

# CLIENT INFORMATION PACKET

**Manda P. Turetsky, MS, MBA, LAPC, NCC**  
*Marietta Counseling for Children & Adults, LLC*  
2440 Sandy Plains Rd. Building 13 Suite 300  
Marietta, GA 30066  
770-971-9311, ext. 1  
Fax: 678-264-0902

Thank you for choosing Manda Turetsky, MS, MBA, LAPC to provide your mental health and personal growth services. This packet will allow me to learn about you, and provide important information about counseling services. Please take the time to read each portion carefully, and be sure to note any questions you might have so that we can discuss them in our first session.

Couples should print out two copies of this packet and fill them out separately. Please bring the completed pages with you to our first session. Thanks!

## CHECKLIST

- Please fill out completely the **Client Information Form** on pages 2-5.
- Read carefully the Informed Consent on pages 6-10.
- Sign and Return the **Consent to Treatment** on page 11.
- Read and Sign the **Credit Card Policy** on page 12.
- If desired, fill out and sign the Release of Information on page 13. (optional)
- Read the Privacy Protection Notice on pages 14-15.
- Sign and return the **Client Notification of Privacy Rights** on page 16.

# CLIENT INFORMATION FORM

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Today's Date \_\_\_\_\_

Client's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Parent/Guardian's Name (if applicable) \_\_\_\_\_

Relationship \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

May I send information to this address?  Yes  No

If No, please provide an address where information can be mailed: \_\_\_\_\_  
\_\_\_\_\_

Home Phone Number \_\_\_\_\_

May I contact you at this number?

Yes  No  Disguised

Cell Phone Number \_\_\_\_\_

May I contact you at this number?

Yes  No  Disguised

Work Phone Number \_\_\_\_\_

May I contact you at this number?

Yes  No  Disguised

If there are any further restrictions when calling you, please list them here \_\_\_\_\_  
\_\_\_\_\_

Education Level Completed \_\_\_\_\_ Occupation \_\_\_\_\_

Person to notify in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

***I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so:*** \_\_\_\_\_

How did you hear about me/MCCA? \_\_\_\_\_

Please briefly describe the concern(s) that bring you to counseling/coaching:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How many weekly sessions do you anticipate to address these concerns?

1-5                  6-10                  11-20                  20+                  I don't know

MEDICAL HISTORY

Please explain any significant medical problems, symptoms, or illnesses:

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Current Medications	Purpose	Dosage	Frequency	Side Effects
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*Please include over-the-counter medications and vitamins*

Past Medications	Date(s)	Purpose	Dosage	Side Effects
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Do you smoke or use tobacco?       Yes  No      If yes, how much per day? \_\_\_\_\_

Do you consume caffeine?           Yes  No      If yes, how much per day? \_\_\_\_\_

Do you drink alcohol?               Yes  No      If yes, how much per day/week/month? \_\_\_\_\_

Do you use any illicit drugs?       Yes  No      If yes, which? \_\_\_\_\_

Do you exercise?                     Yes  No      If yes, how often? \_\_\_\_\_

Have you ever talked with a mental health professional before today?  Yes  No

If yes:    Date(s)                    Type of Treatment                    Reason                    Professional Seen

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Would you like me to contact any of your previous providers?  Yes  No

If yes, please provide their contact information: \_\_\_\_\_

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RELATIONSHIPS & SOCIAL SUPPORT

Are you currently in a relationship?       Yes  No      If yes:  Married  Partnered

How long in current relationship? \_\_\_\_\_

Please rate your current relationship satisfaction: 1 2 3 4 5 6 7 8 9 10

Any previous marriages/significant relationships?       Yes  No

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Do you have children?  Yes  No

If yes, please list names & ages

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Please list other people or groups who are important social support for you:

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Is spirituality an important part of your life? If so, what would you like me to know?

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FAMILY HISTORY

How would you describe your relationship with your mother?

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How would you describe your relationship with your father?

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Are your parents still living? \_\_\_\_\_ Still married? \_\_\_\_\_

If they divorced, how old were you when they separated or divorced, and how did this impact you?

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Were there any other primary care givers who you had a significant relationship with? If so, please describe.

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How many sisters do you have? \_\_\_\_\_ Ages? \_\_\_\_\_

How many brothers do you have? \_\_\_\_\_ Ages? \_\_\_\_\_

How would you describe your relationships with your siblings?

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Briefly describe one event or situation from the past (the first one that comes to mind is fine), which you feel had an impact on who you are today, or on the issue that brings you to counseling.

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## CHECKLIST OF CONCERNS & SYMPTOMS

Please check all concerns that apply, even if they do not seem relevant to your current issue.

Difficulty with....	Now	Past	Difficulty with....	Now	Past	Difficulty with....	Now	Past
Anxiety			People in General			Nausea		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger/Temper			Marriage/ Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears/Phobias			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often make careless mistakes		
Drugs			Hurting Self			Fidgeting		
Alcohol			Thoughts of Suicide			Speaking without thinking		
Caffeine			Sleeping too Much			Impatience		
Frequent Vomiting			Sleeping too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking too early			Easily Distracted		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head injury			Chills/Hot Flashes		

FAMILY HISTORY OF.... (check all that apply)

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		"Nervous Breakdown"	

Any additional information you would like to include:

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# INFORMED CONSENT

**Manda P. Turetsky, MS, MBA, LAPC**  
*Marietta Counseling for Children and Adults, LLC*  
2440 Sandy Plains Rd. Building 13 Suite 300  
Marietta, GA 30066

The following contains important information about the professional services provided by Manda Turetsky, MS, MBA, LAPC. This document is designed to inform you about what you can expect from therapy, and from me as a professional. This includes confidentiality, emergencies, and several other important details regarding your treatment. Please read carefully, since this document is the agreement that allows me to provide therapeutic services to you. Counseling is a collaborative experience, and I welcome your questions, concerns and suggestions throughout the process.

## BACKGROUND & EDUCATION

I attained my Master of Science (MS) in Professional Counseling from Georgia State University in May 2008. As part of my educational and post-graduate experience, I have been working directly with clients under supervision since June of 2007. I am a certified mediator, and I also have advanced training in several of my specialty areas. I seek ongoing education as part of my professional commitment to provide my clients with the most current treatment modalities.

I also hold a Master of Business Administration (MBA) and a Bachelor of Arts in English, both from the University of Georgia in Athens. Previous to my work as a counselor, I worked for several years in the corporate marketing and non-profit development realms. I have consulted with organizations to train employees and managers in interpersonal skills. When I am not counseling, I often spend time writing articles, web content, and even some fiction. I have traveled extensively, including spending six months backpacking in Europe a few years ago.

## SUPERVISION

I am licensed as an Associate Professional Counselor. The State of Georgia requires all associate therapists to seek out supervision on cases they are involved with. Supervision helps to ensure that my clients are receiving the best possible care, and that appropriate measures are being taken to ensure that your needs are being met. I have contracted with a State Board approved supervisor (Rebecca Beaton, PhD, LPC, Licensed Psychologist) to oversee all of my cases. This supervisor is legally bound to all the confidentiality restrictions listed above. Your case may or may not be discussed with a supervisor at some point during your work with me. During supervision I do not disclose names of clients or other identifying information. If you have any questions about this process, please feel free to ask me at any point during your time in therapy.

## THEORETICAL VIEWS AND CLIENT PARTICIPATION

I believe that therapy is most effective when it is engaging and empowering. Our sessions will be based on a collaborative partnership in which we work together to help you find the solutions that work best for you. While I can serve as a guide on this journey; ultimately, the answers are yours to discover. During our therapeutic relationship, I will help to create a safe, supportive environment; and invite you to explore the issues that bring you to counseling and to find or create the solutions that work best for you.

Like many things in life, the benefits of therapy are closely related to the effort put into the process. Clients who take an active role in counseling, work between sessions, and express themselves honestly will generally

derive the most benefit. As the client, you are in control: you may choose to alter the direction of therapy or discontinue at any time.

## SERVICES PROVIDED

At your first session, I will speak with you about the reasons that you scheduled your first appointment. During this time a decision will be made between client and therapist as to whether or not we are a good fit for treatment or if an outside referral will be made to someone with more expertise in your area of need.

Each therapy session typically lasts 45-50 minutes. The duration of the therapeutic process varies for each client. Some clients may feel resolution to their concerns in just a few sessions while others may take years to complete their process. In most cases, therapy is more effective when both client and therapist make a regular, weekly commitment to work together – particularly during the initial 6 to 10 weeks of therapy. Some treatments may require more frequent meetings; we will discuss this when we develop a treatment plan.

Together, we will periodically evaluate your progress toward the goals that brought you to counseling and adjust as necessary. If at any time you wish to stop receiving services from me, I ask that you schedule one final session in order for us to have appropriate closure and to address any remaining needs that you may have.

## RISKS

Given the work required for personal growth and change to occur, therapy may involve some risks. Since therapy involves discussing difficult aspects of life, you may experience uncomfortable feelings or strong reactions. Making and adapting to changes in your life may have a profound impact on you and your relationships as well as challenge long held assumptions or behaviors. Reasonable efforts will be made to discuss the potential impact, positive and negative, that may result from the changes you make in your life as a result of therapy. Please ask questions if you have any concerns.

There are no guarantees for successful therapy due to the overall complexity of the process and the multiple variables brought into it by each individual.

## CONFIDENTIALITY

The information you share with me both written (i.e. intake paperwork) and verbally is part of your Protected Health Information (PHI) and is considered confidential. A detailed description of PHI is included with this intake packet. I will not release your information to anyone, including your family and insurance company if you are a legal adult, without *written* consent. If you are a minor, it is the legal right of your parents to have access to the information that we discuss in our sessions. I will discuss with each minor client and their parent/guardian the expectations of exchange of information between parent/child, therapist/child, and therapist/parent for their particular situation.

It is important that you understand the legal limitations to confidentiality which include, but are not limited to:

- 1) When individuals express intent to harm themselves or others, the therapist may be required to break confidentiality to assure the health and safety of all concerned.
- 2) Therapists are mandated by law to report to the appropriate state authorities information documenting child and/or elder abuse or neglect.
- 3) When a judge orders that information be disclosed. I cannot guarantee that an appeal will be upheld, but I will do everything in my power not to disclose your confidential information.

4) The PATRIOT Act of 2001 requires me in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits me from disclosing to my client that the FBI sought or obtained the items under the Act.

Your confidential files will be routinely accessed only by your therapist and, on occasion, administrative personnel employed by MCCA. Administrative assistants will only access the portions of your file pertinent to administration, such as your contact information and payment history, not your medical records or psychotherapy notes. In the event of an emergency, your file may also be accessed by Lynn Louise Wonders, LPC, Director of Therapy Services at MCCA, for the purpose of notifying you of the emergency.

#### WAIVE RIGHT TO SUBPOENA

In order to protect you and the information you and/or your child(ren) provide to me during our sessions I ask each client to waive their right to call me as a witness to court for any reason. The communication that you/your child(ren) provide during session is considered privileged by O.C.G.A. §24-9-21(7) and covers communication provided by “a licensed...marriage and family therapist... during the psychotherapeutic relationship.” If you anticipate the need for a therapist’s involvement in court activity I will be happy to refer you to someone who is more suited to meet your needs.

#### COMMUNICATION

The most effective way to communicate with your therapist is in-person, within the regular 45-50 minute session time. Any phone consultations should be mutually agreed-upon in advance, and will be billed at the regular rate every 15 minutes. Psychotherapy by telephone is **not** ideal, however, and frequent phone consultations between sessions may be an indication that you need additional support – such as more frequent sessions, group therapy, or more intensive treatment.

Clients who choose to contact me by e-mail should be aware that I cannot guarantee the confidentiality of e-mail communication, and I discourage the use of e-mail to address clinical issues for a number of reasons. Please note that e-mail communication should be used only for scheduling/logistics issues; and I cannot respond to the clinical content of e-mail messages. I do not communicate with clients via text message, Instant Messages (IM) or social networking sites (like Facebook, MySpace or LinkedIn).

#### FEES

Clients seen by Manda P. Turetsky, MS, MBA, LPC agree to pay \$100.00 per 45-50 minute session. Services will be provided by me, as contracted through Marietta Counseling for Children and Adults. Any services beyond the standard 45-50 minute session – such as a phone consultation exceeding 15 minutes, paperwork outside the ordinary course of treatment, reports prepared for third parties, or court appearances/preparation – will incur additional fees to be discussed prior to service provided. You are responsible for the full payment at the time service is provided.

MCCA reserves the right to announce fee increases, which upon effective date shall become current for all existing clients. As of January 1, 2009 cash, checks and credit cards will be accepted as forms of payment. *If you are using a credit card a processing fee of \$3.00 will be added to your session fee.* I will be happy to provide you with a receipt for payment upon request. Receipts of payment may also be used as a statement for insurance if applicable to you. Please note that there is a \$25 fee for returned checks. Should you miss a payment, for whatever reason, therapy sessions may be postponed until the full payment is rendered.

Periodically, I am able to provide a limited number of reduced-fee or scholarship slots in my case load. If you feel that you qualify for one of these slots and would like to apply, please inform me *before* our first session

(or when a financial hardship occurs, if applicable). Because these slots are limited there may be a waiting list. If there are no slots immediately available I am able to provide you with other low-cost referrals.

## INSURANCE

The services I provide are fee-for-service, which means I do not accept or file insurance on behalf of my clients. At your request (and with your written permission), I will be happy to provide you with a “superbill” – a statement of diagnosis, sessions attended and fees paid – so that you may file with your insurance company for reimbursement if you choose to do so. **Please be aware that submitting information to your insurance company for payment compromises your confidentiality;** your diagnosis code and other information may be kept on file by your insurance company and transmitted to others in the future. This could have a detrimental impact on future employment or insurability. I encourage clients to consider carefully before submitting mental health claims for insurance reimbursement.

Should you choose to seek reimbursement, please note that insurance companies have many rules and requirements specific to certain plans. It is your responsibility to understand the requirements and limitations that apply to your particular plan. I cannot guarantee payment of any claim, nor am I able to speak with the insurance company on your behalf.

## CANCELLATIONS

You are expected to attend all scheduled sessions with your therapist. Therapy is most effective for clients who make it a priority and attend regularly. Keeping our scheduled appointments not only shows respect for my time; but also (more importantly) demonstrates your commitment to yourself and your therapeutic growth. Schedule changes, and even some illnesses, can be a manifestation of anxiety about therapy, or your body’s response to feelings you may be avoiding. I strongly recommend bringing these feelings of apprehension to session with you so that we can process them together.

If, after reflection, you do need to cancel your appointment, please call **NO LATER THAN 24 HOURS PRIOR** to your scheduled time. Our fee is \$50.00 for appointments missed or cancelled with less than 24 hours notice. MCCA requires all clients to provide a credit card number to keep on file in the case of missed or cancelled appointments. This information is kept in a confidential file that is locked at all times. **If you miss or cancel your appointment for any reason without 24-hour notification, the \$50.00 cancellation charge *plus* the \$3.00 process fee for credit cards will be charged to your card.** Please note that insurance companies do not reimburse for missed appointments.

Any files that have no activity for a period of 3 months will be closed.

## EMERGENCIES

Manda P. Turetsky, MS, MBA, LAPC does not provide emergency services. I do not carry a pager and I am not available at all times. If this does not feel like it will be sufficient support for you, please inform me and we can discuss additional resources or transfer your case to a therapist or clinic that has 24 hour availability.

Generally, I will return phone calls within 24-48 hours. Should I be out of town, I will make every effort to alert you of my absences. If you have a mental health emergency at any time, I encourage you not to wait for a call back, but to do one of more of the following:

- 1) Call Ridgeview Institute at 770.242.4567 or Peachford Hospital at 770.454.5589
- 2) Call 911
- 3) Go to the emergency room of your choice
- 4) Cobb County Mental Health Crisis Line 770.422.0202

5) Fulton County Mental Health Crisis Line 404.730.1600

## ETHICAL CONSIDERATIONS

I am committed to professional behavior that is consistent with the Code of Ethics of the American Counseling Association. You may view the Code of Ethics on the “Resources” page at [www.counseling.org](http://www.counseling.org).

In order to maintain ethical standards I find it helpful to occasionally consult with other professionals. In these consultations I do not reveal the identity of my client(s). The consultant is also bound to keep any information about a case confidential by the ethical standards of their own professional association. I do not consult with therapists who are not bound by such ethical standards.

## INFORMATION SPECIFIC TO CERTAIN CIRCUMSTANCES

### WORKING WITH CHILDREN

Due to the importance of trust between client and therapist, when the client is a minor child I will offer parents general information about the therapeutic process and overall themes, but not specific details about what information is exchanged during each session. If, at any time, I feel like your child is engaging in dangerous behavior I will immediately inform you of the situation, or have your child do so as part of the therapeutic process. I will regularly update you on your child’s progress and I encourage you to contact me as frequently as you feel is needed.

I will not provide you updates after each session, however if you need to speak with me about your child’s behavior please call prior to their weekly session or arrange a time to come in and speak with me. It is important that your child feel that my office is a place where they can trust me enough to share the sensitive things that may be underlying the presenting problem. I am sensitive to a parent’s needs to be involved in the process and that is why parenting and family sessions are typically a regular occurrence during the treatment process.

### COUPLES, GROUPS & CONFIDENTIALITY

If you are participating in therapy as part of a couple or a member of a group, please be aware that, though every effort will be made to do so, I cannot completely guarantee your confidentiality will be kept by others participating in the therapy session. The legal concept of privilege also does not apply when more than one client participates in a therapy session. In most cases, this will not impact my ability to keep all information confidential; but in certain (very rare) situations involving legal proceedings I may be unable to assert privilege to protect the content of our sessions. **In all cases, I will always exhaust every legal option available before being compelled to break confidentiality.**

### COUPLES THERAPY

In couples’ therapy, my client is the couple as a unit, rather than each individual separately. This means that we will work toward agreed-upon goals together, and in the best interest of both partners, rather than exploring the agenda of one person or the other. During relationship counseling, I often recommend that one or both partners seek a separate therapist to work on individual issues that are impacting the relationship; in this case, I will be more than happy to make a referral or recommendation for you.

Please note that in couples’ therapy, I do not agree to keep secrets between partners. Information disclosed by either partner in any context may be discussed with the other partner at any time.

## CONSENT TO TREATMENT

By signing below you agree that you have read (or have had read to you) all of the above sections of the Informed Consent document and that you understand the risks and benefits associated with the therapeutic process. You understand that you can ask questions about the process at any time. You agree to pay the disclosed fee for services rendered and to provide 24 hours notice to cancel your appointment.

\_\_\_\_\_  
Client Signature (or Parent/Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

### **ALL CLIENTS**, initial here:

\_\_\_\_\_ I have read & agree to the "Waive Right to Subpoena" section.

\_\_\_\_\_ I have read & agree to the "Cancellation" section.

### **COUPLES** and **PARENTING SKILLS CLIENTS**, initial here:

\_\_\_\_\_ I have read & agree to the "Couples, Groups & Confidentiality" section.

\_\_\_\_\_ I have read & agree to the "Couples' Therapy" section, including the "No Secrets" policy.

### **PARENTS** of **MINOR CLIENTS**, initial here (if the child is being seen in therapy):

\_\_\_\_\_ I have read & understand the "Working with Children" section.

### **GROUP THERAPY MEMBERS**, initial here:

\_\_\_\_\_ I have read & agree to the "Couples, Groups & Confidentiality" section.

# CREDIT CARD POLICY

Marietta Counseling for Children & Adults, LLC  
2440 Sandy Plains Rd. Bld. 13, Ste. 300  
Marietta, GA 30066

"I am hereby entering into a contract for Manda Turetsky's professional time and services when I set an appointment. I understand that by entering this contract for Manda Turetsky's professional time I am specifically contracting for her services to prepare for my session in advance. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and consultations with other professionals as agreed in writing by me to assist with my treatment.

I understand that Manda Turetsky's cancellation policy requires 24 hours advance notice in order to be released from the contract for Manda Turetsky's time and services of preparation for my session. I agree that if I fail to cancel my appointment within the 24 hour minimum time period prior to my session I will be charged for the missed session and the services provided in preparation of \$50.

I hereby authorize Marietta Counseling for Children & Adults, LLC to charge my

**Visa/MC/Discover/ AMEX (please circle)**

**credit card number** \_\_\_\_\_ **exp. date** \_\_\_\_\_ **cvcode** \_\_\_\_\_

if I indeed fail to observe this cancellation policy. I understand I am paying for preparation services rendered and time contracted for when I set the appointment."

I have read and understand the above credit card policy for services provided by Manda P. Turetsky, MS, MBA, LAPC, through Marietta Counseling for Children & Adults, LLC. Please have all consenting adults sign below.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Signature Date

# RELEASE OF INFORMATION

**Manda P. Turetsky, MS, MBA, LAPC**

*Marietta Counseling for Children and Adults*

2440 Sandy Plains Rd. Building 13 Suite 300

Marietta, GA 30066

**\* This form is required if you would like for me to be able to speak with another professional (such as a psychiatrist, primary care physician, or another mental health professional) about your case. It is also required if you wish me to release information about our sessions to someone else. The form must be completed in full in order to be valid\***

Client's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I hereby request and authorize Manda P. Turetsky, MS, MBA, LAPC :

To **release** the information indicated at right to:

Name \_\_\_\_\_

(Must be an individual's name. No Organizations)

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

To **request** the information indicated at right from:

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Please check the information you would like released:

- All treatment-related Information
- Treatment Summary
- Treatment Plan
- Clinical Assessment
- Psychiatric Evaluation
- Financial Information
- Attendance
- Other (please describe)

\_\_\_\_\_  
\_\_\_\_\_

**For the purpose of:**  Coordination of Treatment  Other: \_\_\_\_\_

*Medical records frequently contain information which may be privileged and/or confidential. This could include remarks furnished by the client, client's family, or medical staff. If, in the judgment Manda P. Turetsky, MS, MBA, LAPC disclosure of the privileged/confidential information will be harmful to the client, release of such information may be withheld in accordance with specific state and federal regulations. Records released may contain alcohol and drug treatment information, AIDS/HIV, psychiatrics/psychological/and other mental health privileged/confidential information. Certain communications are privileged and not subject to release without your consent understate and/or federal law. Please note that once information has been released to the designated party, neither Manda P. Turetsky, MS, MBA, LAPC nor Marietta Counseling for Children and Adults, LLC are liable for the misuse of information by that party.*

After giving due consideration to the above statement, I authorize Manda P. Turetsky, MS, MBA, LAPC to furnish/receive information, including faxed copies of my Protected Health Information, including matters privileged under the laws of the state of Georgia, and applicable federal laws and regulations, to the above person(s). I further agree to indemnify and hold harmless Manda Turetsky, MS, LAPC and Marietta Counseling for Children and Adults, LLC from all liability that may arise from the release of the information herein requested. I understand that this authorization is subject to revocation at any time *in writing* except to the extent that action has been taken in reliance and is only valid for a period of 1 year from the date of my signature unless I specify another date or event here:

\_\_\_\_\_

Client/Parent/Legal Guardian Signature Date

# PRIVACY PROTECTION NOTICE

**Manda P. Turetsky, MS, MBA, LPC**  
Marietta Counseling for Children and Adults, LLC  
2440 Sandy Plains Rd. Bldg. 13, Suite 300  
Marietta, GA 30066  
770-971-9311

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

*This notice shall go into effect January 1, 2009 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.*

## **I. Preamble**

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. **PHI consists of three (3) components: treatment, payment, and health care operations.**

**Treatment** refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

**Payment** is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you.

**Health care operations** are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The **use** of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks *within* my office related to your care.

**Disclosures** refer to activities you authorize which occur *outside* my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

## **II. Uses and Disclosures of Protected Health Information Requiring Authorization**

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate from the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are *my* notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes.

Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental

status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of your care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your "designated mental health record."

You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

### **III. Business Associates Disclosures**

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service over my therapeutic work and refers to these people as "Business Associates." I do consult with business associates to assist with my administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

### **IV. Uses and Disclosures Not Requiring Consent nor Authorization**

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child or Elder Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s)).

### **V. Client's Rights and My Duties**

You have a right to the following:

- *The right to request restrictions* on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- *The right to receive confidential communications by alternative means and at alternative locations.* For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;
- *The right to inspect and receive a copy* of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- *The right to amend* material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- *The right to an accounting of non-authorized disclosures* of your protected health information;
- *The right to a paper copy* of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- *The right to revoke your authorization* of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s).

My duties as a Licensed Associate Professional Counselor on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

### **VI. Complaints**

Lynn Louise Wonders, MA, LPC, the clinical director of Marietta Counseling for Children & Adults, LLC is the appointed "Privacy Officer" for my practice per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to contact her immediately about this matter. You will always find her willing to talk to you about preserving the privacy of your protected mental health information. You can reach her by letter at 2440 Sandy Plains Rd. Bldg. 13, Suite 300 Marietta, GA 30066 or by phone at 770-971-9311. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

# CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records (“privacy rules”), and storage and access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion.

Please read this document as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Manda P. Turetsky, MS, MBA, LAPC

I, \_\_\_\_\_, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

\_\_\_\_\_  
Client Signature or Parent if Minor or Legal Charge

\_\_\_\_\_  
Date

If Legal Charge, describe representative authority: \_\_\_\_\_