undividedsoul professional counseling
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PROFESSIONAL DISCLOSURE AND INFORMED CONSENT
PLEASE KEEP FOR YOUR RECORDS

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it.

About the Counselor

My name is Kathryn (Katy) Gelinas, LPC. I hold a Master's degree in Clinical Mental Health Counseling from Regent University School of Psychology and Counseling. I am board-certified by the National Board for Certified Counselors and licensed as a professional counselor in the state of Connecticut. I have worked in the mental health field since 2010. I primarily work with individuals with mental health and substance abuse concerns. I also help people with general life problems such as relationship & family issues, stress, or making changes. I use what is known as an "eclectic" approach to therapy, meaning that I draw from many different counseling theories such as EMDR, cognitive-behavioral therapy (CBT), person-centered counseling, solution-focused therapy, and Dialectical Behavioral Therapy (DBT). I can also provide faith-based (Christian) counseling.

Benefits and Risks of Therapy

Deciding to seek counseling is an important step towards personal growth. Counseling can provide you with the opportunity to learn about yourself, explore your inner thoughts and feelings, make changes, relieve distress, foster hope, and realize possibilities for your life. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Discussing sensitive topics or making important changes may bring up feelings of anger, depression, or anxiety. There are no guarantees that counseling will "change" or "cure" any problem, as individual results often depend on the level of willingness, openness, and honesty a client brings to treatment. I encourage you to share with me if you experience difficulties in session or feel that our approach is not effective for your desired goals.

The Therapeutic Process

After an initial assessment, you will decide what your counseling goals will be and we will form an action plan to begin that process, including an estimate of how long we may be working together and how often we will meet. I will create a treatment plan based on your chosen goals and we will work together to help you make the changes you desire. We may use assessments, books, workbooks, art, music, role-playing, writing, relaxation, or other activities and resources during therapy. It is expected that you will engage in working towards your goals outside of session, so there may be homework that you are expected to complete,

such as journaling, worksheets, reading books, or observing your behavior. As you accomplish your goals, we will eventually create a termination and going-forward plan.

Appointments & Attendance

Counseling appointments are generally 60-90 minutes for the initial evaluation and 50-60 minutes for regular sessions (please note that if you arrive late, we will still end the session on time as another session may be scheduled after yours).

In order to make the lasting changes in your life that you want, it's important to make your counseling sessions a priority - this includes attending all scheduled appointments. You must give **24 hours notice** if you will miss an appointment. In last-minute or emergency situations, notify me **as soon as you become aware of needing to miss the appointment**. If you miss a scheduled appointment without notifying me, it is considered a "no call/no show." Both late cancellations and no-shows may be subject to the full session fee (*for those commercially insured or private pay*); because I know that "life happens," I do allow one "freebie" missed appointment. After three incidents, I reserve the right to discontinue counseling until you are more able to commit to attending regularly.

It is your responsibility to contact me to reschedule after missing an appointment. If I do not hear from you, I may attempt to reach you by phone. I may send a letter by mail after 3 weeks. For legal and ethical reasons, if after 30 days there are no sessions kept or scheduled, I will consider the professional relationship discontinued, unless we have made prior arrangements to pause treatment (for example, due to extended illness or traveling). You are welcome to return to counseling when you are able to commit to regular attendance.

Ending Therapy

Counseling is a voluntary process and you may stop at any time. Similar to personal relationships, you might not "click" with the first therapist you meet. If you feel that you might work better with a different therapist, I will happily refer you to another professional who may be a better fit. I do encourage you to discuss with me prior to ending therapy so that we may review our time together and prepare an appropriate referral.

There are some circumstances in which I may end the therapeutic relationship; for example, if I feel I am not equipped to best serve your needs, I may refer you to another professional or recommend a higher level of care. I may also terminate therapy in the event of repeated attendance problems. At termination, I will provide you with follow-up referrals to ensure your needs continue to be met.

Confidentiality

The session content and all relevant materials to the your treatment will be held confidential unless you request in writing to have all or portions of such content released to a specifically named person/persons. Clients under the age of 18 who receive services have the right to have their information kept private, however, I am obligated to provide parents or legal guardians with general information about progress.

Limitations of such client-held privilege of confidentiality exist and are itemized below:
1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named person is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse, or neglect, of children under the age of 18 years, elderly persons, or disabled persons.
4. If a court of law issues a legitimate subpoena for information stated on the subpoena.
5. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name or other identifying information.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office. Likewise, I may not engage in a social relationship with you outside of counseling, including social media (e.g. Facebook). I am also not allowed to receive gifts or attend social events with you. These boundaries are in place for your protection and benefit.

Contacting Me

Please note that I am not available outside of normal business hours, and I do not answer phone calls when in session with other clients. **If you experience an emergency, please call 911 or Mobile Crisis at 211 or 1-866-794-0021.** For non-emergency matters, you may call me and leave a message at any time; you may also send a text message through the secure "Spruce Health" mobile app. I will make every effort to return your call by the following business day. If I need to contact you, please specify how you prefer to receive communications (phone, email, secure text). **Please be advised that regular SMS text messages and your personal email server are not secure forms of communication.** I will not share any sensitive information through unsecured email without your consent.

Ethics
I am bound to the code of ethics of both the American Counseling Association and the National Board for Certified Counselors as well as the laws of the state of Connecticut pertaining to Professional Counselors. Information about these standards may be obtained from the following Web addresses. I can provide you with a printed copy if desired.
ACA Code of Ethics: *http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=4*
NBCC Code of Ethics: *http://www.nbcc.org/Assets/Ethics/NBCCCodeofEthics.pdf*
Connecticut General Statutes Chapter 383c, "Professional Counselors":
http://www.ct.gov/dph/lib/dph/practitioner_licensing_and_investigations/plis/professionalcounselor/lpc_stats.pdf

I will always do my best to serve you in the most professional manner. If you have any concerns about the care you receive from me, I encourage you to discuss your concern with me directly. I can provide you with alternate referrals if you do choose to discontinue services.

NOTICE OF PRIVACY PRACTICES

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
a. For my use in treating you.
b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you acknowledge that you have received a copy of HIPAA Notice of Privacy Practices.

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AGREEMENT TO BEGIN COUNSELING SERVICES

Client Name (print): _____ Date of Birth: _____

EMERGENCY CONTACT INFORMATION
If an emergency arises while we are working together or if I become concerned about your personal safety or the safety of someone else, I am obligated to contact someone close to you. Please provide the information of your chosen emergency contact:

Emergency Contact Name: _____ Relationship to You: _____

Phone: _____ Address: _____

____ *(Initials)* *I give consent for the above named person to be contacted in case of emergency.*

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_____ (*Initials*) *I acknowledge that I have received a copy of HIPAA Notice of Privacy Practices.*

CONSENT FOR TREATMENT
I agree that I have read, understood, and agree to the information and policies detailed in the disclosure statement of which I have received a copy. I agree to abide by the attendance policy. By my signature below, I consent to receive treatment from Undivided Soul LLC with the understanding that my participation is voluntary and I may terminate services at any time.

_____ _____
Client or Parent/Guardian Signature* Date

_____ _____
Kathryn Gelinas, MA, LPC, NCC Date

If someone has legal guardianship over your affairs, this form must be signed by your authorized representative. If you are the legal representative, please attach copy of legal appointment and specify representation type:
☐ *Conservator of Person* ☐ *Executor of Estate* ☐ *Legal Guardian of Minor* ☐ *Other:_____*