

## MINDFULNESS COUNSELING SERVICES LLC

### CONSENT FOR TREATMENT and HIPAA COMPLIANCE ACKNOWLEDGMENT

(Revised 7/6/2020)

#### CONFIDENTIALITY AND PRIVACY

Sessions are confidential. Information regarding treatment may be shared with a third-party only with written consent from you, with few exceptions. Exceptions to confidentiality include when a client is in imminent danger of harming self or others, or when child or elder abuse is suspected. When the client is a minor, legal guardians may know about general treatment plans, though the minor's privacy will be respected as much as possible. More complete information regarding your privacy rights can be found in the document, "HIPAA Notice of Privacy Practices," which has been provided to you. You may request an additional copy at any time. You may discuss any questions or concerns regarding confidentiality and privacy with me.

#### SOCIAL MEDIA POLICY

I do not accept friend or contact requests from current or former clients. Please do not message me on any social media site as I will not respond.

#### COMMUNICATION

Please know that neither my mobile phone nor my direct email are secure or HIPAA compliant. If you wish to speak to me about confidential or session-related content and it cannot wait until your next scheduled session, the best way to reach out is through my secure email:

<https://sendsafe.to/barbshaya@aol.com>.

I do send appointment reminders via text message the day before your appointment to avoid having to charge late cancellation fees. Please inform me if you prefer I do not send a reminder.

#### SCHEDULING APPOINTMENTS

It is preferred that we schedule our next session at the conclusion of your current session. If you need to schedule an appointment or modify an existing appointment, you may phone or text me. Do not include any personal or session-related content in your message as this is not a secure or confidential method of communication.

#### FEES

Payment shall be made at the time of service unless other arrangements are made in advance. As I do not participate directly with insurance providers, you are responsible for paying my fees in full. I am able to provide an invoice which you can submit to your insurance company for reimbursement. I am considered an out-of-network provider. It is your responsibility to contact your insurance company to determine how much they will reimburse you for my services. By signing below, you acknowledge that you are fully responsible for payment of any charges incurred and for all services provided to you/your child.

## CANCELLATION POLICY

Appointment times have been reserved for only you/your child. If you need to cancel your appointment, you must provide a 24-hour advance notice. You will be charged your regular session rate for any missed appointment without a 24-hour notice.

## ONLINE APPOINTMENT CONSIDERATIONS

While in-person counseling sessions are preferred, there may be times when appointments are conducted over the phone or via an online video platform. In these instances, I remain professionally obligated to the ACA Code of Ethics regarding my work with you. The following are examples of the risks and limitations of technology-based sessions:

- Equipment failures due to lost power or poor internet service or provider connections. Whether this occurs on your end or mine, we will do our best to communicate the issue and attempt to restore connection.
- Loss of privacy due to my inability to control *your* environment. I commit to being in a private and locked physical space with a white noise machine running to ensure your privacy. I ask that you also ensure you are in a space where others will not hear or walk-in during our appointments.
- Under no circumstances will I record, audio or video, our sessions without your expressed written authorization.
- Under no circumstances shall you record, audio or video, our sessions without my expressed written authorization.
- I reserve the right to determine whether technology-based services are an appropriate counseling modality for you. If I deem they are not, and you are unable to attend in-person sessions, I will provide referrals to other potential therapists.

**By signing below I acknowledge that I have read and understand the above policies and guidelines applicable for both in-person and technology-based (online or phone) sessions. I also acknowledge receipt and understanding of the [HIPAA Notice of Privacy Practices](#).**

\*Please keep a copy of this form for your records.

\_\_\_\_\_  
Client name (printed)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature of Client, Parent or Guardian (circle)      Date



mindfulness counseling