use, the time and money commitment we will make. Take time to evaluate this information along with your own opinions of whether you feel comfortable working with me as counseling involves a large commitment of time, money, and energy. 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 practitioner for a second opinion.

An important part of healing will be practicing new skills that you will learn in your sessions. We will work together to create "experiments" to play with them outside of our meetings. For example, we might have you keep a food journal, read, or practice relaxation techniques outside the session to deepen your learning.

**THE BENEFITS AND RISKS OF THERAPY**

As with any powerful treatment, there are some risks as well as many benefits through the process. You may want to think about the benefits and the risks when making any treatment decision. While benefits are expected from working alongside a practitioner, there may be periods of increased anxiety or confusion, which may affect significant relationships, your job and your understanding of self. Therapy often times needs to go deep. Rather than turning away from our suffering, healing sometimes requires an exploration into the depth of the wounds that fuel our beliefs, feelings, and behaviors. It is impossible to predict the extent to which you experience these changes.

While you consider these risks, you may also know the benefits of body centered therapies including counseling, nutrition consultation, and body work have been shown by scientists in hundreds of well-designed research studies to be effective resulting in lasting change. We will work together to maximize the benefits of our therapeutic process. I do not take on clients I do not think I can help. Therefore, I enter our relationship with optimism about our progress. Benefits may include: an improved ability to relate to you; a clear understanding of self, connection to your body, values, and/or goals, and ability to cope with everyday stress, to others, and the earth. There are no guarantees that counseling goals will be achieved.

**CONSULTATIONS**

If you could benefit from a treatment I am unable to provide, I will help you get it. You have the right to ask me about such other treatments, their risks, and their benefits. Based on what I learn about your experience, I may recommend another health professional. If I do this, I will fully discuss my reasons with you, so that you can decide what is best. If another professional treats you, I will coordinate my services with them and with your medical doctor.

If for some reason treatment is not going well, I might suggest you see another therapist or another professional for an evaluation. As a responsible person and ethical practitioner I cannot continue to treat you if my treatments are not working for you. If you wish for another professional's opinion at any time, or wish to talk to another therapist, I will help you find a qualified person and will provide her or him with the information needed.

**HIPPA – NOTICE OF PRIVACY**

The following notice is an introduction to your rights and responsibilities as a client of *Nature & Nurture Holistics* services. This notice, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), describes how your medical information may be used and disclosed and how you can get access to this information.

I am required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

**Effective July 16, 2009:**

**How I Protect Your Health Information**

- All of your health information that I collect is confidential.
- Access to your health information is restricted to clinical staff that needs to know your health information in order to provide services to you.
- Physical, electronic, and procedural safeguards which comply with federal and state regulations guarding your health information.
- Records of client health information are maintained in a confidential, locked file system. The client files remain the property of your counselor, but the information belongs to you.

**Voluntary Release of Health Information**

- Your practitioner may disclose information to outside treatment or healthcare providers with your written authorization. You may revoke such authorization at any time provided each revocation is in writing.
- Your practitioner may use your information to develop accounts receivable information and with your consent, provide information to your insurance company for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider, name/identifier, and other information about your condition and treatment.

**MANDATORY DISCLOSURE WITH NEITHER CONSENT NOR AUTHORIZATION**

Your practitioner may disclose your health information without your consent or authorization in the following circumstances:

- **Abuse –** If your practitioner has reason to believe that a minor child, elderly person, or person with disability has been abused, abandoned, or neglected, your counselor must report this concern to the appropriate authorities.
- **Judicial and Administrative Proceedings as Required –** If you are involved in a court proceeding and a court subpoenas information about the professional services provided you and/or the records thereof, your practitioner may be compelled to provide the information. Your counselor will not release your information without attempting to notify you or your legally appointed representative.
- **Injury to Self or Others –** If you communicate to your practitioner an explicit threat of imminent physical harm to yourself or others, we have a legal duty to take the appropriate measures, including disclosures information to the police.
- **USA PATRIOT Act of 2001 –** Under certain circumstances, I may disclose information for specialized government purposes, such as military, national security and intelligence, or protection of the President.

**Client's Rights:**

- **Rights to Request Restrictions –** You have the right to request additional restrictions on certain uses and disclosures of protected health information. Your practitioner may not be able to accept your request, but if they do, they will uphold the restriction unless it is an emergency.
- **Right to Alternative Means and at Alternative Locations –** You have the right to request and receive confidential communications of health information by alternative means and at alternative locations. (For example, you may not want a family member to know you are being seen by a practitioner. On your request, your practitioner will send your information to another address).
- **Right to Inspect and Copy –** You have the right to inspect or obtain a copy of your clinical records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases, you have a right to request a review of that decision. 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 in writing an amendment of your health information for as long as the health information records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provide to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, I will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.

- **Right to an Accounting –** You generally have the right to receive an accounting of disclosures of health information. If your health information is disclosed for any reason other than treatment or health operations, you have the right to an accounting for each disclosure of the previous six (6) years, but the request cannot include dates before November 1, 2006. The accounting will include the date, name of person, or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

- **Electronic Information –** Requests for client health information for the purpose of consultation are honored through phone and postal mail communication only.

- **Grievance –** If you believe I have violated your privacy rights, you may file a complaint in writing to me. I will not retaliate against you for filing a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services.

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

**This Notice is effective as of July 16 2009:**

**I am required:**

- By law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this notice upon request.

- To abide by the terms of the *Notice of Privacy Practices* that is most current. I reserve the right to change the terms of the *Notice* at any time. Any changes will be effective for all protected health information that I maintain. The revised *Notice* will be posted in the waiting room (IF APPLICABLE: and on my web site). You may request a copy of the revised *Notice* at any time.

I am my own Privacy Officer. If you have any further questions about this *Notice of Privacy* please feel free to contact me. My contact information is 508.843.1880. Email: jannae@naturenurtureholistics.com

**Your counselor will only disclose your protected health information in order to carry out treatment, payment, and health care operations.**

**I may use or disclose information:**

- In your record to provide treatment to you. I may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if I want an opinion about your condition from a specialist, I may disclose information to the specialist to obtain that consultation.

- From your records to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinate care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

_____ Date_____

**Client Signature**

**ABOUT OUR APPOINTMENTS, FEES AND PAYMENTS AND CANCELLATION POLICY**

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**ABOUT OUR APPOINTMENTS**

Intake sessions are 90 minutes and follow up sessions are typically 50 minutes in length. Frequency of sessions varies depending upon issues presented and will be established during consultation with your practitioner. The termination policy can be determined by you or your practitioner at any time. I will tell you in advance of my vacations or any other times we cannot meet, due to illness or other circumstances.

**FEES AND PAYMENTS**

***At this time I am NOT taking insurance.*** My current fees are below. If there is financial hardship no one will be turned away as sliding scale fees are available. You will be given notice if my fees should change.

| | |
|---|---|
| *INTAKE INTERVIEW* | $110 |
| *INDIVIDUAL 50-MINUTES SESSION* | $85 |
| *FAMILY OR COUPLE* | $95 |

Occasionally it may be better to go on with a session, rather than stop or postpone a process on a particular day. When the extension is more than 10 minutes, I will tell you, because sessions that are extended beyond 10 minutes will be charge on a prorated basis.

Fees will be collected at the time of service of your session. I usually do not send bills. However, if we have agreed to bill you, I ask the bill be paid within 5 days of receipt. I will assume that our agreed upon fee-paying schedule will continue as long as I provide services to you. I will assume this until you tell me in person, by telephone, or by certified mail that you wish to end it. Cash, check, debit/credit are accepted at this time. Any check that is returned for insufficient funds will be charged the amount of the check and $25.00 processing fee. In the event of unpaid fees, I may choose to utilize a third party collection agency if you fail to pay the full balance due.

**CANCELATION POLICY**

If you fail to cancel a scheduled appointment, I am unable to use this time for another client and you will be billed for the entire cost of your missed appointment. A full session fee is charged for missed appointments or cancellations with less than 24 hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment. Thank you for your consideration regarding this important matter.

_____

**Clients Signature (Client's Parent/Guarding if under 13)**

_____

Today's Date

**IF YOU NEED TO CONTACT ME**

I cannot promise that I will be available at all times. Although I am in the office on Mondays and Saturdays, I do not take phone calls, texts or emails when I am with a client. You can always leave a message on my voicemail or an email and I will respond as soon as I can. Generally I will return phone and emails messages daily, except on Sundays and holidays.

If you have an emergency or crisis and are unable to reach me immediately, you or your family members should call 911 or go to the nearest emergency room. The National Suicide Hotline number is 1.800.273.8255. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary.

**IF I NEED TO CONTACT SOMEONE ABOUT YOU**

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you. I am also required to contact this person or the authorities if I become concerned about you harming someone else. Please provide the name of information of two (2) emergency contacts in the blanks provided.

Name _____ Phone_____

Relationship to you _____

Name _____ Phone_____

Relationship to you _____

**OUR AGREEMENT**

I, the client (parent or guardian), understand I have the right not to sign this form. My signature indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand that any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in the form, I can talk with you about them and you will do your best to answer them.

I understand that after treatment begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending the relationship.

I understand that no specific promises have been made to me by this practitioner about the results of treatment, the effectiveness of treatment, or the number of sessions necessary for healing to be effective.

I have read, or have had read to me, the issues and points of this form. I have discussed the points I did not understand, and have had any questions fully answered. I agree to act accordingly to the points covered in this form. I hereby agree to enter into treatment with this practitioner, and to cooperate fully and to the best of my ability. As shown by my signature here.

_____

**Client's Signature (Client's Parent/Guarding if under 13)**

_____

Today's Date

I, the therapist have met with this client (parent or guardian) for a suitable period of time, and have informed them of the issues and points raised in this brochure. I have responded to all of their questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into treatment with this client as show by my signature here.

_____

**Practitioner's Signature**

_____

Today's Date

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_____

**Practitioner's Signature**

_____

Today's Date