**Serenity Coaching and Counseling, LLC**

www.SerenityCoachingCounseling.com

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**Welcome!** This form provides information about our services. Please review and feel free to ask questions.

**Overview of Services:** This form is called a Consent for Services (the "Consent"). Your therapist, counselor, psychologist, doctor, or other health professional ("Provider") has asked you to read and sign acknowledgement of this Consent before you start therapy. Please review the information. If you have any questions, contact your Provider.

**Confidentiality/Personal Health Information:** Your provider makes it a priority to keep all communications and records held in strict confidence. Please see information below on our HIPPA, privacy rules, client rights, confidentially of communication, and telehealth services.

**Work Agreement, Scheduling, and Cancellations:** It is agreed that the client shall engage in the counseling/couching process as an important priority in their life. Scheduling an appointment is a commitment that both counselors and clients honor. Appointments can be cancelled or rescheduled if 24 hour notice is provided. If sessions are canceled or rescheduled with less than 24hrs notice, or if a client misses a session, the client agrees to pay a $25 dollar fee. (Insurance will not pay for missed appointments). Please know that exceptions to this policy can be made in the instance of a serious medical emergency, or serious family emergency. Clients who consistently cancel or no-show appointments will have their cases closed.

**All fees will be expected at the time of service:** If you are planning to use your insurance for coverage, please make sure you are aware of your mental health benefits and allowable co-pay. The co-pay will be collected each session. Please connect with your individual provider about self-pay rates and costs of services. We are open to discussing a reduced fee for clients on a limited income.

**Session Length:** Most sessions last around 50 minutes. If you arrive late for a scheduled appointment, you may not be able to complete the entire 50 minute session. Please make every effort to be punctual.

**Emergency/After Hours:** Serenity Coaching and Counseling (Serenity) makes it a priority to be available for our clients and will make reasonable efforts to help. We maintain a 24/7 call service and on call provider. If your call is urgent or life threatening, please call 911 or connect with the Emergency Services unit that is available 24/7 for on-site or mobile assessment and screening at 1-800-977-5555.

**Emotional Support Animal:** Please be aware that we are animal friendly and sometimes have an Emotional Support Animal (primarily dog/s) at Serenity. Please let us know if you have concerns or an allergy.

**IN-PERSON VISITS & Public Health Concerns:** If you attend therapy in-person, you understand: You can only attend if you are symptom-free (If you are experiencing symptoms, you can switch to a telehealth appointment or cancel). You must follow all safety protocols established by the practice.

**We agree to make reasonable efforts to ensure proper continuation of care**: If you decide that the services that Serenity offers are not the right fit for you, we will make reasonable efforts to provide you with alternative counseling sources and referrals. (In the event of termination or after two weeks without contact or an understanding about continuation of care, we will close your file. Should you decide to re-enter into counseling/coaching, the file can always be re-opened. We make efforts to coordinate with resources in the area and strive to create a dynamic therapeutic relationship.)

(Consent for Services con’t)

**THE THERAPY PROCESS**

Therapy is a collaborative process where you and your Provider will work together on equal footing to achieve goals that you define. This means that you will follow a defined process supported by scientific evidence, where you and your Provider have specific rights and responsibilities. Therapy generally shows positive outcomes for individuals who follow the process. Better outcomes are often associated with a good relationship between a client and their Provider. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit.

Therapy begins with the intake process. First, you will review your Provider's policies and procedures, talk about fees, identify emergency contacts, and decide if you want health insurance to pay your fees depending on your plan's benefits. Second, you will discuss what to expect during therapy, including the type of therapy, the length of treatment, and the risks and benefits. If your Provider is practicing under the supervision of another professional, your Provider will tell you about their supervision and the name of the supervising professional. Third, you will form a treatment plan, including the type of therapy, how often you will attend therapy, your short- and long-term goals, and the steps you will take to achieve them. Over time, you and your Provider may edit your treatment plan to be sure it describes your goals and steps you need to take. After intake, you will attend regular therapy sessions at your Provider's office or through video, called telehealth. Participation in therapy is voluntary - you can stop at any time. At some point, you will achieve your goals. At this time, you will review your progress, identify supports that will help you maintain your progress, and discuss how to return to therapy if you need it in the future.

**TELEHEALTH SERVICES**

You have a right to confidentiality with regard to treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions also apply to my Telehealth services.

To use telehealth, you need an internet connection and a device with a camera for video. Your Provider can explain how to log in and use any features on the telehealth platform. If telehealth is not a good fit for you, your Provider will recommend a different option.

• Risks: Privacy and Confidentiality. You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your Provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards. Technology. At times, you could have problems with your internet, video, or sound. If you have issues during a session, your Provider will follow the backup plan that you agree to prior to sessions. Crisis Management. It may be difficult for your Provider to provide immediate support during an emergency or crisis. You and your Provider will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services. If you require emergency care, you understand that you may call 911, proceed to the nearest hospital emergency room for immediate assistance, or connect with mobile crisis support at 1-800-977-5555. \* Telehealth may not be as effective or provide the same results as in-person therapy. If your provider believes you would be better served by in-person therapy, you provider will discuss this with you and refer you to in-person services as needed. If such services are not possible because of distance or hardship, you will be referred to other therapists who can provide such services.

• Benefits: Flexibility. You can attend therapy wherever is convenient for you. Ease of Access. You can attend telehealth sessions without worrying about traveling, meaning you can schedule less time per session and can attend therapy during inclement weather or illness.

• Recommendations: Make sure that other people cannot hear your conversation or see your screen during sessions. Do not use video or audio to record your session unless you ask your Provider for their permission in advance. Make sure to let your Provider know if you are not in your usual location before starting any telehealth session.

**CONFIDENTIALITY**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (“HIPAA”), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, the AMHCA and ACA Code of Ethics and Massachusetts statutes and regulations. It also describes your rights regarding how you may gain access to and control your PHI.

(Consent for Services – Confidentiality con’t)

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

**USES/DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, REQUIRING CONSENT**

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. We may use or disclose your PHI for treatment, payment and health care operations purposes with your consent as discussed below:

**For Treatment.** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. An example of treatment would be when we consult with another health care provider, such as a family physician or another mental health provider. We may disclose PHI to any other consultant only with your authorization.

**For Payment.** We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your consent. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes. PHI will be disclosed only with your authorization.

**USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION**

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

**Child Abuse:** If we, in our professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, we must immediately report such condition to the Massachusetts Department of Children and Families.

**Elder Abuse:** If we have reasonable cause to believe that an elderly person (age 60 or older) is suffering from or has died as a result of abuse, we must immediately make a report to the Massachusetts Department of Elder Affairs.

**Abused of a Disabled Person:** If we have reasonable cause to suspect abuse of an adult (ages 18-59) with mental or physical disabilities, we must immediately make a report to the Massachusetts Disabled Persons Protection Commission.

**Health Oversight:** The Board of Registration of Allied Mental Health and Human Service Professions has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release information without written authorization from 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 you communicate to an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, we must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. We must also do so if we know you have a history of physical violence and I believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment, and we have a reasonable basis to believe that you can be committed to a hospital, we must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you.

**Worker’s Compensation:** If you file a workers’ compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker’s Compensation.

(Consent for Services con’t – uses and disclosure)

**Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

**Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Your Provider will not disclose your personal information without your permission unless required by law. If your Provider must disclose your personal information without your permission, your Provider will only disclose the minimum necessary to satisfy the obligation. Your Provider may speak to other healthcare providers involved in your care connected to Serenity Coaching and Counseling LLC for consultation, referral, and support. Your Provider may speak to emergency personnel. If you report that another healthcare provider is engaging in inappropriate behavior, your Provider may be required to report this information to the appropriate licensing board. Your Provider will discuss making this report with you first, and will only share the minimum information needed while making a report. If your Provider must share your personal information without getting your permission first, they will only share the minimum information needed.

**RECORD KEEPING**

Your Provider is required to keep records about your treatment. These records help ensure the quality and continuity of your care, as well as provide evidence that the services you receive meet the appropriate standards of care. Your records are maintained in an electronic health record provided by TherapyNotes. TherapyNotes has several safety features to protect your personal information, including advanced encryption techniques to make your personal information difficult to decode, firewalls to prevent unauthorized access, and a team of professionals monitoring the system for suspicious activity. TherapyNotes keeps records of all log-ins and actions within the system.

**COMMUNICATION**

You decide how to communicate with your Provider outside of your sessions. You have several options:

• Texting/Email: Texting and email are not secure methods of communication and should not be used to communicate personal information. You may choose to receive appointment reminders via text message or email. You should carefully consider who may have access to your text messages or emails before choosing to communicate via either method. Please limit the use of electronic communications to issues related to scheduling. If you choose to email, please be aware email responses will be brief and may call you to discuss the matter. We will not respond to text messages not related to scheduling.

• Secure Communication: Secure communications are the best way to communicate personal information, though no method is entirely without risk. Your Provider will discuss options available to you. If you decide to be contacted via non-secure methods, your Provider will document this in your record. Serenity Coaching and Counseling LLC maintains a HIPAA compliant email system but can not guarantee security of your email portal. Serenity also maintains a HIPAA compliant fax system.

• Social Media/Review Websites: If you try to communicate with your Provider via these methods, they will not respond. This includes any form of friend or contact request, @mention, direct message, wall post, and so on. This is to protect your confidentiality and ensure appropriate boundaries in therapy. Your provider may publish content on various social media websites or blogs. There is no expectation that you will follow, comment on, or otherwise engage with any content. If you do choose to follow your Provider on any platform, they will not follow you back. If you see your Provider on any form of review website, it is not a solicitation for a review. Many such sites scrape business listings and may automatically include your Provider. If you choose to leave a review of your Provider on any website, they will not respond. While you are always free to express yourself in the manner you choose, please be aware of the potential impact on your confidentiality prior to leaving a review. It is often impossible to remove reviews later, and some sites aggregate reviews from several platforms leading to your review appearing other places without your knowledge. To leave a review of your services on Serenity's website, please go to <https://www.serenitycoachingcounseling.com/clients>

**FEES AND PAYMENT FOR SERVICES**

You may be required to pay for services and other fees. You will be provided with these costs prior to beginning therapy, and should confirm with your insurance if part or all of these fees may be covered. You should also know about the following:

(Fees con’t) (Consent for Services con’t)

• No-Show and Late Cancellation Fees. If you are unable to attend therapy, you must contact your Provider before your session with 24 hr notice. Otherwise, you may subject to fees outlined in your fee agreement. Insurance does not cover these fees.

• Balance Accrual : Full payment is due at the time of your session. If you are unable to pay, tell your Provider. Your Provider may offer payment plans or a sliding scale. If not, your Provider may refer you to other low- or no-cost services. Any balance due will continue to be due until paid in full. If necessary, your balance may be sent to a collections service.

• Insurance Benefits. Before starting therapy, you should confirm with your insurance company if:

 • Your benefits cover the type of therapy you will receive; • Your benefits cover in-person and telehealth sessions;

 • You may be responsible for any portion of the payment; and • Your Provider is in-network or out-of-network.

• Sharing Information with Insurance Companies. If you choose to use insurance benefits to pay for services, you will be required to share personal information with your insurance company. Insurance companies keep personal information confidential unless they must share to act on your behalf, comply with federal or state law, or complete administrative work.

• Covered and Non-Covered Services: When your Provider is in-network, they have a contract with your insurance company. Your insurance plan may cover all or part of the cost of therapy. You are responsible for any part of this cost not covered by insurance, such as deductibles, copays, or coinsurance. You will also be responsible for any services not covered by your insurance. When your Provider is out-of-network, they do not have a contract with your insurance company. You can still choose to see your Provider; however, all fees will be due at the time of your session to your Provider. Your Provider will tell you if they can help you file for reimbursement from your insurance company. If your insurance company decides that they will not reimburse you, you are still responsible for the full amount.

• Payment Methods: The practice recommends that you keep a valid credit or debit card on file. This card will be charged for the amount due at the time of service and for any fees you may accrue unless other arrangements have been made with the practice ahead of time. It is your responsibility to keep this information up to date, including providing new information if the card information changes or the account has insufficient funds to cover these charges.

**YOUR RIGHTS AND OUR OBLIGATIONS**

You have the following rights regarding PHI we maintain about you:

 **Right of Access to Inspect and Copy.** You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your access may be denied in certain circumstances, but in some cases, you may be able to have this decision reviewed. On your request, we will discuss with you the details of the request and denial process. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

**Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. On your request, we will provide you with details of the amendment process.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of PHI for which you have neither provided authorization nor consent. On request, we will discuss with you the details of the accounting process. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

**Right to Receive Confidential Communications by Alternative Means and at Alternative Locations.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. (For instance, you may not want a family member to know you are seeing us. Upon your request, we will send your bills to another address.) We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

**Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

**Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice upon request, even if you have agreed to receive the notice electronically.

**Our Obligations.** We are 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. We reserve the right to change the privacy practices described in this Notice. Unless we notify you of such changes, however, we are required to comply with the terms currently in effect. If we revise our privacy practices, we will mail, email, fax, or give to you at the next scheduled session, depending on what is most convenient for our clients, any changes to this policy.

**COMPLAINTS**

If you feel your Provider has engaged in improper or unethical behavior, you can talk to them, or you may contact the licensing board that issued your Provider's license, your insurance company (if applicable), or the US Department of Health and Human Services. If you believe we have violated your privacy rights or you disagree with a decision we made about access to your records, you may contact Nicole Daigle, LMHC (Director) Serenity Coaching and Counseling, LLC 51 Union St. Suite G02 Worcester, MA 01608, by calling (508) 556-0745, or faxing (508) 519-6539. You may also send a written complaint to the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

**CLIENT RIGHTS**

To have reasonable access to safe and effective care within our mission, our scope of service, and in compliance with law and regulation. To be referred to other providers when additional, alternative or special services are needed, and to have this access to care regardless of race, creed, age, gender, national origin, handicap, economic status, or sexual orientation. Respect and Dignity of Clients. You have the right to be treated with respect and dignity. You have the right to considerate respectful care at all times and under all circumstances, with the recognition of your personal dignity and worth. Services Without Discrimination. Serenity Coaching and Counseling offers its services to clients without regard for race, color, sex, age, disability, medical condition, marital status, national or ethnic origin, religion or source of payment. To receive considerate care that respects personal values, beliefs, and preferences, including the expression of psychosocial, spiritual and cultural values which influence the perception of illness and the response to care. To have respect for personal dignity, privacy and safety during care, and safety and security within our facility, and to be free from abuse, neglect, or exploitation. To have effective communication with staff, and to understand or be assisted with written, spoken and other communication.

**CLIENT RESPONSIBILITIES**

Answer Questions Fully. You have the responsibility to provide an accurate and complete history in order for you to receive effective treatment. This includes authorizing release of health records from previous health care providers. Cooperate and Communicate with Providers. You have the responsibility to participate in discussions and ask questions about your care. You have the responsibility to request further information concerning anything you do not understand regarding diagnosis and treatment. Respect and Consideration. You have a responsibility to respect the rights, privacy and confidentiality of other clients. You have a responsibility to notify your provider as soon as possible if you must be late or cancel a scheduled appointment. Financial Obligations. You have the responsibility for the costs of your care and treatment. You are responsible for assuring the financial obligations of your care are fulfilled. You have a responsibility to adhere to the guidelines of your insurance coverage regarding referral policies.

**Further Acknowledgements:**

**If using insurance, by signing acknowledge of this, you consent to Release Information & Authorization of Benefits to your insurance provider.** Serenity will require a copy of your insurance card upon intake. You authorize the release of information as may be required by your insurance company, their reimbursing agency, or as may be otherwise necessary for payment of claims resulting from my mental health treatment. You understand information will be disclosed for processing claims for treatment you have received, quality review and continuity of care purposes. This may include information contained in records that concerns medical illness, mental illness or substance abuse, and/or domestic violence. You authorize payment directly to Serenity Coaching and Counseling, LLC of benefit otherwise payable to me. You understand that you are financially responsible for any deductible, co-insurance, non-covered charges, or charges resulting from my failure to follow my insurers’ referral guidelines. You understand that I may revoke release at any time, but I must notify Serenity Coaching and Counseling, LLC of revocation in writing.

**Upon intake – we require signed acknowledgement that upon intake, you received and agree to the following information:**

\* **Privacy Notice (HIPAA)**

**\* Notification of clients’ rights**

**\* Agency policies and procedures**

**\* Grievance Procedure**

**\* Copy of the Orientation to Treatment and Client Policies Pamphlet**

**\* Telehealth Consent**

**\* Payment and Insurance Policies**

**\* You understand that it is your responsibility to attend all scheduled appointments. If you need to reschedule an appointment, you will call with at least (24) hour notice. You understand that there will be a $25.00 fee for any appointments that I do not attend and do not cancel (no shows). I understand that I am responsible for this fee.**

**\* You understand that if you “no show” two appointments, if you cancel two appointments within a 30 day period, or we have no contact with you for a two week period, that your case will be closed.**

 4/12/2016 – Effective Date of Privacy Notices. Updated 8/2022. ND