



High Country Counseling

Joan Zimmerman, LMFT, LCAS Professional Disclosure Statement (Information and Consent for Treatment)

Welcome. I am giving you the following information to insure that you have the information you need to make an informed decision regarding therapy.

I am a licensed Marriage and Family Therapist, and a licensed Clinical Addictions Specialist. I also am an AAMFT Approved Supervisor. I graduated from ASU in 2003, with a master's degree in Marriage and Family Therapy, and an Expressive Arts Therapy Certificate. I completed my LCAS in 2006. In 2010, I became an AAMFT Approved Supervisor.

My approach to therapy is based on a systemic perspective. I am interested in working with individuals (adults, adolescents and children), couples and families. Theoretically, I apply a variety of treatment strategies that will best fit the client's need. These theoretical orientations often include family of origin work, structural strategies, and a client-based approach. I often use experiential approaches to therapy, and expressive arts in my work. Since I believe that we each contain what we need to heal ourselves, I will usually not give you answers, but rather encourage you to come to your own truths.

During the therapy process, we will work together to identify and work on issues that are important to you. Together, we will set goals for your work, and will periodically review your goals, and assess your progress.

It is important to understand that there are potential risks, as well as benefits, of therapy. You may find that change is sometimes smooth and easy, and at other times much more difficult and slow-coming. During the process of therapy, you may deal with difficult emotional issues which may, at times, lead to unanticipated emotional stress, as well as emotional improvement. There is no guarantee of particular results or outcome from the therapy process. Of course, you are free to discontinue therapy at any time.

My cell phone number is 828/964-9211, and I try to be available in emergencies. Should you require such service and not be able to reach me, please call the local police or sheriff, medical emergency service, or other appropriate agency. Dialing 911 will connect you with emergency services.

My privacy policies are described in my Privacy Policy. In addition, it is important that you understand that when your therapy involves members of your family or significant others, all information may not be kept confidential among your client unit. It is your responsibility to be aware of what information may be shared with the other people involved in your therapy, such as your spouse. Information regarding affairs is one example. When in doubt, please ask me.

I appreciate payment after each session, unless other arrangements are made. My fees and policies regarding insurance and cancellations are attached. Policies regarding privacy and confidentiality are also explained separately.

Please feel free to ask questions about this statement at any time. By signing below, you are acknowledging that you have read, you understand and accept the terms of this disclosure statement, and that you are consenting to treatment. I will keep one copy for my confidential files, and give you a copy for your records.

Therapist's Signature _____ Date_____

Client's Signature _____ Date_____



Please print, review and keep for your records



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Joan Zimmerman, LMFT, LCAS
Appointment Cancellation, Payment and Insurance Policies

1. Appointment Cancellation

An important part of the therapy process is accepting responsibility for making and keeping appointments. I make every effort to provide you with your chosen appointment time, and set that time aside for your consultation. I understand that there are times when cancellation is unavoidable, but I reserve the right to charge for "no show" appointments, and appointments canceled with less than 24 hours notice.

2. Payment

I appreciate your payment at the end of each therapy session, unless we have made other arrangements. My fee is \$120.00 per hour.

3. Insurance

4. I accept BCBS insurance. In other cases, I will provide you with a detailed receipt that you can use to file with your insurance company. Since insurance coverage varies from company to company, your treatment may not be covered. I encourage you to insist upon reasonable coverage from your company, and will be happy to provide you with whatever information you request. I am dedicated to protect your confidentiality and your privacy, and therefore, will not answer questions from insurance claims representatives without your written permission.

I have read and understand the above written Appointment Cancellation, Payment and Insurance Policies and/or have had them explained to me. By signing and dating below, I am agreeing that I will comply with the policies.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____



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Joan Zimmerman, LMFT, LCAS Notice to Persons Regarding My Privacy Practices

During this initial contact with you, we discussed confidentiality and privacy issues. These practices are designed to protect your individual identifiable information and confidentiality. Although we are legally required to tell you about our privacy practices, we also believe that telling you about confidentiality is the right thing to do.

Although we have discussed our privacy and confidentiality practices with you, we will give you a written copy of our *Notice of Privacy Practices* if you request. The written *Notice of Privacy Practices* outlines how we can use and disclose information along with the rights that you have regarding your information maintained by us.

Also, we must obtain written acknowledgement that we have discussed our privacy practices with you. By signing this form, you are only acknowledging that you have been informed about our practices to maintain privacy and confidentiality. Please indicate if you want a copy of the *Notice of Privacy Practices*.

Finally, if you have any questions about your privacy at our practice, please contact Joan Zimmerman.

If you believe your rights have been violated or have a complaint about our practice, you may contact Joan Zimmerman or the Secretary, Department of Health and Human Services.

By signing this document I am acknowledging that I have

___ been informed about how my privacy and confidentiality will be maintained by Joan Zimmerman.

___ requested and received a copy of Joan Zimmerman's *Notice of Privacy Practices*

Client Signature

Date

Relationship to Client

Person Providing Notice



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Joan Zimmerman, LMFT, LCAS
Use and Disclosure of Therapy Notes

The information in this policy applies to all staff and other contractors granted access to protected health information.

Definition of a Therapy Note: Therapy notes are defined as documentation that captures the provider's impressions about the client, couple, or family containing details of the conversation to be inappropriate for the designated record and are used by the therapist for future sessions. Therapy notes can also be recorded in any medium by the provider who is documenting or analyzing the contents of the conversation during a private counseling/therapy session or a group, joint, or family session. Therapy notes are kept separate from the rest of the client's designated record.

Therapy notes shall be maintained separately from the designated record or file.

Release of Therapy Notes: Joan Zimmerman, MA, MFTA, LCAS may not release therapy notes, except in specific situations or required by law.

Summary information such as current state of the client, diagnoses, problems, symptoms, summary of themes of therapy sessions, and other information needed for treatment or payment shall be placed in the client's designated record.

The client does not have the right to inspect or obtain a copy of the therapy notes. A client may not request a review of the provider's denial of access to therapy notes. However, the client may be provided access to a summary of treatment/therapy.

The authorization for therapy notes may not be combined with an authorization for any other protected health information. An authorization for the use and disclosure of therapy notes may only be combined with another authorization for the use and disclosure of therapy notes.

When Authorization is Not Required: Authorization for the disclosure of therapy notes is not required in the following circumstances:

- For use of the provider for treatment;
- For use in supervision or training for supervisees to learn to practice therapy and counseling;
- To defend a legal action brought by the client;
- For the purposes of the Department of Health and Human Services in determining compliance with the privacy rule (Health Insurance Portability and Accounting Act);
- As otherwise required by law;
- By a oversight agency for a lawful purpose related to oversight of the therapist;
- To law enforcement in instances of permissible disclosure related to a serious or imminent threat to the health or safety of a person or the public; or,
- To a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death, or other duties authorized by law

Enforcement: Joan Zimmerman is responsible for enforcing this policy. Individuals who violate this policy will be subject to the appropriate and applicable disciplinary process, up to and including termination or dismissal.

References: 45 CFR 164.508 (a)(2)
45 CFR 164.524



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**Joan Zimmerman, LMFT, LCAS
Notice of Privacy Practices**

My practice follows professional standards and laws to protect your privacy. Federal laws require me to provide you with a notice of my privacy practices.

This notice describes how your individual identifiable information may be used or disclosed. Also, this notice describes how you may get access to your individual identifiable information that is maintained by my practice. Please read this notice and ask me any questions you have on how I keep you information confidential.

Ways I Can Use and Disclose Information WITHOUT Your Permission

Typically, my practice will ask for your written permission or authorization to share or obtain information with others. However, I may use and disclose information about you without your authorization in the following circumstances:

1. **Treatment:** I may use your information and disclose it to manage or coordinate treatment provided to you. For example, your therapist may share information with another therapist or your physician to coordinate services
2. **Payment:** I may use and disclose necessary information about you to obtain payment for my services. For example, this information could include information that your health insurance plan may require before it approves or pays for treatment services I recommend for you.
3. **Health Care Operations:** I may need to use or disclose information for my practice activities. Examples of these activities include:
 - clinical supervision of staff to meet state licensure and/or certification requirements.
 - Education and training of students and other professionals.
 - Compliance activities to ensure I am properly following policies, procedures, laws, regulations, and professional standards.

I may use or disclose information about you in several other circumstances in which you do not have an opportunity to agree or object. These situations include:

1. **Required by Law:** I may need to disclose information for judicial or other administrative proceedings. For example, I may need to disclose information in response to a court order.
2. **Abuse or Neglect:** I am required to disclose information if I believe that you or a family member have been a victim of abuse or neglect OR if you or a family member is abusing or neglecting another person.
3. **Danger to Self or Others:** I am required to take steps to prevent you harming yourself or another person.
4. **Law Enforcement:** Law enforcement purposes may include:
 - Legal processes required by law
 - Limited information requests for identification and location purposes.
 - Pertaining to victims of a crime.
 - In the event that a crime occurs on our premises
5. **Public Health:** I may be required by law to report health related information for public health activities.
6. **Other Circumstances:** Although not typically encountered in my practice, there are other situations when I may disclose information without your written authorization. Examples of these circumstances include providing information for research, information on inmates or military veterans, and national security activities.

For any reason other than those listed above, I will ask for your written authorization before I use or disclose information about you. Also, any authorization can be canceled any time in writing. (If you tell me you are canceling an authorization, I will have you sign a request during the current or next visit.) If cancelled, I will no longer disclose information that was allowed under that specific authorization.

Important!: Therapy notes have special protections and I will not release or disclose therapy notes without your permission to do so, except when required by law. I have a



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specific policy on the use and disclosure of therapy notes. This policy can be shared with you if you request.

Your Rights About Your Private Identifiable Information

1. **Request Restrictions**: You may request further restrictions on my uses and disclosures of your information. I may not be able to agree to all requested restrictions. Please let me know if you want specific restrictions on your information.
2. **Different Ways to Communicate**: Typically I will communicate by mailing or phoning your residence. However, you may prefer a different way for us to contact you. For example, you may ask for me to contact you at a specific address or phone. Please note that cell phones and e-mail may not offer confidentiality or privacy protection.
3. **Right to See and Copy Information**: You may see and receive copies of your information maintained in your designated record. I may charge for copying your designated record. There are situations in which I do not have to comply to your request. However, I will say in writing if I cannot comply to a request.

Please note that therapy notes are not part of your designated record. Because therapy notes are not part of your designated record, you may not have access to therapy notes. If you want to see therapy notes, please discuss this request with your therapist.

4. **Right to Request Amendment of Your Information**: You may request that information about you be amended or changed. I may deny your request if I did not create the information (it was obtained from another source). Also, I may deny your request if I believe the information is correct. Denials will be written and will describe your rights for further review. If I agree to amend, I will make reasonable efforts to share with any person who may have received your information that it needs amending. Please ask me if you want to amend you information that I maintain in your designated record.
5. **Listing Of Disclosures I Have Made**: You may request a list of certain disclosures of your information for up to the last six (6) years. This list does not include disclosures made prior to April 14, 2003 (when the Federal Privacy Rule took effect) or disclosures related to your treatment, payment or my practice operations, and those disclosures required by law. Ask me if you desire a listing of disclosures.
6. **Copy of This Notice**: You may request a copy of this notice at any time. A copy is available at my practice site.
7. **You May File a Complaint About My Privacy Practice**: If you think I have violated your privacy rights described in this notice, or you want to complain to me about my privacy practices, you can contact me.

Also, you may send a written complaint to the secretary, Department of Health and Human Services.

If you send a complaint, I will not take any action against you or change my treatment of you in any way.