Counseling E-Mail Policy

Email communication between therapist and clients may be useful, but will only be practiced if you give consent, as there are important privacy/confidentiality issues that arise. Please read through the following questions to determine whether or not you would like to consent to use of email during the course of our work.

Q. Are you required to use e-mail with me?
No. Both you and I must agree to use e-mail. Not everyone is comfortable using e-mail, and there may be times when I feel that e-mail is not the best way to communicate.

Q. How confidential is e-mail between us?
I treat your e-mail with the same high level of confidentiality as your other medical information. However, messages must travel (unencrypted) over the Internet, and there is a remote possibility that a message could be intercepted by a third party. If you use your office e-mail to communicate with me, it is also possible that your employer may read your message as part of routine monitoring of employee e-mail usage.

Q. Why don't you use encryption for e-mail?
Standards for e-mail encryption are still evolving, and there is no clear consensus about the best method to use. Until a consensus is reached, most people will not use encryption for their e-mail. I will continue to monitor progress in this area, and may choose to use encryption when it is practical.

Q. How quickly will you reply to my e-mail?
I monitor my email at least once per day during the work week, Monday through Friday during from 9am-5pm. You should receive a reply within two working days (Monday through Friday), unless I am out of the office for a period of time for vacation or another reason. Please anticipate that it is unlikely that I will respond to email over the weekend, on holidays, or after business hours but will attend to your message during the work week.

I generally find it most helpful for us to discuss your experiences and questions in person during our sessions. You may find it helpful to share certain things with me throughout the week, or have logistical questions that arise between sessions. You are welcome to email me your thoughts, experiences and questions between sessions. Please note that I will respond to clinical material in person and often will respond email by letting you know that I have received and read your message and will look forward to discussing the content in person.

Q. Are e-mail messages placed in my medical record?
Yes, the content of each e-mail message exchanged between us will become part of your medical record.

Q. I need to speak with you today for urgent communication. Can I use e-mail for this?
No, please do NOT use e-mail for urgent communication or crisis needs. Always use the telephone when you need to be in touch more urgently; I do my best to respond to phone calls within 24-hours during the work week. If you are in crisis and need clinical attention immediately, please report to the emergency room and feel free to call to let me know you've done so from the emergency room.

Q. Are there some topics that I should avoid in e-mail messages?
You should not discuss the following topics via e-mail: mental health diagnoses (including sexual assault and domestic violence); sexually transmitted diseases, HIV/AIDS, alcohol and drug treatment, and abortion.

Q. May I request, reschedule, or cancel an appointment with you via e-mail?
Yes, unless the request is very time sensitive. Remember, it may take two working days to receive a reply.

Q. Can I stop using e-mail with you?

Yes, you may stop using e-mail at any time by providing a written request to Dr. LaTonya Zibi.

LaTonya Engon-Zibi, PhD, LMHC, LPC, MDiv, MTS
Email Informed Consent

In order to communicate with you by email, I need to make sure you are aware of the confidentiality and other issues that arise when we communicate this way and to document that you are aware of these and agree to them. Please sign the form below and return it to Dr. LaTonya Zibi.

I understand that all e-mail messages are sent over the Internet and are not encrypted, are not secure, and may be read by others. I understand that my e-mail communications with Dr. LaTonya Zibi will NOT be encrypted and, therefore, Dr. LaTonya Zibi cannot guarantee the confidentiality and security of any information sent to her or that she may send to me/my child via e-mail. We have also discussed Dr. LaTonya Zibi's guidelines for the use of e-mail and I understand and agree to the parameters stated in those guidelines. I have read and understand the Frequently Asked Questions sheet regarding the use of e-mail. I hereby give permission for Dr. LaTonya Zibi to reply to my messages via e-mail, including any information that she deems appropriate, that would otherwise be considered confidential. I agree that Dr. LaTonya Zibi shall not be liable for any breach of confidentiality that may result from this use of e-mail via the Internet. I understand that email communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. If I believe I need a response within 48 hours, I will not use e-mail but will call Dr. LaTonya Zibi. If I do not receive an answer to a routine email message within two working days, I understand that I should call Dr. LaTonya Zibi. I understand that all e-mail communications may be made part of my permanent medical record. I also understand that I may withdraw permission for Dr. LaTonya Zibi to communicate with me via e-mail by notifying her in writing.

I give Dr. LaTonya Zibi permission to e-mail me at the following e-mail address:

_____

_____

Client's Signature

_____

Date

Fee Information Form

I truly appreciate your choosing to come to me for psychological help. As part of providing high-quality services, we need to be clear about our financial arrangements.

A. Patient's name: _____ Birthdate: _____

Address: _____ Home phone: _____

Occupation: _____ Employer: _____Work phone: _____

Address of employer:_____

B. Third Party Payer(s): _____

Occupation: _____ Employer_____

Work phone: _____

Address: _____

Fees for Individual psychotherapy ❑ Yes ❑ No
Fees for Group psychotherapy ❑ Yes ❑ No

C. Insurance Type/Number:_____

A. I understand that I am responsible for completing all payments the day of my session
B. I understand that the agreed upon fee must be paid before the next session to continue services
C. I understand if there is a frequent pattern with late payments services may be terminated
D. I understand there are no refunds for discontinuation of prepaid number of visits
E. I understand that I am responsible for all charges.
F. I understand that I am responsible for paying the $50 cancellation fee if I do not show for my appointment or if I cancel less than 24 hours
G. I understand that I am responsible for paying $50 if I do not reschedule after canceling the appointment (sickness and emergencies do not apply).
H. I understand that I am responsible for paying the fees for bounced checks

_____ _____
Client's (or parent/guardian's) signature Date

Confidentiality
What You Should Know about Confidentiality in Therapy

I will treat what you tell me with great care. My professional ethics (that is, my profession's rules about values and moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the "confidentiality" of therapy. But I cannot promise that everything you tell me will never be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a "secret" that I cannot keep secret. So please read these pages carefully and keep this copy. At our next meeting, we can discuss any questions you might have.

1. When you or other persons are in physical danger, the law requires me to tell others about it.

Specifically:

a. If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.

b. If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.

c. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.

d. If I believe or suspect that you are abusing a child, an elderly person, or a disabled person I must file a report with a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

2. In general, **if you become involved in a court case or proceeding**, you can prevent me from testifying in court about what you have told me. This is called "privilege," and it is your choice

to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:

a. In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.

b. In cases where your emotional or mental condition is important information for a court's decision.

c. During a malpractice case or an investigation of me or another therapist by a professional group.

d. In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.

e. When you are seeing me for court-ordered evaluations or treatment. In this case we need to discuss confidentiality fully, because you don't have to tell me what you don't want the court to find out through my report.

f. If you were sent to me for an evaluation by worker's compensation or Social Security disability, I will be sending my report to a representative of that agency and it can contain anything that you tell me.

3. There are a few other things you must know about confidentiality and your treatment:

a. I may sometimes consult (talk) with another professional about your treatment. This other person is also required by professional ethics to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist will be available to help my clients. I must give him or her some information about my clients, like you.

b. I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you.

4. Here is what you need to know about confidentiality **in regard to insurance and money matters:**

a. If you use your health insurance to pay part of my fees, the insurance company, the managed care organization, or perhaps your employer's benefits office will require me to provide information about your functioning in many areas of your life, your social and psychological history, and your current symptoms. I will also be required to provide a treatment plan for your problems and information on how you are doing in therapy.

b. I usually give you my bill with any other forms needed, and ask you to send these to your insurance company to file a claim for your benefits. That way, you can see what the

company will know about our therapy. It is against the law for insurers to release information about our office visits to anyone without your written permission. Although I believe the insurance company will act morally and legally, I cannot control who sees this information after it leaves my office. You cannot be required to release more information just to get payments.

c. If you have been sent to me by your employer's employee assistance program, the program's staffers may require some information. Again, I believe that they will act morally and legally, but I cannot control who sees this information at their offices. If this is your situation, let us fully discuss my agreement with your employer or the program before we talk further.

d. If your account with me is unpaid and we have not arranged a payment plan, I can use legal means to get paid. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to me.

5. **Children and families create some special confidentiality questions.**

a. When I treat children under the age of about 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, most of the details in things they tell me will be treated as confidential. However, parents or guardians do have the right to general information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told, especially if these others' actions put them or others in any danger.

b. In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes and my role. Then we can be clear about any limits on confidentiality that may exist.

c. If you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep it confidential. I will work with you to decide on the best long-term way to handle situations like this.

d. If you and your spouse have a custody dispute I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluations.

e. If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify.

f. At the start of family treatment, we must also specify which members of the family must sign a release form for the common record I create in the therapy or therapies. (See point 7b, below.)

6. **Confidentiality in group therapy is also a special situation.** In group therapy, the other members of the group are not therapists. They do not have the same ethics and laws that I have to work under. You cannot be certain that they will always keep what you say in the group confidential.

7. Finally, here are a few other points:
a. I will not record our therapy sessions on audiotape or videotape without your written permission.
b. If you want me to send information about our therapy to someone else, you must sign a "release-of-records" form. I have copies you can see, so you will know what is involved.
c. Any information that you tell me and also share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Please bear in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you talk to a lawyer to protect your interests legally and to act in your best interests.

The signatures here show that we each have read, discussed, understand, and agree to abide by the points presented above.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

TELEHEALTH CONSENT FORM

I, [ ] (Patient) hereby consent to engage in Telehealth with [LaTonya Zibi, LMHC, LPC] (Therapist). I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

9. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my

insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the [Informed Consent Form or Name of Payment Agreement Form].

10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

[For conjoint or family therapy, patients may sign individual consent forms or sign the same form.]

_____ _____

Patient's Signature Date

_____

Patient's Printed Name

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us. When I use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his, her, or their name here:

When you are examined, tested, diagnosed, treated, or referred, I will be collecting what the law calls "protected health information" (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how I can use and share your information.

If you do not sign this form agreeing to my privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change my notice of privacy practices. If I do change it, you can get a copy from my website, spiritbecoming.com, or by calling me at, 781-832-0166.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to me, the privacy officer. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____

Printed name of client or personal representative

_____

Relationship to the client

_____

Description of personal representative's authority

_____

Signature of authorized representative of this office or practice

Date of NPP: _____

❑ Copy given to the client/parent/personal representative

Notice of Privacy Practices

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.

Our 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.

How we use and disclose your protected health information with your consent

I will use the information collected about you mainly to provide you with treatment, to arrange payment for my services, and for some other business activities that are called, in the law, health care operations. After you have read this notice I will ask you to sign a consent form to let me use and share your information in these ways. If you do not consent and sign this form, I cannot treat you. If I want to use or send, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require therapists to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

Your rights regarding your health information

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try our best to do as you ask.
2. You can ask to limit what to tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but may be charged for it. We can discuss how to arrange to see your records.
4. If you believe that the information in your records is incorrect or missing something important, you can ask to make additions to your records to correct the situation. You have to make this request in writing and send it to me. You must also tell me the reasons you want to make the changes.
5. You have the right to a copy of this notice. If a change is made to this notice, I can get a copy of it for you.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human

Services. All complaints must be in writing. Filing a complaint will not change the health care provided to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. I am happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or health information privacy policies, we can discuss this further.

The effective date of this notice is _____

Sign: _____

SpiritBecoming
Dr. LaTonya Zibi

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Notice: Confidential mental health information generally cannot be released to others without your consent. Do not sign this release form unless it is completely filled out and you believe that the release of this information is in your best interest.

Name: _____ Date of Birth:_____/_____/_____

Address:_____ Phone: (_____)_____-_____

I do hereby authorize and direct _____ to (Please check only one):

Exchange information with __ Release information to __ Receive information from __

Name: _____

Address: _____

Phone/Fax: _____

regarding myself, including treatment and diagnosis (for purpose of completing the Mental Health Information only as requested by _____ pertaining to the following dates: _____.

This authorization will expire in 365 days from the date signed.

I understand that I may revoke my authorization at any time by providing a written request for such, except as to actions that have been taken in reliance upon it.

Signed _____ Date _____

Witness _____