**Joslyn Reedy-Kay** **and Associates, LLC**

3268 Jefferson Avenue Cincinnati, OH 45220

513-914-1777

jreedykay@gmail.com

**PRACTICE POLICIES**

**APPOINTMENTS AND CANCELLATIONS**

Scheduling of appointments can be done at your convenience by calling or emailing us at the contact information above.

If you are late for an appointment, the session must still end at the scheduled time, as there will usually be someone else waiting for the next appointment time.

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for a $50 late cancellation fee if you cancel within 24 hours of our appointment.

Cancellations and re-scheduled session will be subject to a $50 if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you.

The standard meeting time for psychotherapy is 55 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 55-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

**ADJUNCT SERVICES**

• If you are involved with the judicial system for divorce, custody, criminal or any other reason, be aware that we do not go to court as your advocate. If you are looking for a therapist for forensic reasons, we can refer you to someone else.

• We do not provide written documentation or completion of forms requested by you or other agencies (i.e. Social Security Administration, short-term disability companies, etc.).  However if formal request is made, a fee of $80 per document will be charged and must be paid prior to completion of the document.

**TELEPHONE ACCESSIBILITY** If you need to contact us between sessions, please leave a message via voice mail. I am often not immediately available; however, we will attempt to return your call within 24 hours. You may also contact us via secure messaging through the client portal which you gain access to upon establishing as a client. If a true emergency situation arises, please call 911 or any local emergency room.

**SOCIAL MEDIA AND TELECOMMUNICATION** Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

**ELECTRONIC COMMUNICATION** We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, we will do so. While we may try to return messages in a timely manner, we cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

**TELECOUNSELING/TELEMEDICINE** If previously agreed to, we may choose to meet via “tele-therapy.” I understand that “tele-therapy” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Ohio or outside of Ohio. Because of recent advances in communication technology, the field of tele-therapy has evolved. It has allowed individuals who may not have local access to a mental health professional to use electronic means to receive services. Because it is relatively new, there is not a lot of research indicating that it is an effective means of receiving therapy. An important part of therapy is sitting face to face with an individual, where non-verbal communication (body signals) are readily available to both therapist and client. Without this information, tele-therapy may be slower to progress or less effective. With the telephone, the client’s tone of voice, pauses and choice of words become especially important and therefore an important focus of the sessions. With, therapy via email, the written word is the exclusive focus. What is important here is that you are aware that tele-therapy may or may not be as effective as in-person therapy and therefore we must pay close attention to your progress and periodically evaluate the effectiveness of this form of therapy. Because we may not have met you in person, we may request that you be interviewed by a professional in your area and allow me to talk to that individual before proceeding with therapy. We will be bound by laws in the state of Ohio (outlined below) as this is where I practice tele-counseling.

**MINORS** If you are a minor, your parents may be legally entitled to some information about your therapy. We will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

**TERMINATION** Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. We may terminate treatment after appropriate discussion with you and a termination process if we determine that the psychotherapy is not being effectively used or if you are in default on payment. We will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, we will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, we must consider the professional relationship discontinued.

**FEES & INSURANCE**

• Self Payment - The standard rate is $115 for a 55-60 minute session for Joslyn Reedy-Kay and $75 for Jeralyn Giffin. Payment is expected at the time of service.

• Out-of-Network Insurance – You are responsible for determining next steps for billing if you wish to use your out of network insurance and will be considered a “self-pay” client.  We are happy to provide a “super bill” to assist you with getting reimbursed by your insurance company.

• In-Network Insurance - If you will be using your insurance benefits for payment, it is your responsibility to be familiar with your insurance coverage.  If your insurance/managed care company requires a referral or preauthorization for services, it is your responsibility to obtain the initial authorization.  If you come to your appointment without the authorization, you will be responsible for payment in full until you provide an authorization number.  Your insurance co-payment is due at the time of services and, if for any reason your insurance company does not pay for services, you will be responsible for the balance of your bill. Please be aware that your insurance company will require me to provide a clinical diagnosis.

• We accept cash, checks, and all major credit cards.  There will be a $25 fee for returned checks.

We will discuss this form during your first session.  If you have questions about any of the above prior to that time, please email me or call me.   By signing below you are agreeing to accept both my professional services as well as to pay the agreed upon fee of   $115 (Joslyn) or $75 (Jeralyn)  per session for these services if self-paying, OR a reduced fee if previously agreed OR giving authorization for me to submit claims to your health insurance company for services rendered, to be paid directly to me, and authorizing me to release pertinent information to your insurance company.  You also understand that I use a billing service and you are authorizing pertinent information to be released to that service.  You are also agreeing that your financial relationship with me will continue until you inform me in person that you wish to end it and that you have read and agree to act according to everything stated in this document.

BY CLICKING ON THE CHECKBOX BELOW/SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

**Joslyn Reedy-Kay** **and Associates, LLC**

911 W. 8th Street Cincinnati, OH 45203

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**Informed Consent for Psychotherapy**

This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

**Services**

• We provide individual therapy and specialize in trauma informed care and maternal mental health.

• You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. We cannot promise that your behavior or circumstance will change. We can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

• As with nearly any type of treatment, there is the chance that it may not be helpful.  The “fit” between client and therapist is usually key to good treatment outcome. In the beginning of treatment, things may feel worse before they feel better.  *Therefore, we want to hear from you throughout our work together about how we are doing—so that we can make needed adjustments to help you more effectively.*

• We do not work in isolation.  We do meet with colleagues and we provide ongoing supervision for each other. Any information we share about you will be anonymous and for the purpose giving you the best service possible.

• We do not have the staff to manage crises on days and times when we are not in the office, and encourage clients to utilize other crisis services (if needed) during those times.  These include calling 281-CARE (2273), 1-800-273-TALK (8255) the national crisis hotline, your primary care physician and/or psychiatrist, or going to your nearest hospital emergency room.

**Consent for Tele-Counseling**

If we agree to complete our psychotherapy sessions via a secure telecounseling platform (telehealth by simple practice, doxy.me, vsee) I am aware of the following:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Ohio law.

**Confidentiality**
The session content and all relevant materials to the client’s treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. 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/her self 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 victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. 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.

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.

BY CLICKING ON THE CHECKBOX BELOW/SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

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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 (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client’s personal health information without the patient’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 AUTHORIZATION. 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.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on September 20, 2017

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 checking the box below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

BY CLICKING ON THE CHECKBOX BELOW/SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.