Professional Disclosure Statement, Agreement for Services, Notice of Privacy Practices and Informed Consent

Donna Bracher, MA, LPC, NCC
1310 Turner Street, Suite A, Lansing, MI 48906
517-974-2393

Introduction: Thank you for choosing to work with me. This document is intended to provide important information to you regarding your treatment. The terms "counseling" and "therapy" are used interchangeably throughout this document. Please read the entire document carefully and be sure to ask any questions you may have regarding its contents.

Description of Practice: This is an individual counseling practice owned and operated by Donna Bracher, MA, LPC as a sole proprietor. Although I may share office space with other providers or organizations, my practice is an individual one and others are not responsible for treatment provided by me, nor am I responsible for treatment provided by others.

About your Counselor: My approach to counseling is client-centered and my intention is to provide a safe place for you to explore your feelings and thoughts and to practice new behaviors. I will work to help you explore options, facilitate your awareness of your beliefs and values, and help you discover for yourself what is best for you in your circumstances. The therapeutic approaches I use include psychodynamic, Sandtray-Worldplay Therapy, Cognitive Behavioral Therapy (CBT), and meditation and mindfulness based techniques.

Education and Experience

I received a Bachelor of Science degree in Psychology from Michigan State University in 1990 and a Master of Arts degree in Counseling from Central Michigan University in 2008. Through the State of Michigan I am a Licensed Professional Counselor (LPC). I am also board certified as a National Certified Counselor (NCC) through the National Board of Certified Counselors (NBCC). My counseling experience includes completion of a practicum and internship at a domestic violence shelter where I provided individual, group, and family counseling for adults and children. I continued to work as a counselor at the shelter for one and a half years after completing my degree. Subsequently I spent a year working as a substance abuse and mental health counselor for adults receiving medically assisted opioid treatment as well as therapy for other substance addictions, trauma, crisis and other mental health issues. I currently work in private practice.

Fees and Insurance: I offer free 20-minute initial consultations via phone or in person. A consultation appointment gives us an opportunity to briefly discuss the counseling process, what you would like to get out of therapy, and whether we may be a good match to work together to help you reach your goals.

Fees:

45 minute individual therapy session: $120*
1 hour individual therapy session: $150
Cancellation with less than 24 hour advance notice: $75
Intake/assessment fee (1st session): $175
Returned check fee: $15
Additional services outside of session, such as letters or treatment summaries: $150 per hour (pro-rated)
Involvement in legal proceedings: $225 per hour plus costs
Copies (e.g. of information in your file): $2 per page, plus postage if mailed.

*I am able to offer a discounted fee to a limited number of clients for individual therapy sessions. Feel free to ask if I have any openings available for the discounted rate, which is $90.

All fees are due at the time of service. Unpaid fees may result in termination of counseling services.

Fees are reviewed annually. If my fee changes at any point in the future, I will provide a 60 day notice of the change.

Client initials_____

Insurance:
You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understating the limits of your insurance coverage.

I participate as an in-network provider with some insurance companies. If you are insured by a company that I am an in-network provider for, I may be able to bill your insurance company directly as a service to you. However, I cannot guarantee such benefits or amounts covered, since in some cases insurance companies may determine that certain services are not covered or do not meet medical necessity constraints. In such cases, you will be responsible for payment. Even if your insurance company does provide some coverage, you may be responsible to pay co-payments and/or deductibles. I am not able to bill your insurance for late cancellations or no-shows and may also not be able to bill insurance if you are more than 10 minutes late for an appointment. All payments are due at the time of service.

Client initials_____

Confidentiality
Counseling services, including information discussed in session, treatment provided, and your identity as an individual receiving or having received counseling services, is kept confidential unless you provide written permission to release information to a third party or in the case of certain exceptions as noted below.

Exceptions to client confidentiality include, but are not limited to:

- Information regarding the suspicion that a client may bring harm to him/herself or others.
- Information regarding suspected child or elder abuse or neglect.
- Information regarding a crime committed on the premises or against a person who works at this office, or the threat to commit such crime.
- If required by law or by court order.
- If you provide written consent to disclose information to a third party, such as another healthcare provider.
- Information provided to your insurance company for billing purposes.
- Billing invoices sent to your address, unless you opt out by making alternate arrangements in advance.

Please note that because email is transmitted through third party providers and has the potential to be breached in transit by hackers, the confidentiality of information sent via email cannot be guaranteed.

Client initials_____

Appointment Scheduling and Cancellation Policies
Counseling sessions are typically scheduled for 45-55 minutes, once per week, and on the same day and time if possible. We may determine that a different schedule or frequency is appropriate for you, depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome.

In order to cancel or reschedule an appointment, notify me by phone/voicemail at least 24 hours before your scheduled appointment. If you do not provide 24 hour notice, you will be responsible for a late cancellation fee of

$75, which cannot be billed to your insurance, and which is due before the next session. I do allow two "freebees" per year, to allow for emergencies or illnesses. Once you have used the two "freebees", the late cancellation fee will apply. If you do not show up and do not call to cancel for three sessions, counseling services will be terminated.

Coordination of Treatment

It is often important that your various health care providers work together. Completing the section below gives me permission to communicate with your primary care physician, psychiatrist, or other relevant health care provider, or allows you to decline such contact. If you give permission, you have the right to revoke this authorization, in writing, at any time by sending me notice or completing the appropriate form at my office. However, a revocation does not affect information or contact already shared between providers during the period in which permission was authorized. If you prefer to decline consent, no information will be shared.

_____ You may inform my physician/healthcare provider (s)

or

_____ I decline to allow you to inform my physician/healthcare provider(s)

Physician or Health Care Provider Name: _____

Clinic/Office Name: _____

Address: _____

Phone: _____

Client signature _____ Date _____

Counselor Availability/Emergencies

Telephone consultations between office visits are available; however they will generally be kept brief due to my belief that important issues are better address within regularly scheduled sessions.

You may leave a message at any time on my voicemail. If you would like a return call, please leave your name, phone number, a brief message regarding the nature of your call, and whether it is ok to leave a message if you do not answer the call. Non-urgent phone calls are returned Monday through Thursday within 48 hours, unless otherwise indicated on the voicemail greeting. If I am on vacation and unable to return calls, instructions for alternate contacts will be provided on the voicemail greeting or will be communicated in session.

If you have an urgent need to speak with me, please indicate that fact in your message and follow any instructions provided on my voicemail. While I will do my best to return urgent calls within 24 hours, I am not able to provide emergency mental health services. **If you experience an emergency, please call 911 or go to your nearest emergency room.**

You should also be aware of the following community resources that may be able to assist individuals who are in crisis:

The Listening Ear Crisis Intervention Center:	517-337-1717
National Suicide Prevention Hotline	800-273-TALK (8255)
Community Mental Health Crisis Services	517-346-8460 or 800-372-8460
Domestic Violence Help:	
EVE (End Violent Encounters) Hotline:	517- 372-5572
National Domestic Violence Hotline:	800-799-SAFE
MSU Sexual Assault Crisis Line	517-372-6666

Client signature _____ Date _____

About the Counseling Process

It is my intention to provide counseling services that will assist you in reaching your goals. Based on the information that you provide and the specifics of your situation, I will provide recommendations to you regarding your treatment. We are partners in the therapeutic process and you have the right to agree or disagree with any recommendations I may provide. We will also periodically exchange feedback regarding your progress.

Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy or to guarantee a specific outcome.

Counseling can be a very emotional experience and can bring about many changes in your life. At any time you are welcome, and encouraged, to discuss any concerns or questions you have regarding the counseling process, techniques, or the positive or negative effects of the experience. We can work through them together with your best interests in mind.

Though the counseling relationship may seem very intimate psychologically, it must remain professional in order to maintain your best interests and personal rights. Information shared during our counseling sessions is done with a focus on counseling objectives, rather than social objectives.

Termination of Counseling

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for the completion of your counseling treatment in collaboration with your counselor.

You may discontinue counseling at any time. If you or I determine that you are not benefiting from counseling or that your needs may be better met in a different way, either of us may elect to initiate a discussion of your alternatives. Alternatives may include, among other possibilities, referral to another practitioner, changing your treatment plan, or terminating your therapy.

Notice of Privacy Practices

I. THIS NOTICE DESCRIBES THE CONFIDENTIALITY OF YOUR PSYCHOLOGICAL AND MEDICAL RECORDS, HOW THE INFORMATION MAY BE USED AND DISCLOSED, YOUR RIGHTS AND HOW YOU MAY OBTAIN THIS INFORMATION.

II. LEGAL DUTIES: I have a legal duty to keep your protected health information (PHI) private. I am legally required to provide you with this notice informing you of my privacy practices, and this notice must explain how, when, and why I will "use" and "disclose" your PHI. PHI refers to information in your health care record that could identify you. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice. PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made.

    I am required to abide by these policies until replaced or revised. I have the right to revise this policy for all records, including records kept before policy changes were made. Before I make any important changes to my policies, I will promptly change this notice and make it available in my office, on my website, and at your request.

III. USE AND DISCLOSURE OF PHI FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS: I may use or disclose your PHI for treatment, payment, and health care operations purposes with your consent. Treatment is when I provide, coordinate, or manage your mental health care and other services related to your mental health care. An example of this would be when I consult with another health care provider such as your primary care physician. Payment is when I obtain reimbursement for your health care, for example by contacting your insurance company for reimbursement or to determine eligibility or coverage. Health care operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.

IV. USE AND DISCLOSURE OF PHI REQUIRING AUTHORIZATION: I may use or disclose PHI for other purposes when you provide written authorization above and beyond the general consent that you provide to obtain counseling services from me.

You may revoke all such authorizations at any time, provided each revocation is in writing. Revocations will stop any future uses and disclosures by me to the extent that I haven't taken any action in reliance on such authorization.

V. USE AND DISCLOSURE OF PHI NOT REQUIRING AUTHORIZATION OR CONSENT:

a. Information regarding the suspicion that a client may bring harm to him/herself or others.
b. Information regarding suspected child or elder abuse or neglect.
c. Prenatal exposure to controlled substances that are potentially harmful.
d. Public safety: Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious health threats to public safety, essential government functions, military and when complying with worker's compensation laws.
e. Health oversight activities, such as a subpoena or other lawful request from the Department of Health or the Michigan Board of Counseling.
f. Judicial and administrative proceedings. If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under law, and I will not release information without your written authorization 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.
g. Legal defense. If I need to defend myself in a legal action or proceeding brought by you, I may disclose this information.
h. Other legal requirements may also necessitate disclosure of this information.
i. Decedents: To the extent permitted by law, I may use and disclose this information as requested by medical examiners or others who have a legal right to request information.

VI. YOUR RIGHTS:

a. The right to request restrictions on certain uses and disclosures of PHI. I will consider your request, but I am not legally required to accept them. You may not limit the uses and disclosures that I am legally required or allowed to make.

b. The right to choose how I will send you confidential communications. You have the right to request and receive confidential communications of PHI by alternate means and at alternative location. For example, you may not want a family member to know that you are seeing me, and at your request I may send your bills to a different address.

c. The right to see and obtain copies of your PHI. If I don't have your PHI, but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations I may deny your access to PHI, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. If you request copies of your PHI, the charge is $2.00 per page plus postage.

d. The right to get a list of the disclosures I have made. Request this in writing. The list will not include any uses or disclosures that law dictates I do not provide, which may include disclosures for national security purposes or to law enforcement.

e. The right to amend your PHI and/or disagree with the records in my files. You may request that this information be changed. Although I may refuse to change the record, you have the right to make a statement of disagreement, which will be placed in your file.

f. The right to a paper copy of this notice, upon request, even if you have previously agreed to receive it electronically.

VII. COMPLAINTS:
In the event that a client would like to file a complaint regarding my counseling services, a written complaint should be sent to the following location:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Investigations & Inspections Division
P.O. Box 30670
Lansing, MI 48909
(517) 241-0205

VIII. EFFECTIVE DATE OF THE NOTICE: This notice went into effect on October 1, 2014, most recent revision on October 1, 2019.

Counselor Communications
I may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform me if you do not wish to be contacted at a particular time, place, or by a particular means. If this information changes, please provide the updated information in writing; you may request a form on which to do so.

❒ My counselor may contact me at home. My home number is _____ Message ok? _____

❒ My counselor may contact me on my cell phone. My cell # is _____ Message ok? __Text ok? ___

❒ My counselor may contact me at work. My work number is _____ Message ok? _____

❒ My counselor may send mail to my home address which is: _____

_____

❒ I prefer my counselor send any mail to this alternate address: _____

❒ My counselor may contact me by email. (I understand that email has the potential to be hacked and is therefore not completely private) my email address is: _____

In case of an emergency, I prefer my counselor contact _____ at this number: _____

Please ask your counselor to address any questions or concerns you have about this information before you sign. Your signature indicates that you have read all proceeding pages of this agreement for services carefully and understand its contents, that you have read the above privacy practices and that you have been offered a copy for your records. Your signature also indicates that you consent to treatment for counseling services by Donna Bracher, LPC, and agree to pay for services including any applicable insurance deductibles or co-pays, missed appointment fees, or other fees not covered or paid by your insurance.

_____
Printed Client Name

_____ _____
Signature of Client Date

_____ _____
Signature of Guardian (if client is under 18 years of age) Date