Notice of Privacy Policies and Practices

THE HEALING JOURNEY LLC
PO Box 694
25 S. West St.
Nunda, NY 14517
(585) 281-9947
Jeanne@HealingJourney.info

This includes a brief summary highlighting the requirements established by the Health Insurance Portability and Accountability Act or HIPAA.

The Health Insurance and Portability and Accountability Act (HIPAA) is a federal law that addresses privacy protection and your privacy rights as they apply to the use and disclosure of your Protected Health Information (PHI) and any other confidential information in your record. This notice describes how the client's mental health information may be used or disclosed. It also describes how the client may gain access to his/her information. *Please review carefully, as you will be asked to sign a document indicating that you have received and reviewed this information*. Feel free to ask any questions regarding the contents contained herein.

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

Therapist may use or disclose your protected health information (PHI), for treatment, supervision, payment, and other health care operations with your consent. To help clarify these terms, here are some definitions:

- **PHI** refers to protected health information contained in your health record that could identify you (name, address, birthdate, etc.).
- **Use** applies to activities within the therapist's office such as examining, analyzing, applying, or sharing of information.
- **Disclosure** applies to communications or exchange of information that leaves the therapist's office or is entered in the record from another provider such as obtaining medical information from your physician or providing a summary to a legal representative. If a client is involved in a court proceeding and a request for information is made to the therapist, such information is privileged under state law and generally cannot be released without the client's authorization, although there are rare exceptions.
- **Treatment** is when the therapist provides care or coordinates or manages your (mental) health care services toward improving your mental health outcomes. Examples of treatment would be assessing needs and developing a treatment plan with the client or consulting with another health care provider, such as client's physician or previous mental health provider, or psychiatrist (Dr. Isaac Koilpillai) that the therapist has a contract with to provide consultation.
- **Payment** is compensation to the therapist at the time the services are rendered. **The Healing Journey's** fees are agreed upon and paid by client directly (self-pay) unless covered by a health insurance plan that therapist is participating with, although all copays/deductibles need to be met. In order for insurance to pay for services, they will require documentation from the client's record.
- **Health Care Operations** are activities related to the performance and operation of the practice of psychotherapy and **The Healing Journey LLC.** Examples of (mental) health care operations arc case management, care coordination, or business-related matters such as audits or administrative services.

II. Therapist may use/disclose confidential information where client authorization is obtained. An **authorization** is written permission for specific disclosures where client knowledge and consent are required. When therapist is asked to obtain from or disclose information to a third party, a signed consent will be obtained from the client authorizing the release of this information. Time limit for the authorization will be designated on the consent form. Generally, treatment is not contingent upon signing any consent for release of information, but it could be (as in mandated treatment, for example). Client may revoke in writing, an authorization for release of information at any time. However, client should not revoke an authorization if it was understood by client that the therapist has relied on that authorization in order to provide treatment or for when the authorization was obtained as a condition of obtaining insurance coverage or reimbursement for services. Revocation of the authorization could result in termination of psychotherapy services by **The Healing Journey LLC**.

III. Uses and Disclosures Requiring Neither Consent nor Authorization

Therapist may use or disclose confidential information *without client consent or authorization* in the following circumstances:

-Child/Adult Maltreatment or Abuse As a mandated reporter, if during the course of performing her duties, the therapist becomes aware that there is reasonable cause to suspect that a minor child, a dependent adult, or vulnerable elderly person has been maltreated or abused, the therapist must

report such suspicions to the statewide central registry for child abuse and maltreatment, or to the local child or adult protective services agency. Contact and possible exchange of information with law enforcement or another legal authority may also be required.

-Health Oversight If there is a formal inquiry or formal complaint made regarding the therapist's professional conduct, therapist must furnish to the proper authorities any relevant information from the client record including mental health information in response to any such inquiry or complaint.

-Judicial or Administrative Proceedings If there is a legal proceeding where the client is claiming negligence on the part of the therapist, the therapist has a right to disclose confidential information in order to defend the allegations. If there is a court order such as a subpoena requiring disclosure either through release of records, testimony, or written summary, privilege does not apply. As long as the safety of client and others is maintained, the therapist could inform the client of any such proceeding or legal order.

-Serious Threat to Health or Safety Confidential information may be disclosed to protect the client from self-harm or to protect others from potential harm. Should there be an imminent risk for harm, the therapist has a duty to warn potential victims of any known threat and to notify law enforcement in order to provide safety and protection to the client, to other individuals, and to the community.

-Worker's Compensation If the client files a worker's compensation claim, and the therapist is treating client for the issues directly related to that claim, then information must be furnished to the chairman of the Worker's Compensation Board for processing your claim. Disclosure could include information regarding your psychological condition and mental health treatment.

IV.Therapist/Social Worker Duties/Rights

- **Privacy of Confidential Information** Therapist is required by law to maintain the privacy of client's confidential information and to provide a notice of therapist's legal duties and privacy practices with respect to that information. Limits to confidentiality can include, but are not limited to situations where you pose a threat to yourself or someone else, in cases of suspected neglect or abuse of a child or of any vulnerable or dependent adult, including an elderly person, in the case of your death, or for national security. Limits also apply when the therapist is court ordered to supply information or testify in a legal proceeding.
- **Reserves the Right** Therapist will abide by the terms stated in both the **Disclosure Statement and Policies for Psychotherapy Services and the Notice of Privacy Policies and Practices,** but reserves the right to change any policy or practices not required by law. Changes will be discussed with client and provided in writing. If revisions are made, the client will be asked to read/review/discuss with therapist and sign a statement indicating that a review took place.
- **Concerns/Complaints** Any concerns or complaints regarding your rights with regard to mental health treatment should be discussed initially and directly with the therapist with the intent to resolve concerns. However, if during the course of treatment, a serious concern or complaint is not resolved satisfactorily, the client is free to seek treatment with another therapist. Client has a right to file a formal complaint to the New York State Board for Social Work or to the U. S. Department of Health and Human Services.

V.Client Rights

- **Right to Inspect and Copy** Client has the right to inspect and/or obtain a copy of information contained in therapist's record regarding the client. All requests should be made in writing and in advance of need. It is advisable to discuss the need with the therapist to avoid misunderstanding of the information contained in the client record. Therapist could deny access to the record under certain circumstances, especially if it could be considered detrimental to the client or detrimental to client's treatment.
- **Right to Amend** Client has the right to request in writing, an amendment to the confidential information contained in client record. This can be done anytime during the period of time when the information/record is maintained by the therapist. Upon receipt of the written request, client will be informed of the details of the amendment process. Therapist could deny client request for an amendment for legal or therapeutic reasons.
- **Right to Request Restrictions** Client has the right to request restrictions on certain uses and disclosures of your confidential information. However, there may be situations when the therapist cannot adhere to the request.
- **Right to an Accounting** Client has the right to receive an accounting of any disclosures made of client's confidential information for which the client has neither provided consent nor authorization (see Section III of this Notice).
- **Right to Receive Confidential Communications by Alternative Means and/or at Alternative Locations** Client has the right to request that confidential information or communications with the therapist be done through alternative means such as messages left on another phone number or information sent to an alternate address.

Disclosure Statement and Policies for Psychotherapy Services

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This document provides important information to you regarding The Healing Journey LLC and your mental health treatment. Please read this entire document and ask any questions that you may have regarding it.

The Healing Journey LLC is a single-member limited liability corporation of Jeanne Matossian. As the sole psychotherapist (herein referred to as therapist) Jeanne Matossian, LCSW-R is a Licensed Registered Clinical Social Worker in the state of New York. Information regarding professional licensure or this therapist's license can be found on the NYS Office of Professions website. Jeanne Matossian is a member in good standing of the National Association of Social Workers (NASW). According to the NASW, psychotherapy is a specialized' formal interaction between a social worker or other mental health professional and a client (either individual, couple, family, or group) in which a therapeutic relationship is established to help resolve symptoms of mental disorder, psychosocial stress, relationship problems, and difficulties in coping in the social environment" (NASW Standards for Clinical Social Work in Social Work Practice, 2005). Therapy is a collaborative process between the therapist and the client.

Benefits of Therapy Therapy can provide clarity, relief, and resolution of a variety of issues or concerns. The process of treatment ebbs and flows. The client could experience some discomfort or stress, especially initially. This is considered a normal part of the change process. The client will work with the therapist to address issues as they arise and to develop effective coping strategies/skills toward managing or resolving any discomfort. Generally, the benefits of therapy outweigh these temporary effects, making it well worth your commitment to it. While there are no guaranteed outcomes, the process of identifying needs, working toward and reaching your goals can have far-reaching positive effects. Clients often report a reduction in negative feelings, improved view of self, and improvement in relationships. Many report a greater sense of well-being and purpose as well.

Is this therapist or this form of treatment right for you? Therapy is a collaborative process designed to assist the client in meeting his/her own needs. During the initial evaluation/assessment phase, both the therapist and the client will have an opportunity to review and assess these. Questions and concerns will be addressed, both early on and at any time during treatment. The client may choose to continue in treatment, ask for a referral to another therapist, or terminate therapy altogether. The therapist could recommend other options to consider as well. Staying informed and engaged with treatment is consistent with client self-determination. This creates a more enriching experience, increasing the likelihood of improved outcomes.

Treatment and Goals Psychotherapy can take many forms, incorporating a variety of theoretical models, skills and treatment approaches. This therapist most often uses cognitive-behavioral, solution focused, and EMDR therapies while incorporating DBT, relaxation, mindfulness, or play therapy with children. Couples therapy or marriage counseling is also provided. Treatment goals will be developed with the client(s) following initial assessment. Progress is evaluated on an ongoing basis and "success" in treatment varies, depending upon client needs, frequency of sessions, and level of engagement or commitment. Determinations as to whether treatment goals need to be added, dropped, modified, etc., are all made in collaboration between the therapist and the individual client/couple. Occasionally, involving other family members/significant others enhances the therapeutic process. With client approval, family members could be included.

Scheduling and Cancellation Policy Sessions are typically scheduled to occur weekly or biweekly based on client need and therapist availability. Adjusting the frequency is determined by the client and therapist. I will always give you as much advance notice as possible about vacations or appointments that need to be rescheduled, and I ask that you do the same. If you must cancel an appointment, I will make every effort to reschedule it that week. However, if an appointment is canceled with less than 24 hours' notice, and it cannot be rescheduled that week, I must hold you financially responsible for that session. Of course, in cases of illness, prohibitive weather, or other emergencies, exceptions to this will certainly be made. For scheduling or rescheduling an appointment, simply text the therapist unless advised otherwise.

Contacting the Therapist/Availability/Emergencies Call or text me at 585-281-9947. Non-urgent messages are generally responded to within 24 hours and during normal workdays (Mon-Fri) or on the next business day. Understand that as a solo, outpatient practitioner, this therapist is unable to provide 24-hour crisis service, 7 days/week. In the event of a mental health emergency that cannot be ameliorated by phone or if there an emergency involving potential harm such as a threat to your safety or others, call 911 to request assistance or go to the nearest emergency room. When the therapist is unavailable or out of town, every reasonable attempt will be made to inform the client in advance. Should the therapist be unavailable unexpectedly, the client may receive a text or will be given direction on the voice mail messaging system.

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Fees/Billing In most cases, once I am credentialed by your insurance, I will be able to help you in obtaining insurance reimbursement. Please discuss your plan with me and we will work out the details together. In the event that you have a copayment or coinsurance, it is generally easier for us to initially bill your insurance first and collect the copayment/coinsurance once it has been established. In the case of divorced parents, one parent must accept responsibility for the full treatment fee, collecting when necessary, the "co-payment" from the other parent. Once established, fees are due at the time of service; prior to that, within one month of bill.

If you decide to self-pay, fees are due at the time of service. Your fee is $ per session. Payment is by cash or check. Should a check be returned for insufficient funds, the client will be charged an additional fee of $30.00 to cover bank fees and re-processing of the payment. Therapist has the right to adjust the fee, and if so, will notify the client in advance. If there is extended phone contact or consults lasting longer than 10 minutes, the client may be charged. If there is a need to provide other professional services such as writing treatment summaries, engaging in lengthy consults with other professionals, or testifying on behalf of the client by request of the client, a fee will be negotiated on a case by case basis.

Confidentiality & Limits to Confidentiality For detailed information about confidentiality and its limits, please refer to the Notice of Privacy Policies and Practices document provided to you by the therapist.

Consultation, Supervision & Collaboration with other Professionals Professional consultation and supervision are important components of a healthy psychotherapy practice. Therapist participates in consultation with Dr. Isaac Koilpillai, psychiatrist, and may occasionally engage in clinical, ethical, and/or legal consultation with other professionals for the purpose of incorporating best practices. Additionally, the therapist may recommend or request communication/collaboration with other providers or professionals such as client's physician, psychiatrist, or previous mental health providers. Client will be asked to sign a consent for release of information authorizing these exchanges of information. Important Note-In some cases, the therapist may decline the provision of psychotherapy services if the client refuses to provide written consent (examples: mandated treatment, treatment of a minor).

Therapist/Client Privilege Due to the unique working relationship between the therapist and the client, information disclosed by the client, as well as any other information gathered in the client record, is subject to the therapist/client privilege. Therapist will act in the best interest of the client and confidentiality is generally maintained. Remember, there are exceptions to confidentiality. For example, if there is a subpoena, the therapist may be required to turn over case information or testify in a legal proceeding. You should address any concerns you may have regarding the therapist-client privilege with your therapist and/or your legal representative. See the Notice of Privacy Policies and Practices for more details.

Records and Record Keeping Notes taken during or made after sessions, plus other records gathered, constitute the therapist's clinical and business records, which a therapist is required to maintain. Such records are the sole property of the therapist/practice. Should the client need information from the therapist record, a request should be made in writing, stating the purpose for the request.

If another provider requests information from the client record, such as a treatment summary or verification of participation in treatment, the information will be provided with the client's knowledge and a signed consent, unless otherwise required by law or by an ethical standard to disclose. Due to the time required for lengthy communications or for documentation that leaves the office of The Healing Journey LLC, an additional fee may be involved for such requests. This fee would be decided on a case by case basis and, in most cases, will be agreed upon in advance.

Termination of Therapy The length of and eventual termination of your treatment, depends upon your specific needs, the goals you have set for yourself, and a mutual assessment between client and therapist regarding the progress made. If either the client or the therapist determines that the client is either not progressing or has reached full benefit from therapy, then either may initiate a discussion regarding treatment options, including the possibility of termination.

This information is yours to keep. Mark or highlight as needed. Again, feel free to ask questions regarding this or anything else related to your treatment with The Healing Journey LLC.

As your therapist, I will do my best to provide a safe, caring, and therapeutic environment. We will engage in open discussions about your mental health treatment, making any needed adjustments along the way. You are encouraged to become engaged in your treatment, pursuing the suggestions or recommendations offered to you. In short, make this your own." I am looking forward to our work together.

Jeanne

Insurance Information

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Client Name: _____

Person Responsible for fee:

Name: _____

DOB: _____ SSN: _____

Address: _____

Telephone: _____

Employer: _____

***If you are a client seen through an EAP referral, you or your health insurance company are responsible for bills after the initial sessions paid for by your EAP (generally two sessions).**

Complete Insurance Identification Number (include prefix letters before the number and suffix numbers that follow your name, if any): _____

Insurance Company: _____

Policy # _____

Phone Number listed for Providers (if none specifically, please list the number that you call):

_____

Secondary Insurance Company: _____

Policy # _____

Phone Number listed for Providers (if none specifically, please list the number that you call):

_____

In order to avoid misunderstanding and confusion regarding my payment policy, please see my Disclosure Statement under Fees/Billing section.

I hereby authorize direct payment by my insurance company to Jeanne Matossian LCSW-R/The Healing Journey LLC, and/or her staff to release my medical information needed by an insurance company, Managed Care Organization, Independent Practice Association, or third party organization to secure said payment.

Patient/Parent/Guardian Signature: _____

Date: _____

Agreement for Services/Reminders

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Individual, Couples, or Family Psychotherapy

By signing below, you acknowledge and agree to the following:

I acknowledge that I have reviewed the information, terms and conditions found in the Disclosure Statement and Policies for Psychotherapy Services and in the Notice of Privacy Policies and Practices provided to me by Jeanne Matossian, LCSW-R of The Healing Journey LLC.

I acknowledge that I have discussed the contents of the above documents with the therapist as needed and had the opportunity to ask questions and address concerns. I therefore consent to participate in psychotherapy with Jeanne Matossian of The Healing Journey LLC and to abide by the terms and conditions found in the above mentioned documents.

Client Name (please print) **Date:**

Signature of Client/Guardian:

Witnessed by Jeanne Matossian, LCSW-R **Date:**

I would like to receive text and/or email appointment reminders or communications, and am aware that although Jeanne Matossian of The Healing Journey LLC has taken precautions to maintain privacy, this does not preclude the possibility that there can be technological failures in security, and it is my responsibility to maintain security precautions to keep this information safe on my devices.

Client Name (please print) **Date:**

Signature of Client/Guardian:

Witnessed by Jeanne Matossian, LCSW-R **Date:**

The Healing Journey LLC Youth Intake Form

Please complete the following information to help me better understand how I might help your child.

Name of Child:_____ DOB: _____

Name Child likes to be called: _____Social Security # _____

Primary Address: _____

Mother's Name: _____ Age: _____

Father's Name: _____ Age: _____

Are parents married, never married, separated, or divorced?

If divorced or separated, who has custody? _____

Are there any ongoing custody issues? YES NO
Do both parents have a legal right to information regarding counseling? YES NO
Please list who resides at above address with the child:

	NAME	RELATIONSHIP	AGE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Please indicate important phone numbers for this address and to whom they belong:
(H) _____ (C) _____

(W) _____ (C)_____

Other parent/guardian regularly visited by the child: _____

Address: _____

Please list who resides at above address and relationship to child:

	NAME	RELATIONSHIP	AGE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Please indicate important phone numbers for this address and to whom they belong:

(H) _____ (C) _____

(W) _____ (C)_____

Please provide the following information about your child that is being seen. The information will better assist me in helping your child.

CHILD/TEEN STRENGTHS SCALE

Please use the following rating system to answer each of the statements below:
1 = Seldom 2 = Just a Little 3 = Pretty Much 4 = Very Much N/A = Doesn't Apply

HOME:

1. ____ Feels part of the family
2. ____ Gets along with brothers/sisters
3. ____ Is physically healthy
4. ____ Brings friends home
5. ____ Feels accepted by parents and relatives

SCHOOL:

1. ____ Demonstrates the ability to learn
2. ____ Participates in class activities
3. ____ Follows basic classroom rules
4. ____ Gets along with teachers
5. ____Completes required assignments

COMPLIANCE:

1. ____ Is respectful to grownups
2. ____ Is well behaved for age
3. ____ Expresses needs appropriately
4. ____Cooperates with adults
5. ____ Follows directions

SELF-CONTROL:

1. ____ Controls excitement
2. ____ Shows maturity for age
3. ____ Copes well with frustration
4. ____ Can wait for attention/rewards
5. ____ Tolerates correction well
6. ____ Can share attention of adults with others
7. ____ Accepts responsibility for own mistakes
8. ____ Able to think before acting

SOCIAL:

1. ____ Able to make/keep friends
2. ____ Cooperates with others
3. ____ Is considerate with others
4. ____ Stands up for self
5. ____ Shows leadership
6. ____ Demonstrates a sense of "fair play"

ATTENTION:

1. ____ Copes with external distractions
2. ____ Maintains attention to task
3. ____ Is able to follow through on tasks

PROBLEMS THAT YOUR CHILD IS CURRENTLY HAVING

Please check all that apply.

___ Depression
___ Suicidal thoughts
___ Suicidal behaviors
___ Has access to guns. In your house? Y N
___ Anxiety
___ Fears
___ Moody
___ Panic Attacks/Intense fears
___ Anger Problems (physical)
___ Anger Problems (verbal)
___ Anger Problems (rages)
___ Shy/Clingy
___ School Problems (truancy)
___ School Problems (academic)
___ School Problems (behavioral)
___ Communication Problems
___ Low self-esteem
___ Gender/Sexual Orientation Issues
___ Alcohol/Drugs
___ Problems with parents
___ Marital problem of parents
___ Problems with brothers/sisters
___ Running away
___ Disobedient
___ Violence in the family
___ Stealing, lying, or cheating
___ Does not think before acting
___ Major losses/changes
___ Financial problems in family
___ Problems with friends
___ Setting fires
___ Verbal/emotional abuse
___ Sexual abuse
___ Physical abuse
___ Eating Disorder
___ Bedwetting
___ Legal Issues
___ Other

PROBLEMS WITH COPING

Please check all those that apply to your child currently.

___ Difficulty falling asleep
___ Waking in the middle of the night
___ Waking too early
___ Sleeping too much
___ Nightmares or night terrors
Number of hours per night of sleep ____
___ Moody or crying more than usual
___ Disturbing thoughts child cannot stop
___ Feeling guilty/worthless/hopeless
___ Repeated actions child cannot stop
___ Cannot stop counting, checking, or washing actions
___ Believes people are out to get him/her
___ Hear, see, smell, or feel things that are not real
___ Weight gain
___ Loss of weight
___ Not hungry
___ Vomiting after eating
___ Feeling nauseous
___ Constipation or diarrhea
___ Withdrawing from others
___ Memory Problems
___ Hyper/too much energy
___ Fatigue/low energy
___ Loss of Interest in things
___ Low self-esteem
___ Other

PREVIOUS MENTAL HEALTH TREATMENT

PROVIDER DATES INPATIENT/OUTPATIENT

1. _____

2. _____

3. _____

4. _____

Has your child attempted suicide? ___Yes ___No When _____ How _____

When _____ How _____

PREVIOUS DRUG/ALCOHOL TREATMENT

PROVIDER DATES INPATIENT/OUTPATIENT

1. _____

2. _____

3. _____

Please list the things in your child's life that might be causing your child stress:

1. _____ 2. _____

3. _____ 4. _____

Please place an "X" on the following scale indicating how well your child is coping with things currently.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100 %
severe: at risk of hurting self or others		having delusions/ hallucinations		serious symptoms	moderate symptoms		mild symptoms		no/minimal symptoms	

FAMILY MENTAL HEALTH HISTORY

Please list any diagnosed mental health conditions that family members have experienced, and how that person is related to the child:

1. _____ 2. _____

3. _____ 4. _____

FAMILY SUBSTANCE ABUSE HISTORY

Please list any alcohol or drug addictions that family members have experienced, and how that person is related to the child:

1. _____ 2. _____

3. _____ 4. _____

How many times per week does your child get physical activity/exercise (playing outside, sports, gym class)?

_____

Does your child smoke? _____ If so, how much? _____

Please list any activities or organizations (e.g. Scouts, sports) that your child is involved in:

_____

Please list any other agencies involved with your child (e.g. DSS, Mentor, Case Management):

_____

Please list the family, friends, pets that are important to your child:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

EDUCATIONAL INFORMATION

Child's school district: _____

Child's grade level: _____ Does your child have an IEP Classification? Yes No

Does your child have a 504? _____ Classification: _____

Other educational in-school resources: _____

What are your child's average grades? _____

Your child's favorite class? _____ Favorite teacher: _____

Does your child receive school counseling? _____ Counselor: _____

LEGAL INFORMATION (including PINS)

1. Current Charges: _____
2. Past Charges: _____
3. Probation ____Yes ____ No Probation Officer: _____

MEDICAL

Child's Primary Care Physician: _____Phone: _____

Approximate Date of last visit: _____Last Physical: _____

Does your child have allergies? _____ Please list: _____

Please list the medications that your child is currently prescribed and the dose.

1. _____ 2. _____

3. _____ 4. _____

Please list the conditions that your child is being treated for, and the provider:

1. _____

2. _____

3. _____

4. _____

Does your child have a history of seizures, other neurological disorders, or head injury? Yes No
Please explain: _____

Please list any surgeries or medical hospitalizations that your child has had:

1. _____

2. _____

3. _____

What are your goals for treatment?
1. _____

2. _____

3. _____