STATE OF MIND
therapy services

Greta Aronson, MS, LPC
1934 NW Copper Oaks Circle
Blue Springs, MO 64015
(816) 463-2581
greta@stateofmindkc.com

PATIENT INTAKE

Date: _____

Patient Name: _____ SSN: ___ - ___ - ____

Date of Birth: ____ / ____ / ____ Gender: ☐ Male ☐ Female ☐ Other Marital Status: _____

Ethnicity: _____ Religion (if applicable): _____

Home Address: _____
Street Address

_____
City State Zip

Email: _____ *May I email you?* ☐ Yes ☐ No

Cell Phone Number: _____ *May I leave a voicemail?* ☐ Yes ☐ No
May I text you? ☐ Yes ☐ No

Home/Work Number: _____ *May I leave a voicemail?* ☐ Yes ☐ No

Referral Source – Who referred you to my office, or how did you learn about me?

☐ Google ☐ Psychology Today ☐ Doctor/PCP ☐ Wellness center

☐ Word of mouth ☐ Facebook/Instagram ☐ CPS Website ☐ Other _____

Emergency Contact Information

In case of an emergency, who should be contacted?

Name: _____ Relationship: _____

Phone Number: _____

Coordination of Care

It is important for your health care providers to speak to each other so we may work together for your benefit. Please complete the information and indicate your approval for me to coordinate care, if necessary.

Primary Care Physician: _____ Ph: _____

Psychiatrist/Psychologist/Therapist: _____ Ph: _____

May I contact your Physician? ☐ Yes ☐ No ☐ I do not have a physician
May I contact your Psychiatrist? ☐ Yes ☐ No ☐ I do not have a psychiatrist
May I contact your Psychologist? ☐ Yes ☐ No ☐ I do not have a psychologist

History Information

Completing the following information as thoroughly as possible will help your therapist provide you the best treatment.

Who is providing the history information? ☐ The patient ☐ The patient's guardian ☐ Other: _____

Please describe the current complaint or problem or reason for appointment as specifically as you can, in your own words:

_____

_____

_____

How long have you experienced this problem, or when did you first notice it? _____

_____

What stressors may have contributed to the current complaint or problem? _____

_____

Check all words/phrases that describe what you are experiencing and explain if possible.

☐ Depression/Sad/Down _____

☐ Loss of interest in activities _____

☐ Change in weight or appetite _____

☐ High/Low energy level _____

☐ Feelings of shame/guilt/inadequacy _____

☐ Poor concentration/Indecisiveness _____

☐ Feelings of hopelessness _____

☐ Suicidal thoughts or plans _____

☐ Anxious/Nervous/Tense _____

☐ Racing or scrambled thoughts _____

☐ Panic attacks _____

☐ Muscle tensions, aches, etc. _____

☐ Sleep problems _____

☐ Withdrawing from people _____

☐ Occupational/Job problems _____

☐ Indecisiveness about career _____

☐ Angry/Irritable _____

☐ Difficulty enjoying things _____

☐ Crying spells _____

☐ Decreased motivation _____

☐ Mood swings _____

☐ Flashbacks _____

☐ Thoughts of running away _____

☐ Bad or unwanted thoughts _____

☐ Thoughts of hurting people _____

☐ Hearing voices/Seeing things _____

☐ People are out to get me or hurt me _____

Are you currently experiencing thoughts of harming either yourself or someone else? ☐ Yes ☐ No
Have you in the past experienced thoughts of harming either yourself or someone else? ☐ Yes ☐ No

Treatment History

Previous psychiatric diagnoses/dates of diagnoses: _____

_____

Previous Outpatient counseling and/or psychotherapy? ☐ Yes ☐ No

Approximate dates/Reason: _____

Previous Psychiatric hospital admissions? ☐ Yes ☐ No

Approximate dates/Reason: _____

Suicide attempts? ☐ Yes ☐ No Approximate dates/How: _____

List any current, or past, medications. (You may provide the information on another sheet of paper if you need more space.)

Medication & Dose Date Reason for Taking Response

_____

_____

_____

Medical History

History of serious childhood illnesses: _____

Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time:

_____

Have you experienced any head injuries? ☐ Yes ☐ No If yes, did you lose consciousness? ☐ Yes ☐ No

Details: _____

Have you experienced convulsions or seizures? ☐ Yes ☐ No

How would you rate your current physical health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

What was the date of your last physical or routine health check up? _____

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)

☐ Yes ☐ No Additional Information: _____

Have you ever tried to cut down on your drinking or drug use? ☐ Yes ☐ No

Are you annoyed when people ask you about your drinking or drug use? ☐ Yes ☐ No

Do you ever feel guilty about your drinking or drug use? ☐ Yes ☐ No

Do you ever take a morning eye-opener of drink or drug? ☐ Yes ☐ No

Family History

Birth Location: _____ Raised by: ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father
☐ Other _____

Describe your relationship with parent figures (good, fair, poor, close, distant, etc):

Mother: _____

Father: _____

Other: _____

Other: _____

List your siblings and describe your relationship with them:

First Name	Age	Gender	Nature of Relationship

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse? _____

Any family history of substance abuse, mental illness, suicide, or violence? _____

Any additional family information: _____

Marital and Relationship History

Which best describes your marital status? ☐ Married, Date: _____ ☐ Never Married ☐ Widowed, Date: _____
☐ Separated, Date: _____ ☐ Divorced, Date: _____

If you are married please briefly describe nature of your marital relationship: _____

If you are married, which best describes your marital satisfaction? ☐ Poor ☐ Fair ☐ Good ☐ Great

Please list any previous marriages/significant relationships, including current:

First Name	Dates	Nature of Relationship

Do you have children? ☐ Yes ☐ No If yes, complete the following:

First Name	Age	Gender	Nature of Relationship

Are there presently any child custody issues involving you or your family? ☐ Yes ☐ No

Social History

Describe your relationship with peers and/or friends: _____

How would you describe your social support network: _____

Describe your hobbies/interests: _____

Have you ever had concerns about how you interact in social situations? _____

Describe any cultural concerns: _____

How important are religious/spiritual issues to you? ☐ Not Important ☐ Somewhat Important ☐ Very Important

Educational History

When attending school were you: ☐ In regular classes ☐ Home Study ☐ Special classes

☐ Ever suspended? For what reason? _____

What is the highest educational level you have completed? _____

Give any additional important educational information (i.e. Did you like school?): _____

Occupational History

What is your current employment status? ☐ Employed Full-Time ☐ Employed Part-time ☐ Unemployed

☐ Self-employed ☐ Student

If employed, who is your employer? _____ What is your position? _____

How would you describe your job satisfaction: ☐ Poor ☐ Fair ☐ Good ☐ Great

How would you describe your job performance: ☐ Poor ☐ Fair ☐ Good ☐ Great

What type of employment or training have you had previous to your current occupation? _____

Legal & Military History

Do you currently have any pending criminal charges? ☐ Yes ☐ No

Have you ever been convicted of a crime? ☐ Yes ☐ No If yes, explain: _____

Does your family currently have Division of Family Services Involvement? ☐ Yes ☐ No

Are you presently, or have you previously served in the military? ☐ Yes ☐ No

Additional Information

Summarize your goals for therapy: _____

_____

_____

Is there any additional information that you believe it is important for me to know in order to provide you with the best care possible? _____

_____

_____

_____ _____

Signature of patient or guardian Date

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therapy services

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TELEHEALTH INFORMED CONSENT AND HIPAA POLICY

AGREEMENT FOR TELEHEALTH

In Missouri, "telehealth" is defined as the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient. This form of service is usually live videoconferencing through a personal computer with a webcam, a smartphone with a camera, or a general voice-to-voice phone call.

Online therapy allows me to provide services to a broader geographic range of clients than in-person services. I am a licensed professional counselor in Missouri (#2015007032) and am able to serve clients throughout the state. ***You must be located in the state of Missouri for me to conduct an online session with you.***

This document provides information about the telehealth process and the business policies for Greta Aronson, LPC at State of Mind Kansas City. This document is important, so please take the time to read it carefully and ask about any items that seem unclear. By signing this form you indicate that you agree to and understand the psychotherapy process and business policies between you and your clinician, Greta Aronson, LPC.

INFORMED CONSENT

Psychotherapy can have benefits and risks. As with most other forms of treatments, results cannot be guaranteed.

Participation in therapy can result in a number of benefits to you. You may experience increased insight into your patterns of feeling, thinking, behaving and relating to others; improvement in your relationships; resolution of any symptoms that brought you into therapy; and insights, lessons, or techniques that will improve current and future life challenges.

Benefits to therapy require openness on the part of the therapy client. When information about your feelings, thoughts, behaviors, relationships, or other difficulties are withheld, it is not possible for the therapist to help you with them or to help you understand how they may be related (or not) to the issue for which you are seeking treatment. Benefits also require consistent attendance in therapy and work both in and outside of therapy sessions.

Therapy involves talking about experiences in your life that may cause you to feel difficult emotions. The goal is to work through, rather than get stuck in, difficult emotions or thoughts. During the process, you may experience painful thoughts or emotions (e.g. anger, hurt, frustration, or confusion). Some people notice an immediate sense of relief when they share their pain with someone else. Others may notice that their symptoms get worse, before they begin to get better. In either case, it's important to share your reactions to therapy.

It is important to talk to your therapist about these reactions to therapy when they come up. They may be a natural, tolerable, and expected reactions to your work in psychotherapy. Other times it may be necessary or preferable to change the pace of your therapeutic work if the feelings are too uncomfortable. Or, if the treatment is not helping, it is important to talk about other treatment options.

SESSIONS AND PAYMENT POLICY

Your first session/s will involve an evaluation of your needs. While evaluation is ongoing, the initial phase of evaluation will result in a discussion of your therapy goals and recommendations about how you might reach those goals. You and I will work together to reach a shared understanding of where your problems come from and what factors in your life contribute to keeping those problems in place. This information guides how you will move forward in resolving them. Should either of us determine that the type of treatment I can offer, or the mode of treatment (online) is not a good fit for you, or even if we find that I am not a good fit, I will share recommendations for the right type of treatment and provider.

While the specific methods of therapy will come from our assessment, it may be helpful for you to understand the general process. Initially, our work will be about getting to know and understand you, together. I make this as comfortable as possible by listening carefully, reflecting back what I hear so that you can let me know if I'm really "getting" you, and collaborating with you to form connections between your experiences with your feelings with your thoughts and your impulses or behaviors. We will also do things to bring immediate relief to areas of suffering – for example if you struggle with sleep or anger or anxiety, we'll assess it deeply and then practice strategies to overcome it.

If you have questions about any of the procedures used in the course of your therapy, their possible risks, the clinician's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

Therapy may also involve recommendations or referrals to additional services that support your wellness (e.g. psychiatrist, neuropsychologist, physician). In some cases these treatments are so vital and central to your recovery that your clinician is unable to ethically continue providing therapy without your concurrent treatment with these providers. Failing to follow these recommendations may result in impaired treatment progress, suicidal thoughts or actions, deteriorating medical condition, or termination of treatment with this clinician. Most often, however, these are recommendations and not requirements.

TECHNOLOGY HOW-TO

I encourage you to do a test log-in prior to our appointment to make sure that everything is working well on your side. You can check that your mic, speakers, and video are working this way. The link to log in to your Therapy Portal is **https://www.therapyportal.com/p/gka64015/**.

It takes a few seconds after you log into the waiting room for us to show up on each other's screens. That's normal. If it seems to be taking an inordinate amount of time, feel free to text, email, or call me so that we can troubleshoot together.

Please be sure to exit out of any programs that steal bandwidth prior to our sessions. Quit (don't just minimize) Skype, Google Drive back-up, or any other cloud backup service. Please ensure that no one in your home is streaming video or playing graphic-heavy online video games, as this will decrease our internet connection.

Tech issues are rare and usually very easy to solve. Turning things off and back on again typically fixes most issues.

ADDITIONAL PRO-TIPS FOR ONLINE THERAPY

- If others will be nearby while you are in therapy, ensure that you have adequate privacy prior to session. Psychotherapy is serious work. You do not want to be interrupted.
- Turn off notifications on your computer and phone once we are connected.
- Bring tissues. If you were in my office, I'd provide them for you.
- You may be extra cozy because you are somewhere familiar to you and you may feel more casual because the work is online and you are used to socializing that way. Remind yourself prior to the session that you are here to do the meaningful work of positive change.
- Research says that the connection between therapist and client is the primary determinant of therapeutic change. I want to make sure that we connect well over video so in our first session, I'll share some tricks to make sure that we can look at each other, rather than the camera, when we talk. If it looks off to you, please let me know. Eye contact matters.

STRENGTHS AND LIMITATIONS OF ONLINE THERAPY

Telephone, chat, and video sessions have some advantages over in-person psychotherapy. Many of my clients share with me that it is more convenient (no commute) and more comfortable (in their own space). Some clients share that they feel more able to share "deep" things because it is online rather than in person.

Online therapy is not for everyone. If a client has a poor internet connection, a lack of privacy, or otherwise would simply be more comfortable meeting in person, it is better to connect them with a provider who offers that service if I'm unable to accommodate. It is important to consider if this applies to you and may impact your therapeutic progress. In some clinical situations, such as crises or suicidal or homicidal thoughts, in-person treatment may be the most appropriate treatment choice.

CONFIDENTIALITY

Information shared by a client during therapy sessions is confidential. This means that I do not share your information with anyone except with legally or ethically bound to do so. Those circumstances are as follows:

- I am required to report suspicion of child abuse, neglect, or abandonment
- I am required to report suspicion of elder/vulnerable adult abuse, neglect, or exploitation
- I will share important and relevant information to protect a person to whom you appear to be an imminent and/or immediate physical threat
- I will share important and relevant information to protect you from imminent or immediate and/or immediate physical threat to yourself
- I may be required by Court Order to disclose treatment information.

Additionally, communication with me via any online or electronic means (i.e. email, text, video chat) is limited in security and thus your confidentiality may not be guaranteed. Please consider the limits of confidentiality in electronic communications outlined in more detail later.

In the event of an injury, illness, or other unexpected emergency situation that results in me becoming unavailable, your basic contact information (name and contact numbers or email) may be provided to a fellow clinician or associated professional. This will allow for your timely notification of appointment cancellations, as well as provide you with an opportunity to obtain further information regarding your continued care.

Considering all of the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful in any way. For any release of information, I will require a document to be completed detailing the information to be disclosed with your signature.

Consultation: I consult regularly with other professionals regarding my clients to provide the best care possible; however the client's name or other identifying information is never disclosed. The clients' identity remains completely anonymous and confidentiality is fully maintained.

Confidentiality in Emergencies: Should you enter a medical or psychological emergency, I need to know your location so that I am able to get help to you. Please share the location from which you will be conducting our sessions.

Physical Location of Client Receiving Services:

_____

_____

_____

Please sign below to indicate that you agree to/will share your location with me at the beginning of session should it be different from the one listed above.

_____

Should you need physical or emotional assistance (e.g. approaching a psychological emergency but not at the threshold of needing to be hospitalized, or feeling dizzy but not in need to an ambulance), I would like to be able to contact someone to assist you. I will contact the person named as your emergency contact on your intake form.

CONFIDENTIALITY OF EMAIL, CHAT, CELL PHONE, VIDEO, AND FAX COMMUNICATION

I use secure and encrypted video software for our sessions. I also use secure and unsecured email, phone, and faxing systems. However, I want you to be aware that if you do not also use secure/encrypted programs on your side of the communication, the communications may not be secure. I will adapt to your comfortability of sharing as we proceed. Security laws state that clients have the freedom to request or opt-in to less secure means of communication if they are aware of the risks, comfortable with them, and find it clinically helpful to do so.

I also want to acknowledge that while I regularly check in on the security of all of our ways of communicating, swift advances in technology preclude my ability to be certain of our security. Just as I cannot guarantee a physical office space isn't broken into, I also cannot guarantee the absolute security of our work online.

Please ensure that you, too, are doing your utmost to protect your privacy by considering who has access to your email, text messages, and so on before choosing online therapy. For example, I would discourage you from using your work email for our communications. Another way to protect your privacy is to sure to fully exit all online counseling sessions and emails before leaving your computer.

SESSIONS AND PAYMENT POLICY

Length of Sessions: All intakes and regular sessions are between 38-45 minutes. If a longer session is needed, we may schedule one and prorate it at the same rate of the regular 45-minute session rate. If sessions last more than 10 minutes over the normal 45 minutes scheduled, I reserve the right to prorate the total time. It is important that you regularly and promptly attend scheduled sessions.

Lateness: Please arrive to your online appointment on time. **If you are running late for whatever reason, we will still end the session by the 45-minute mark after the appointment start time.** Your full fee will be due even if you are late. If I am running late, I will always extend the time to allow a 38-45-minute session.

Insurance: I do not accept insurance. If you wish to seek potential reimbursement from your insurance company, I am considered an "out-of-network" provider. It is your responsibility to ensure that you are covered if you choose to be reimbursed.

Rates: Payments in the form of a debit or credit card are made at each session for the amount of $130 per 38-45 minutes of service. Longer sessions and phone calls in excess of 10 minutes are to be prorated on the basis of this amount. The initial session will be billed at $150, unless otherwise agreed upon. You are responsible for paying the full amount of fees which are not covered by insurance or other 3rd party payers. I reserve the right to terminate services for cause of unpaid balances.

Responsible Party for Payment: _____

Standard Fee (38-45 minute session): $130 (unless otherwise agreed upon)

Please initial that you have read, understand, and agree to the following :

___ I am responsible for the charges I incur as a result of counseling and/or assessment.

___ Charges are based on the amount of professional time used and/or set aside for the appointment.

___ A late cancellation or no-show charge of my ***full session fee*** will be billed to me if I do not notify my therapist 24 hours prior to my appointment. I understand my therapist will run my card on file for the full session fee at the time was service was to be rendered unless I request to hold the charge immediately.

___ All payments are due at the time of service unless other arrangements have been made in advance. I understand that if my credit card does not accept the charge, I will immediately make the payment to the practice.

___ I am responsible for paying the full amount of fees which are not covered by insurance or other 3rd party payers.

___ I will notify my therapist of any changes in my address and/or telephone number, or financial situation.

___ I am aware that my account will be sent to collections if I have an unpaid balance for more than 90 days. If your account is referred to an outside collection agency, the cost of that service will be added to your bill.

Credit Card Authorization: I authorize Greta Aronson, LPC to keep my signature and card information electronically on file in the Therapy Notes EHR software. I understand that I am required to leave a card on file in order to receive telehealth services. I understand this is a HIPAA-compliant platform and I am willing to assume the risk for keeping this information on file. I understand that I still have the option to pay cash or check at each session, if I choose.

I authorize the charging of my card on file as indicated above for both **session payment** and **cancellation fees**. I also authorize the automatic charging of my credit card on record for any balance left 30 days after the time of service. I acknowledge that credit card transactions could be linked to protected health information. I understand that I may ask for and be provided a receipt of payment at any time. I understand that I may ask for a copy of this contract at any time.

_____ _____

Cardholder's Signature Date

I fully understand and agree to the terms and conditions stated above regarding the payment policy.

_____ _____

Responsible Party's Signature Date

Other Professional Fees: Fees and payment schedules for other professional services will be contracted as they are needed. Examples include report writing, consultations, psychological testing, test interpretations, preparation of records, treatment summaries, court appearances, and school visits.

Legal proceedings that require my participation will incur additional charges. These include all professional time, including preparation and transportation costs, even if I am called to testify by another party. Due to the difficulties of legal involvements, the charge for preparation and attendance at any legal proceeding is $300.00 per hour. I am unwilling to be a witness, provide expert testimony, or provide evaluations in any child custody, divorce, domestic or other civil/criminal court proceedings. These services are outside the scope of my expertise and the professional services I provide in my practice.

Reminder Emails: You will receive appointment reminders 2 days in advance of your appointment start time from TherapyPortal.com. The Portal is part of TherapyNotes, which is a HIPAA-compliant electronic health record system that holds all protected health information and credit card information. I will also be able to send you documents through the Therapy Portal.

Cancellation Policy and Fees: I understand that it may be necessary to cancel an appointment. If you are unable to attend a scheduled appointment, you must notify me at least 24 hours before to your appointment time. **If you do not notify me 24 hours ahead of time or simply do not show up to your appointment, you will be charged your full session fee.** Variance from this policy is at my discretion.

Non-payment of Fee: If you have not paid for your sessions and do not respond to my attempts to contact you to work out a payment plan, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount

due. By coming to see me, you agree to this policy. A late fee of 20% of the unpaid balance will be charged each month that a balance remains unpaid.

If you become involved in legal proceedings that require my assistance, you will be expected to pay for all of my qualified time, including planning and transportation costs. Due to the complicated nature and difficulty of legal involvement, the fee is $300 per hour.

CONTACT POLICY

Phone Calls: I am not immediately available by phone. I provide a voicemail for non-emergency situations, i.e. rescheduling, cancellations, and clinical updates. I make every effort to return your call within 24-48 hours, with the exception of weekends/holidays.

Risks of Communication by Email, Text Message, and Other Non-Secure Means: It may be useful during the course of treatment to communicate by email, text message, or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with me, there is the potential chance that a third party may be able to intercept these messages. Some of the potential risks you might encounter using these methods of communication include:

- People in your home or other environments who access your phone/computer/other devices that you use might read your email or text messages
- Loss of your cell phone, computer, or other devices
- Email accounts can be hacked
- Text messages and emails are stored on servers
- Third parties on the Internet (i.e. system administrators) monitor Internet traffic might intercept your communication

Please limit the use of electronic communications to issues related to scheduling and/or billing. There may be situations in which you request that I send "growth work" reminders or documents that we create in session. If you choose to email me, please be aware that my email responses will be brief. Depending on the circumstances, I may choose to call you to discuss the matter directly. I will not respond to text messages that are not related to scheduling/billing or outside of regular business hours. *I will not, under any circumstances, give therapeutic responses or help via electronic communications.* If you need to discuss a clinical matter with me, please call to schedule an appointment or wait so we can discuss it at your next session.

Text Messaging: I will receive and respond to text messages at (816) 463-2581 regarding scheduling and billing Please be advised that text messages are unencrypted forms of communication and could result in an unintended breach of confidentiality. Any texts you send may also become a part of your legal medical record and will need to be documented and archived in your chart.

Email: Feel free to communicate with me regarding scheduling and billing via email at greta@stateofmindkc.com. I will do my best to assure your confidentiality through email but due to viruses, hackers, etc., no email correspondence can be guaranteed to be confidential. Do not send any information that you would consider to be sensitive information through email. Emails may also become part of your legal medical record.

Emergency and Crisis Support: I do not provide 24-hour crisis services. As an individual provider who is not in a group practice, I am generally in a therapy session during working hours and am unavailable outside of working hours. If a life-threatening crisis should occur, contact a crisis hotline, call 911, or go to a hospital emergency room. If it is likely that you may need crisis support, let's discuss this so that I can be sure you have the level of care you need. You deserve support that matches your needs.

Social Media: In order to protect our relationship, I cannot accept invitations to social events or social media requests. Should we run into each other socially in person or online, I will never acknowledge working therapeutically with you. While you are welcome to visit my professional social media pages or website, I would discourage you from leaving messages there that make it obvious you are a client, simply to better protect your privacy and anonymity.

METHODS OF COMMUNICATION

Be aware that basic demographic details like your name, email, and location are considered Protected Health Information (PHI) as is anything clinical in nature like your diagnosis or clinical material. Please initial next to each item you consent to.

I consent to allow Greta Aronson, LPC to use unsecured email, cell/VoIP phone text messaging, calls, faxes, or voicemail to transmit to me the following protected health information:

____ Information related to the scheduling of meetings or other appointments
____ Information related to billing and payment
____ Information that is clinical in nature (e.g. treatment summaries, diagnosis)

We will discuss the options you opted into in our meeting including the clinical utility of communicating in any of the ways mentioned above to decide together if we want to include them in your treatment. Should we decide to share more than basic administrative materials electronically, we need to discuss it first in session so that we can weigh the pros and cons. The delivery of any electronic communication can be intercepted, misdirected, or delayed. Decisions about this should be thoughtful, collaborative, and mutually acceptable.

DISCHARGED FROM CARE

Psychotherapy is typically terminated when it becomes reasonably clear that the client no longer needs care. So that you can process the termination of the therapeutic relationship, a final appointment is helpful when ending therapy. This final appointment can be used to review your therapeutic growth, to plan next steps, and to process the termination of therapy.

If you do not show up to your appointment(s), and/or do not return calls or emails, it will be assumed that you are wanting to discontinue your therapeutic work and you will be discharged from care. You may schedule an appointment after being discharged upon my approval.

Both the therapist and the client have the right to end counseling at any time.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the therapy records be requested.

AGREEMENT

By signing below, you acknowledge you have read the proceeding information, understand your rights as a client, and agree to psychotherapy services under these conditions. Additionally, your signature below indicates that you understand that I, Greta Aronson, LPC, am an independent practitioner; therefore, the providers I contract with (e.g. my video software, my billing software, etc.) are not responsible for or involved in your care or treatment. Your signature below also indicates that you have been informed of the risks, including but not limited to your confidentiality in treatment, the transmission of your protected health information by unsecured means, and that you may terminate this consent at any time.

Client Name (printed) Authorized Signature Date

Please sign and date to signify that you have read and understand the HIPAA Privacy Practices Notice included with this paperwork by law:

Authorized Signature Date

HIPAA PRIVACY PRACTICES NOTICE

This notice describes the parameters of HIPAA, how mental health and medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully.

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

State of Mind Kansas City, LLC (DBA Greta Aronson) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
  -- Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  -- Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  -- Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our practice such as sharing, employing applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our practice, i.e. releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Greta Aronson 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 we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes that have been made about our conversation during a private, group, joint, or family counseling session, which have been 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) we 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

Greta Aronson may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse- If I have reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, we must report the matter to the appropriate authorities as required by law.
- Adult and Domestic Abuse – If I have reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services, I must report this belief to the appropriate authorities as required by law.
- Health Oversight Activities – I may disclose PHI to the Missouri State Committee of Counselors for a proceeding before the Board, if necessary.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services we provided you and/or the records thereof, such information is privileged under state law. We will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety – If I believe that there is a substantial likelihood that you have threatened an identifiable person and that you are likely to act on that threat in the foreseeable future, we may disclose information in order to protect that individual. If we believe that you present an imminent risk of serious physical harm or death to yourself, we may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you.
- Worker's Compensation – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation/other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient Rights and State of Mind Kansas City, LLC/Greta Aronson Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of PHI. However, we are 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 alternate locations. (For example, you may not want a family member to know that you are being seen at my office.) On your request, we will send your bills to another address.
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request & denial process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from Greta Aronson upon request, even if you have agreed to receive the notice electronically.

State of Mind Kansas City, LLC/Greta Aronson Duties:

- Greta Aronson is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- Greta Aronson reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- In situations where specific advice is required, I reserve the right to seek legal advice.
- If I revise our policies and procedures in a substantial way, I will notify you in person or by mail.

V. Limits to Confidentiality

Protection – (1) I am legally mandated to report any suspected child and elder abuse or neglect. (2) I reserve the right to take any step necessary in the prevention of suicide/the imminent and direct self- harm. (3) I have an ethical duty to warn any identifiable person of intended harm.
Consultations – I may occasionally find it helpful to consult other health and mental health professionals about your case. During a consultation I will make every effort to avoid revealing your identity. Other professionals are legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I believe that it is important to our work together. All consultations will be noted as PHI.
Business Practices – I work with a group of independent mental health clinicians under the name Christian Psychological Services of KC. This group is an association of independently practicing professionals which share certain expenses and administrative functions. While the members share a name and office space, I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no members of the group can have access to them without your specific, written permission. Any Greta Aronson, LLC Business Associate will be bound by contract to provide the same level of protection as required by HIPAA.
Professional Records – Professional records, including PHI and psychotherapy notes, are handled in accord with HIPAA requirements.
Clients Rights: HIPAA provides you with several rights with regard to your professional records and disclosures of PHI. These rights included amendments to records, restrictions on disclosures, requests for accounting, and registering complaints.

VI. Complaints

If you are concerned that Greta Aronson has violated your privacy rights, or you disagree with a decision Greta Aronson, makes about access to your records, you may talk with Greta and also may send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

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

Greta Aronson may limit the access, use, or disclosures that we will make to the following "reviewable denials:" If, in the exercise of professional judgment, we determine that access to the record is "reasonably likely to endanger the life or physical safety" of you or another person. If the requested information makes a reference to another person (other than another health care provider), and in the of exercise professional judgment, we determine that access is "reasonably likely to cause substantial harm" to this other person. If a personal representative for you has requested access to the record, and in the exercise of professional judgment, we determine that such access is "reasonably likely to cause substantial harm" to you or another person.

Greta Aronson may limit the access, use, or disclosures that we will make to the following "unreviewable denials:" When access to psychotherapy notes are requested, when information is compiled in reasonable anticipation of, or for use, in a legal or administration action or proceeding. When someone other than a health care provider provides information about the patient under a promise of confidentiality, and the access to the requested information would be reasonably likely to reveal the source of the information. This notice will go into effect on January 1, 2020. State of Mind Kansas City, LLC/Greta Aronson reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI maintained. Greta Aronson will provide you with a revised notice in person or by mail.

I acknowledge that I have been provided access to the HIPAA NOTICE of policies and practices to protect the privacy of your health information maintained by State of Mind Kansas City, LLC/Greta Aronson. I am entitled to a paper copy upon request.