# Counseling Specialists of Birmingham, LLC

**Maggie Klyce, LICSW, PIP, CEDS**

***PLEASE KEEP THE FIRST 3 PAGES FOR YOUR RECORDS***

I am pleased to have the opportunity to serve you and hope that this handout will provide information helpful in making an informed decision concerning my services. Please ask questions at any time. If my work with you leads to areas outside the boundaries of my expertise, I will help you obtain the necessary services from an appropriate specialist.

Credentials: I am a Licensed Independent Clinical Social Worker (LICSW) and am licensed as a Private Independent Practitioner (PIP.). I also have obtained a designation as a Certified Eating Disorder Specialist (CEDS.) I will be more than happy to share more information about my educational background upon your request.

Treatment Philosophy:

Therapy is a process of healing and discovery for the whole person--body, mind, behavior, emotions and spirit. Therapy can help us bring out that which is already within. I seek to listen and understand clients' personal perspective and goals in order to be helpful to the fullest extent of my professional training. I use a strengths centered approach to empower clients to apply skills to tackle any obstacle that may arise in their daily journeys. The reasons a person seeks therapy can range from needing a place to go to talk things through with an objective person to working through painful or traumatic issues. My goal is to meet a client in their need and walk with them as they seek to reconnect with what they deem important.

Confidentiality:

I may disclose PHI for the purposes of treatment, payment, and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care. Part of these steps include authorization and payment from insurance companies which involves disclosing PHI. This informed consent covers the ability for me to able to communicate with your insurance provider. Any other individuals or institutions that you wish for me to communicate with will require that you sign a separate consent form.

A copy of that form is available upon request. The requirement that you sign an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I speak with your physician about your treatment and/or medications. Before I talk to that physician, you will first have signed the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between therapist-patient in treatment settings, HIPAA permits keeping 'psychotherapy notes' separate from the overall 'designated medical record." 'Psychotherapy notes' cannot be secured by insurance companies, nor can they insist upon their release for payment of services. "Psychotherapy notes' are *my* notes and are defined as follows: "notes recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and that are separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you; hence, the need for increased security of the notes. "Psychotherapy notes' are not the same as your "progress notes' which provide the following information about your care each time you have an appointment at my office: assessment/ treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

You may, in writing, revoke all authorizations to disclose PHI at any time. You cannot revoke an authorization to disclose PHI that has already been disclosed.

Uses and Disclosures Not Requiring Consent or Authorizations

*By law, PHI may be released without your consent or authorization in the following instances:*

1. Child abuse
2. Suspected sexual abuse of a child
3. Adult and domestic Abuse
4. Health oversight activities (i.e. licensing boards investigations)
5. Judicial or administrative proceedings (i.e., court ordered treatment and/or evaluations)
6. Serious threat to health or safety (i.e., Duty to Warn law, national security threats)
7. Workers Compensation claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

*No information will ever be released for any sort of marketing purposes.*

Patient's Rights and My Duties

*You have a right to the following:*

- *The right to request restrictions* on certain uses and disclosures of your PHI. I may or may not agree to these restrictions, but if I do, they shall apply unless our agreement is changed in writing.
- *The right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so I will send them to another location of your choosing.
- *The right to inspect and receive a copy* of your PHI in the designated mental health record set for as long as PHI is maintained in the record.
- *The right to amend* material in your PHI, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care.

For more information on how to exercise each of the rights, please do not hesitate to ask me for further assistance. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed. Current practices are applicable unless you receive a revision of my policies at a future time. My duties as a therapist include maintaining the privacy of your PHI, providing you with this notice of your rights and my privacy practices with respect to your PHI, and abiding by the terms of this notice unless it is changed and you are so notified.

Complaints

If you have any concerns of any sort that your privacy rights may have been somehow compromised, please do not hesitate to speak to the appointed privacy officer immediately about this matter. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.
I reserve the right to change my privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable by law.
If you want additional information or further explanation regarding my privacy practices, you may contact me:

Maggie Klyce
500 Southland Drive
Suite 202
Birmingham, Al 35226

Length of Session: The length of therapeutic counseling sessions will range from 45 - 90 minutes, depending on the amount of time scheduled at the time that you made the appointment.

After Hours Contact: Telephone contact between the therapist and client will be limited outside of scheduled appointment time. After office hours, phone calls will be referred to a voice message system. In case of an emergency, contact your local emergency room or call 911; another resource to call after hours if you need extra support but do not find yourself in an emergency is the Crisis Center Hotline *205-323-7777* locally *or 800-273-TALK* nationally. Telephone sessions lasting over ten (10) minutes will be charged at the normal hourly fees. E-mail may not be a secure/ confidential means of communication but may be easy to access and is an acceptable means to communicate between therapist and client. In order to institute boundaries and safety in email communication in the therapeutic relationship, any electronic communication between therapist and client will be discussed in a following session and

documented in the clients' chart.

Referrals: The therapist reserves the right to terminate the therapeutic relationship for any reason deemed to be in the client's best interest. If the therapist or client believes continued counseling is needed, the therapist will provide a referral.

Payment & Pricing:
All payment is expected at the time of service: payment must be paid in cash or by check at the beginning of your appointment time. I currently accept Blue Cross Blue Shield of Alabama. I am unable to guarantee their coverage of sessions and if your claim is denied, you accept responsibility for full payment of any sessions provided. In order to better serve you, I request a copy of diagnoses from a current medical provider such as a general practitioner or psychiatrist for billing insurance. I am unable to bill your insurance until this is received and you will be responsible for full payment of sessions until you provide this information.

*** If a client has a balance of two (2) unpaid sessions, I will not be able to schedule further sessions until the balance is cleared. ***

Cancellations: After the initial session the client must cancel appointments 24 hours in advance of the scheduled session. The office does not practice double booking; therefore, the hour of your appointment is committed to you. The client will be charged the normal fee if the cancellation is not made 24 hours in advance. Insurance will not cover a missed session and you will be required to pay this out of pocket.

Pricing:

Individual Sessions: 45 Minute Session = $125.00

Group Sessions= $45.00

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Pricing:

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*****Unless otherwise requested, records will be kept for 7 years before being destroyed*****

I understand that I am personally responsible for all costs incurred during the counseling process and will be expected to keep my account current. I also agree that if my account is turned over to a collection service because of excessive delinquency, I, the guarantor, will be responsible for any costs incurred for collection. I understand if insurance is being billed that my therapist is unable to guarantee coverage of my claim. If insurance denies my claim I am responsible for full payment of services rendered.

**I have fully read, and clearly understand the above information.**

_____ _____
**Legal Guardian/Custodial Parent's Signature** **Date**

_____ _____

**Client Signature** **Date**

**Consent for Treatment of Minors:**

*As parent/legal guardian and/or custodian I, _____, give permission for my child, _____, to be counseled by Maggie Klyce, LICSW,PIP, CEDS*