Terry Mindfulness Center, LLC
Gail Lois Jaffe, PA, LMHC
Statement of Disclosure
Consent for Treatment

Thank you for selecting me as your therapist. This document is designed to inform you about my background and to ensure you understand our professional relationship.

PROFESSIONAL QUALIFICATIONS:

Master's degree in Counseling Psychology
Licensed by the state of Florida as a Licensed Mental Health Counselor, License #MH000312

THEORETICAL APPROACH:

My theoretical approach is a combination of Jungian, family constellation, mind-body-spirit integration, energy consciousness, Self-Compassion Therapy, Cognitive Behavioral Therapy Coaching, Reality Therapy, Mindfulness, Compassion Therapy, Meditation techniques and Education on particular condition(s). The variety of approaches is needed for the variety of issues presented in therapy. People can make better decisions if they have enough information and understand how these approaches work. Here are some aspects of counseling and therapy as I see and practice it:

1. Counseling includes your active involvement as well as efforts to change your thoughts, feelings, and behaviors. You will be asked to work both in and out of the counseling sessions. There may be homework assignments, exercises, mindfulness exercises, etc. (as appropriate for you).
2. I take an educative approach to counseling and encourage you to learn about the therapy I introduce to you.
3. In working with you, we will need to specify the goals, and benefits of the treatment. Other parameters that will be agreed upon include: cost of treatment, time commitment, and cancellations or rescheduling requirements of the appointments. Periodic reviews of the counseling process will take place and if necessary, restructuring of the treatment plan, goals and methods will take place.

RISKS AND BENEFITS OF COUNSELING

It is important for you to understand that with change, comes some risks and benefits. The risks may show up within relationships with family first and possibly friends or relationships. When you begin to make changes within yourself, the dynamics of how you choose to be with others will change. This may cause some disturbance with others. Other risks include you feeling worse before you begin to feel better about your treatment issues. The benefits with change are growth, a willingness to try something different that works better in one's life, and accomplishing the goals set. Fully informing you, the client, of a diagnosis may pose a risk to your self-image, however, the veracity of this counselor's fully informing you about such diagnosis promotes self-confidence and autonomy which will ultimately promote long term progress.

In working with **children**, if both parents have joint custody and sign this disclosure rendering consent to treat, and after the child has positively engaged in therapy, and one of the parents decide against continuing treatment of their child; this therapist reserves the right to continue therapy based on two conditions: removal of therapy would cause more harm than good to the child and one of the two consenting parents desire continued treatment.

DIAGNOSTIC INFORMATION:

A formal assessment will be conducted in order to help this therapist to gain an understanding of your current situation. It may be possible you will receive a diagnosis and if so, this diagnosis will be reviewed and explained. Diagnoses are also dynamic instead of static due to new information gathered over the course of treatment and you will be informed of any changed diagnosis over the course of treatment. The purpose of the diagnosis is to help us identify the problems you are experiencing and the counseling procedures that may be most helpful in treating those problems. A diagnosis may also be required to receive third-party

reimbursements for services. Not all diagnoses are reimbursable by the insurance industry. An open and honest discussion should exist where the most common problems associated with the diagnosis is covered, benefits of understanding the diagnosis, and what options you have when you may choose not to accept a diagnosis, treatment, or a third-party payer to be involved in your treatment. Any diagnosis submitted to an insurer or others will become part of a permanent record and considered a preexisting condition that can be accessed by future employers, schools, and insurers. Also, if you are involved in any type of litigation, such as child custody situations, your counseling records, including your mental health diagnosis, may be subpoenaed by the courts and released during court proceedings. Lastly, please be aware that your mental health diagnosis and any accompanying records may be revealed if you sign a release of information for disclosure of your medical records to any other agency or individual (e.g., school, probation office, family physician).

COUNSELING EXPERIENCE:
My counseling experience entails working with numerous life issues that vary from sexual abuse, death & dying, grief, substance abuse, depression, post-traumatic stress disorder, and a variety of other diagnoses to couples counseling and individual therapy. I have been an active therapist working predominantly with adults, and couples for over 20 years.

CONFIDENTIALITY:
The privacy and confidentiality of our sessions and my records is a privilege of yours and is protected by state law and my profession's ethical principles, with the following exceptions: 1) When an assessment is made that the client intends to be harmful to self or others, 2) court orders to release information where a judge has signed the order, 3) client written release consents, and 4) reporting of child or elder abuse or neglect. Otherwise, confidentiality will be kept about your treatment, diagnosis, and history or even that you are a client without your full knowledge and a signed Release of Information form.

In working with a child or adolescent, it is important that the parents understand that confidentiality with their children also stands unless they are actively cutting or putting themselves in a position of danger with behaviors such as suicidal ideation and gestures, self-injurious behaviors, dangerous drug use, meeting adult strangers on the internet, running away, and any other behavior deemed dangerous or life threatening. If the child or elder reports any form of abuse from the caregivers, it is a requirement for this therapist to make a report to the Department of Child and Family Services. You will be notified of such report from this therapist.

In working with couples or a family, this therapist cannot guarantee that confidentiality will be maintained between the members of the couple or family. If there is a request for release of information for a couple or family all members must sign the release before anything will be afforded the party requesting documentation. Couples will be asked to sign full disclosure to this therapist where no secrets can be maintained that work against the counseling goals established in therapy.

Cell/computer contact: If you choose to contact me and discuss your issues on a cell phone, text messaging format, or on the computer, this therapist cannot guarantee full confidentiality due to illegal and unprotected access to this material.
Consultation and Instruction: Your case may be discussed in a Peer Consultation Clinical Group in order to review treatment approach and receive valued feedback from clinical peers. Your name and identifiable information will not be disclosed with this group.

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Your Information, Your Rights, Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper mental health record, however, if this clinician finds the information to cause no harm to the client. It is up to the discretion of this therapist to release any clinical notes on the client. If you come in for treatment as a couple or family, all members must sign a release first.
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition, only with a release of information or if there is an expression of harm to self or others

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Filing for insurance reimbursement
- Comply with the law
- Respond to lawsuits and legal actions, with appropriate releases of information signed by appropriate parties.

Request confidential communications

- **You can ask us to contact you in a specific way (for example, home or office or cell phone) or to send mail to a different address.**
- **_____ (initials) I am comfortable with you contacting me by cell phone or text.**
- **_____ (initials) I am comfortable with you contacting by the phone number given to therapist and leaving a voice message that is confirming or changing appointment times.**
- **_____ (initials) I am comfortable with you sending me mail with confidential marked on the envelope to my home address is needed.**

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Your Choices

- **For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

Our Uses and Disclosures:

How do we typically use or share your health information?
We typically use or share your health information in the following ways with proper consent to release information:

Treat you
We can use your mental health information and share it with other professionals who are treating you with the appropriate release of information signed.
Example: Past clinical treatment relevant to treatment given today.

Bill Insurance Companies for reimbursement
Your health info and diagnosis will be shared with your health insurance.

Help with public health and safety issues
We can share mental health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law in response to lawsuits, legal actions, law, law enforcement
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- We can share mental health information about you in response to a court order, or in response to a subpoena connected to a judge court ordering release of information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected mental health information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

RECORD MAINTENANCE Your records will be kept on electronic storage with coded identification or written format under private coding for the next seven years.

EMERGENCIES:
Please note **that I am not available 24 hours a day.** I will be available to answer calls throughout the week and if I do not answer at the time of your call I will return your call as soon as possible. I am unable to provide emergency services, so **if you have an emergency, please call 911.**

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LENGTH OF SESSIONS AND PAYMENT:

You will be assured that my services will be rendered in a professional manner consistent with accepted ethical standards of my profession. Individual, Couple, AND Family Counseling sessions are 60 minutes and may be longer than stated time whereupon you may be charged additional agreed upon fee. The base session fee for each individual session is $150, couples or 2 members of a family session is $200.

_____ (Initials) I also give this therapist permission to use my debit/credit card and/or a designated debit/credit card from another wishing to pay for my treatment understanding and agreeing to the fact that statements will be providing information to the credit card owner about the dates of my treatment.

- It is **preferred that payment be made in cash or check** and is rendered at the beginning of the session to avoid any issues with collections for services rendered. MasterCard or Visa is accepted.

- **Phone calls** are not charged unless they exceed 15 minutes. If you have more than one call between the sessions, you will incur charges prorated to the length of combined calls. If your call is between 15-30 minutes you will be charged on a prorated basis relative to the hourly fee originally agreed upon. It is preferred you call after 10am and before 9pm. **If you are experiencing an emergency around those times, please contact 911 for immediate assistance.** If you call and leave a message, a return call will take place as soon as possible.

- **_____ (Initials) If you are unable to keep an appointment,** please call to cancel or reschedule at least 24 hours in advance. If I do not receive notice, **you will be responsible for paying for the session that you missed.**

- If you decide to **discontinue therapy abruptly** and without notice, I will call you no more than two times to follow up over the two weeks following our last session. If you do not return my calls, I will close your file and note that you terminated therapy with this therapist without notice or consultation.

- Please note that it is impossible to guarantee any specific result regarding your counseling goals, however, together we will work to achieve the best possible results for you.

Please be sure to complete next page: Signature Page for Consent of Treatment

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Signature Page for Consent of Treatment

In signing the below, I understand and agree with the conditions of the disclosure statement and give _____**consent to treat** me.
Counselor

_____ _____
Therapist Signature/Date Client's Signature/Date

For counseling to be effective and provide an environment in which the client feels free to share concerns, the counselor must be able to assure clients that personal information will be kept confidential. Counselors act in the best interest of clients and take measures to safeguard confidentiality. Recording of any session(s) need all-party consent.

Federal Law: State of FL
Florida's wiretapping law is a "two-party consent" law. Florida makes it a crime to intercept or record a "wire, oral, or electronic communication" in Florida, unless all parties of the communication give consent.
If you plan to record telephone calls or in-person conversations (including by recording video that captures sound), you should be aware that there are federal and state wiretapping laws that may limit your ability to do so. These laws not only expose you to the risk of criminal prosecution, but also potentially give an injured party a civil claim for money damages against them.

Any recordings, which are brought to my attention, the person(s) will be prosecuted to the full extent of the law.

I understand and agree. Sign below:

_____
Client's Signature/Date

If applicable, I, _____ also give _____consent to treat the following dependent (s) of which I am his/her legal guardian: counselor

_____ _____
(Name of Child/Youth) and age (Name of Child/Youth) and age

_____
Client's Parent/Legal Guardian Signature (If client is under 18)

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Consent to release Medical and Payment information to Insurance

I, _____ the undersigned client or parent/guardian of the client, hereby authorizes to _____ **(counselor)** *administer psychological assessment and relevant psychotherapies. I understand that no guarantee or assurance has been made as to the results that may be obtained. I hereby authorize the release of pertinent information from my record to any insurer, compensation carrier, or agency who may be providing financial assistance for my treatment.* ***I will be responsible for all charges for treatment.*** *I have read and fully understand the above authorization.*

_____

Client ***Date***

_____

Client's Parent/Guardian ***Date***

Insurance Information (if applicable)

Insurance Company: _____
See Copy of Insurance Card

Subscriber's Name: _____Date of Birth_____

Address:_____

Clients Name_____ Date of Birth: _____

Relationship to Client: _____ Home Phone #: _____

Address if different than Subscribers _____

ASSIGNMENT OF BENEFITS:
I authorize payment of medical benefits for myself or the named client be paid to **Gail Lois Jaffe, PA, LMHC (Counselor)** for services rendered.

RELEASE OF INFORMATION:
I authorize the release of any medical information necessary to process this claim.

_____

Insured signature ***Date***

_____

Client or parent/guardian ***Date***

YOUR COPY

NOTICE OF PRIVACY PRACTICES – BRIEF VERSION

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

My commitment to your privacy:

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information. This pamphlet is a shorter version of the full, legally required NPP which you received along with this so refer to it for more information. However, I can't cover all possible situations so please talk to me about any questions or problems.

I will use the information about your health which I get from you or from others mainly to provide you with treatment, to arrange payment for my services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP I will ask you to sign a Consent Form to let me use and share your information. If you do not consent and sign this form, I cannot treat you.

If I or you want to use or disclose (send, share, release) your information for any other purposes I will discuss this with you and ask you to sign an Authorization form to allow this.

Of course, I will keep your health information private but there are some instances when the laws require me to use or share it. For example:

1. **When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.**
2. **Some lawsuits and legal or court proceedings.**
3. **If a law enforcement official requires to do so.**
4. **For Workers Compensation and similar benefit programs.**

There are some other situations like these but which do not happen very often. They are described in the longer version of the NPP.