Paolo Morena, LLC, MS, NCC, CCMHC *109 Danbury Rd, Suite D-2, Ridgefield, CT 06877*
Licensed Professional Counselor *Phone Number: (203) 837-0055*

Instructions Cover Sheet

The information packet that follows this cover sheet involves your attention and assistance. While I acknowledge that there are many pages in this packet, please understand that these documents are a vital part of the client-counselor relationship and the treatment care process. The following 6 documents are part of this packet:

- Minor Client Intake Form
- Client Informed Consent Disclosure
- Minor Informed Consent
- Patient Rights and HIPPA Authorization
- Notice of Privacy Practices
- Insurance Consent Addendum

Please read, print, complete, sign/date, and initial where indicated and bring them to your first session. Please also bring your current and updated insurance card and photo ID, along with co-pay or payment (cash, check, or credit card). We will review them and discuss any questions that you may have at the beginning of the session. We will also formulate and outline a treatment plan based on our discussion in the first few sessions. Please retain a copy of the information packet for your records.

Thank you,

Paolo Morena

 Initial____

Paolo Morena, LLC, MS, NCC, CCMHC
Licensed Professional Counselor
109 Danbury Rd., Suite D-2, Ridgefield, CT06877
Phone Number: (203) 837-0055

MINOR CLIENT INTAKE FORM

Date: _____ Person completing Form: _____

Childs name: _____ _____ _____
(Last) (First) (Middle Initial)

DOB: ___/____/___ Age: _____ Gender: _____ Race/Ethnicity: _____ Grade: _____

Address: _____

City, State, Zip _____

Home Phone Number: _____

Mother: _____ DOB: ___/____/___

Address (If different): _____

City, State, Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Occupation: _____ Employer: _____

Father: _____ DOB: ___/____/___

Address (if different): _____

City, State, Zip: _____

Home #: _____ Work #: _____Cell #: _____

Occupation _____ Employer: _____

Initial____

Emergency Contact:

Name: _____ Home Phone: ( ) -

Cell: ( ) - Work Phone: ( ) -

What is the best way to contact you to confirm an appointment for your child?

Home Phone: ( ) - May we leave a message? □Yes □No

Cell/Other Phone: ( ) - May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No

*Please be aware that email might not be confidential.

People living in child's home

Name	Relationship to Child	Age	Occupation	Does child get along with this person?

Immediate family members living elsewhere (biological parent, sibling, half/step siblings)

Name	Relationship to Child	Age	Occupation	Does child get along with this person?

What concerns do you have about your child? _____

_____

_____

How long has this been going on? _____

Does anyone else have concerns about your child?_____

If so, who? _____ What are the concerns? _____

_____

_____

What do you think might be causing this? _____

_____

Describe your relationship with the child's other biological parent_____

_____

_____

Is the child adopted? _____ When: ___/___/___Does the child know he/she is adopted? □Yes □ No

Are there any/Have there been serious marital problems leading to separation? □Yes □ No

Date of separation: ___/___/___ Date of Divorce___/___/___

Length of marriage to child's biological parent: _____

Who has legal authority to seek psychological services? _____

Date of remarriage: Mother ___/___/___ Father ___/___/____

Name of step parents, if any: _____

Are step parents allowed to participate in child's therapy? If so, indicate below.

Step Mother: □Yes □ No Step Father: □Yes □ No

Has your child had previous psychotherapy/play therapy? □Yes □ No

If yes, therapist's name:_____ therapist's #: _____

Is your child currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No

If Yes, please list: _____

If No, has your child previously been prescribed psychiatric medications?
□Yes □No

If yes, please list: _____

Physician Information

Pediatrician: _____ Phone: _____

Prescribing Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Last seen by pediatrician: _____

Is your child currently being treated for any medical problems or taking any other medications? If yes, please explain _____

_____

Was there anything that caused either parent significant unhappiness or worry during the child's first three years?

_____

_____

Is your child having any problems in the following areas?:

Bed-wetting or Bowel control □Yes □ No

Eating □Yes □ No

Sleeping □Yes □ No

Fears □Yes □ No

Separation problems □Yes □ No

Thoughts of hurting self or others □Yes □ No

Any deaths your child has experienced? □Yes □ No If yes who? _____

Any moves? If so, list dates □Yes □ No _____

Describe any physical, sexual, emotional or verbal abuse_____

_____

_____

What has been your child's reaction to birth of siblings?

_____

_____

Any history of mental illness OR addictions in the family, diagnosed or undiagnosed in child's blood relatives (e.g. parents, grandparents, siblings, aunts, uncles, cousins)?

If yes, please explain.

_____

_____

_____

Describe any serious health problems or injuries in family: _____

_____

Has your child been exposed to disaster?

Explain_____

_____

What do you consider has been the biggest struggle in your family?_____

_____

What extracurricular activities is your child involved in?_____

_____

Describe your style of discipline_____

_____

Does your child have any responsibilities? □Yes □ No If yes, please list _____

_____

List your child's favorite activities? _____

_____

What does your child like the most? _____

_____

What does your child dislike the most? _____

_____

What are your child's character qualities?_____

_____

What do you admire most about your child?_____

_____

What activities does each parent do with the child that both child and parent enjoy?

Mother: _____ How often? _____

Father: _____ How often? _____

Please rate your child's development in the following areas:

	Below Average	Average	Above Average
Social			
Emotional			
Intellectual			
Physical			
Language			

Name of Child's school_____ Special Class? □Yes □ No

Current school Academic performance: □ Above Average □ Average □ Average □ Failing

Current school Behavior performance: □ Above Average □ Average □ Average □ Failing

Please describe any academic or behavioral problems your child is experiencing in school.

_____

_____

_____ When did problems begin? _____

Initial____

Has your child repeated a grade? □Yes □ No If yes, which one? _____

Has your child changed schools for any reasons? □Yes □ No If yes why? _____

_____

Additional comments or concerns:_____

_____

What are your goals of therapy? _____

_____

_____

_____

I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES REGARDING THE ABOVE INFORMATION.

BY SIGNING THIS COUNSELING SERVICES AND INFORMED CONSENT AS THE UNDERSIGNED PARENT OR GUARDIAN, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL THE TERMS AND INFORMATION CONTAINED HEREIN. I HAVE HAD THE OPPORTUNITY FOR CLARIFICATION AND DISCUSS ANYTHING UNCLEAR TO ME.

PARENTS /PRINTED NAME: _____ DATE: _____

PARENTS / SIGNATURE: _____ DATE: _____

Paolo Morena, LLC, MS, NCC, CCMHC *109 Danbury Rd, Suite D-2, Ridgefield, CT 06877*
Licensed Professional Counselor *Phone Number: (203) 837-0055*

CLIENT INFORMED CONSENT DISCLOSURE

Welcome to my practice. This document contains important information about my professional service and business policies. It also contains important summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

The client/ counselor relationship is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your therapist, I have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include, and then create a treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. I cannot recognize or diagnose medical

conditions. It is recommended that you obtain a medical examination to determine any medical origins for your psychological problems, neurological disorders, endocrinological disorders, side effects of medication etc. Not being a medical doctor, I cannot prescribe medication but will refer you for psychiatric consultation if this appears to be indicated.

COUNSELING SESSIONS

Counseling/psychotherapy sessions are preferred in person, face to face. However, I do provide tele-counseling. Be sure to check with your insurance company to see if you have tele-counseling as a covered benefit. *If a life threatening event should occur, you agree to immediately 1) contact 211, 2) go to your Local Hospital Emergency Room, or 3) call 911.*

APPOINTMENTS & CANCELLATION POLICY

Appointments will be at a time we agree on. Some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone.

In order to be effective, therapy needs to take place on a regular basis. The best results occur when appointments are consistently scheduled and regularly attended. Therefore, in the event you need to miss a scheduled appointment, rescheduling is much preferred over cancellation. If you need to cancel or reschedule a session, I ask that you provide me with 48 hours' notice. If you miss a session without canceling, or cancel with less than 48-hour notice, my policy is to collect the amount of your payment [unless we agree that you were unable to attend due to circumstances beyond your control]. ***Please note that health plans do not reimburse for missed appointments; these charges will be entirely your responsibility.*

If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

FEES

I currently accept checks, cash, and credit/debits cards. Charges made by credit/debit cards will be subject to processing fees. The fees are as follows:

- Individual session: $160
- Couples/Family session: $210 (may not be covered by insurance)

Letters to physicians, attorneys, schools, state agencies/courts, etc.: $50
Forms to be completed such as workman's comp, SS/SSD, insurance, etc.: $40 per form, per page

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment can be made by check or cash. Any checks returned to my office are subject to an additional fee of up to $50.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or a collection agency to secure payment. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of my practice. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify. ***(See Court Action disclosure below).*

Periodically, fees will be increased; no more than once per year. You will be informed in advance of any changes in fees. If you are unable to afford the fee, we can discuss any concern that you may have.

INSURANCE POLICY **(**Insurance Consent Addendum is located at the end of this packet)

If you have health insurance, it will usually provide some coverage for behavioral health services. The services I provide are considered outpatient. As a courtesy to you, I am happy to bill your insurance provider for you. This does not release you from the responsibility of any charges they do not cover. You, the client, are ultimately responsible. I will notify you in writing if they have not paid me within 60 days from the date of service. I will send you a bill if they have not paid me within 90 days from the date of service. If I am listed as in-network with your insurance provider, this means I have contracted with that

provider for a specific rate. I will not charge you the difference between that contracted rate and my customary rate. Copays, coinsurance, and/or deductibles are due at the time of your appointment. Please note that deductibles for behavioral health services are often separate from medical. If you have insurance coverage paid for through the Affordable Care Act rather than an employer, I will provide you with a receipt to submit to your insurance provider for reimbursement to you after each session. You will be responsible for payment in full in advance. Due to identity theft and the fraudulent use of health insurance coverage, I will need to photocopy your current and updated insurance card and photo ID at the beginning our first session. If you have not already done so, please call your insurance provider to see if you need an authorization number. If so, they will give you an authorization number, the number of sessions for which you are approved, and a date for when the sessions must be used by. Please verify that I am in-network, if you are allowed to see a Licensed Professional Counselor, if you need a Physician's referral, if you have a behavioral health deductible, and what your copay or coinsurance is. It is your responsibility to inform me of any changes to your insurance. We will review this at the start of each calendar year. Please inform me of any changes to your address and/or employment, as well. Please note that I do not accept Medicare or secondary insurance plans.

If I am listed as out-of-network, I am happy to provide you with a receipt to submit to your insurance provider for reimbursement to you after each session. You will be responsible for payment in full in advance. Often times you are reimbursed more, or come out better, than if you were to pay your copay. If you have Medicaid/Husky or Medicare, you will need to contact them to see if you are allowed to pay out-of-pocket.

Please be aware that insurance providers often require an update on how counseling is going, any concerns or stressors you may have, as well as your general level of functioning. They also require a diagnosis for reimbursement of any counseling services. A diagnosis is a term used to describe the nature of your problem, and indicates if the problem is considered long-term or short-term. All diagnoses come from the DSM V. I am happy to show you a copy of this book, and discuss any diagnostic impressions I have made.

Paying out-of-pocket helps avoid a diagnosis altogether, thus further ensuring your privacy. There are many benefits to paying out-of-pocket for counseling services. Confidentiality is lessened when protected health information (PHI) must be reported to your insurance provider. When this information is reported, it becomes a part of your mental health record and a national databank. Certain diagnoses may hinder your ability to receive disability, health insurance, life insurance, or even certain employment

opportunities. Furthermore, insurance providers often dictate who you may see, the number of sessions you may have, and the length sessions may be. Struggling with one of life's many challenges, such as divorce or grief, may not meet your insurance provider's criteria as being medically necessary to receive counseling services. For example, most insurance providers do not recognize couples/family counseling. Such struggles are common, and do not necessarily mean you are suffering from a mental illness. Additional benefits to paying out-of-pocket are the ability to keep costs down. Insurance providers contract with Counselors for a percentage of their customary rates, causing Counselors to have higher rates in order to keep their practices open and services flowing. Paying out-of-pocket means less paperwork is required of the Counselor, thus freeing up their resources, time, and energy to devote to the direct care of each client. Overall, care is more personalized, treatment options are more flexible, sudden rate increases are prevented, certain costs may be waived should you face a hardship, labels may be avoided, any stigma associated with counseling may be removed, and true privacy may be maintained. The costs of this practice are kept below fair market value for the area, as I do not want anyone to be discouraged from seeking counseling due to financial concerns. If you wish to decline, and thus forego the use of insurance, please let me know. You may make this decision at any time, making you responsible for payment in full at the beginning of each session. Insurance companies normally do not pay for telephone emergencies, court testimony, the fee for marriage/couples or family therapy, or additional time spent in session or no shows. Your co-payment and any services not covered by your insurance benefits are your personal responsibility and must be paid at the time of service.**(*Please see Limits on Confidentiality below with regard to disclosure to insurance companies*).

PRE-SESSION RESPONSIBILITY

I strongly encourage that you do not use mood-altering substances for at least 24 hours before our session, as this affects how you think and feel, and may impede your therapeutic progress. This includes, but not limited to, alcohol and marijuana. If you arrive to session under the influence of alcohol and/or drugs, we will not proceed with a session. Together we will arrange for transportation, and either a person of your choice or local authorities will attend to you. If you think you may have problems with alcohol or drugs, I can provide you referrals to substance use providers.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location. I keep brief records noting that you were here, your reasons

for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

***Please note that psychotherapy notes recorded on any medium (i.e., paper, electronic) by a mental health professional, such as a psychologist or psychiatrist, must be kept by the author. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. The above mentioned exclusion (a-e) is what would be made available to any other health care provider, subject to your written request.*

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between us. In most situations, I will only release information about your treatment to others if you sign a written Authorization of Release Form for each release. My release form meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of the client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note any consultations in your Client Record (which is called "PHI" in our Notice of Privacy Practices).

- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. There are some situations where I am permitted or required to disclose information without either your consent or authorization.

- If you are involved in a court proceeding and a request is made for information concerning our professional services, I will not provide any information without your written authorization, unless I am ordered to do so by a court. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order my practice to disclose information.

- If you are submitting to your Insurance Provider for reimbursement, I may disclose to them information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for the agency.

- If a client files a complaint or lawsuit against my practice, I may disclose relevant information regarding that client in order to defend my practice.

There are some situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a client's treatment. These situations are very unusual in my practice.

- If I have reason to believe that a child has been neglected or abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Children and Families. Once such a report is filed, I may be required to provide additional information. When possible, we will work collaboratively in the process.

- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report to an agency designated by the Department of Social Service, Protective Services for the Elderly.

Once such a report is filed, I may be required to provide additional information.

- If it is determined that a client presents a serious danger of violence to another, my practice may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client. If such a situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit our disclosure to only what is necessary.

- If it is determined that a client has admitted to possible transmission of AIDS/HIV to other parties or other health issue such as prenatal exposure to controlled substances, I am obligated to report and take action.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

My policies about confidentiality, as well as other information about your privacy rights, are described within this document. You will be provided with a copy of this document to keep for your records. Please remember that you may reopen the conversation at any time during our work together.

COURT ACTION/DIVORCE AND CUSTODY CASES

***I am not a custody evaluator and cannot make any recommendations on custody. I can refer you to a mental health professional who may provide custody evaluation if needed**.*

Due to the sensitive nature of divorce and all potential issues that may arise in cases, I have very specific policies to which you MUST agree before we enter a counseling relationship:

- If I am seeing a child whose parents are in the process of divorce or who are already divorced, I require a copy of the standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session. I will need to have contact with the parent who has legal custodial decision making for medical issues before I see the child for counseling and will need to obtain written consent for the child to participate in counseling from the legal custodian(s) and prefer to have contact with both parents prior to seeing the child.

- I will be available to provide an interview with a guardian ad litem (GAL) assigned to investigate the best interest of any child I am counseling upon production of court order demonstrating the GAL's right to examine your clinical record or speak with me. Otherwise, the adult client or parents of child client will need to sign a release for me to speak with the GAL. The client will be charged a full session fee for me to have such meeting with a GAL.

- I will provide an identical summary of a child's therapy progress, treatment plan information and parent recommendations to both parents who share in the legal custody of the child I am seeing for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way.

- Family sessions will likely be recommended and depending on the case, may need to see the child with each parent separately along with siblings and/or other significant family members who live in the homes where the child lives.

- **I ask all my clients waive his/her right to subpoena me to court.** This policy is set in order to preserve the efficacy and integrity of my therapeutic progress and relationship with you and/or your child/children. It is my experience that my appearance in court often damages my therapist-client relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of my clients. By signing this agreement you are waiving your right to have me subpoenaed and agreeing in fact not to have me or my records subpoenaed. I will be happy to provide a referral to another therapist who will be willing to appear in court if needed as an alternative if you would prefer.

- In the case I am subpoenaed to appear in court even with this waiver – whether I testify or not – I charge my full standard fee for Court Related work of $550/hour of my professional time. You are responsible with all fees associated with any attorney who may represent me. Any of my time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance and any time spent waiting at the court house in addition to time on the stand as well as any travel time.

I understand these policies and hereby agree not to subpoena Paolo Morena and his clinical record on any current or future legal proceedings. This agreement extends to any attorney who may represent me.

Printed Name_____Signature_____Date_____

Printed Name_____Signature_____Date_____

PARENTS & MINORS

Privacy in therapy is crucial to successful progress. Parental involvement can also be essential. It is my policy not to provide treatment to a child 14 and under unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 15 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless it is deemed to be a safety concern (*see also above section on Confidentiality for exceptions*), in which case I will make every effort to notify the child of the intention to disclose information ahead of time and make every effort to handle any objections that are raised. In the case of divorce, the authorization must be signed by *both parents* or the court document presented giving sole custody. ***(See below for signatures)

CONTACTING ME

I am often not immediately available by telephone. I do not answer the telephone when in session. At these times, you may leave a message on my voice mail (203-837-0055) and your call will be returned as soon as possible. If, for any number of unseen reasons, your call is not returned, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, *1) contact 211, 2) go to your Local Hospital Emergency Room, or 3) call 911*. I will make every attempt to inform you in advance of extended absences and provide you with the name of a colleague to contact, if necessary. *Regarding email: I will **only** use email for routine administrative issues, such as request to cancel or reschedule appointments. I **will not** reply to messages about clinical conditions. The best and preferred method of all communication is by phone.*

Initial____

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with current or former clients. In marriage and family counseling, I hold a "no secrets" policy. All members of the couple or family system are treated equally and "secrets" are not kept by me. There is no differential or discriminatory treatment of family members.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement (with a particular attention to the Parents and Minors section noted above), Minor Consent Form, and the Notice of Privacy Practices and agree to their terms. Your signature also denotes your understanding and agreement that if your insurance company fails to pay for any reason, including bankruptcy of the insurance company, you are responsible for any unpaid balances and upon notification will pay what is due.

_____

Client Signature or Personal Representative, *(Parent/Guardian if client is under 18)*

_____

Printed Client Name or Personal Representative, *(Parent/Guardian if client is under 18)*

Date _____

Initial____

Paolo Morena, LLC, MS, NCC, CCMHC *109 Danbury Rd., Suite D-2, Ridgefield, CT 06877*
Licensed Professional Counselor *Phone Number: (203) 837-0055*

MINOR CONSENT FORM

I/we _____/_____ give consent to Paolo Morena, LPC to conduct psychotherapy with my child_____.

In most cases the holder of the privilege is the parent, yet legally and ethically minors like adults are entitled to confidential communication with their licensed therapist. While confidentiality is an important element of therapy, I will be sensitive to your concerns as a parent. I will provide you with information regarding your child's progress without breaching your child's confidence. I can also provide you with parenting strategies specific to your child.

By law I am compelled to breach confidentiality to authorities in incidents that involve child, dependent, elder abuse or intent of grave danger to self or others.

Thank you for allowing me to assist your child.

Signature_____Relationship_____Date_____

Signature_____Relationship_____Date_____

Initial____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

Initial____

NOTICE OF PRIVACY PRACTICES:

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and this Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for addition copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you without your consent or authorization for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you or for the management of healthcare and related services. It also includes but is not limited to consultations and referrals between one or more providers.

Payment: We may use and disclose your health information to obtain payment for services provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operation include quality assessment and improvement activities, case management, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Initial____

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Client Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for healthcare, but only in you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosures of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences in your best interest in allowing another person to pick up health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information if we are required to do so. For example, when ordered to do so by a court having jurisdiction of an appropriate matter.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials, having lawful custody of protected health information of inmate or client under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages).

Initial____

CLIENT RIGHTS:

Access: You have the right to inspect or obtain copies of your health information, except for therapist's notes and certain other limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information list at the end of this Notice. We will charge you a reasonable cost-based fee for providing your health information in that format. If you request copies, we will charge you $1.00 for each page to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for printing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.) If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the decision and a description of how you may complain to the secretary of the U.S. Department of Health and Human Services.

Disclosure Accounting: you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these addition restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicated with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances. We have 60 days after the request is made to act on the request. A single 30 day extension is permissible if we are unable to comply by the deadline. If the request is denied in whole or in part, we will provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have the statement included with any future disclosure of your Protected Health Information (PHI).

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices, or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or an alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Officer:

Paolo Morena, LLC, 109 Danbury Rd, Suite D-2, Ridgefield, CT 06877, Phone Number: (203) 837-0055

Initial____

INSURANCE INFORMED CONSENT ADDENDUM

If you have health insurance, it will usually provide some coverage for behavioral health services. The services I provide are considered outpatient. As a courtesy to you, I am happy to bill your insurance provider for you. This does not release you from the responsibility of any charges they do not cover. You, the client, are ultimately responsible. I will notify you in writing if they have not paid me within 60 days from the date of service. I will send you a bill if they have not paid me within 90 days from the date of service. If I am listed as in-network with your insurance provider, this means I have contracted with that provider for a specific rate. I will not charge you the difference between that contracted rate and my customary rate. Copays, coinsurance, and/or deductibles are due at the time of your appointment. Please note that deductibles for behavioral health services are often separate from medical. If you have insurance coverage paid for through the Affordable Care Act rather than an employer, I will provide you with a receipt to submit to your insurance provider for reimbursement to you after each session. You will be responsible for payment in full in advance. Due to identity theft and the fraudulent use of health insurance coverage, I will need to photocopy your current and updated insurance card and photo ID at the beginning our first session. If you have not already done so, please call your insurance provider to see if you need an authorization number. If so, they will give you an authorization number, the number of sessions for which you are approved, and a date for when the sessions must be used by. Please verify that I am in-network, if you are allowed to see a Licensed Professional Counselor, if you need a Physician's referral, if you have a behavioral health deductible, and what your copay or coinsurance is. It is your responsibility to inform me of any changes to your insurance. We will review this at the start of each calendar year. Please inform me of any changes to your address and/or employment, as well. Please note that I do not accept Medicare or secondary insurance plans.

If I am listed as out-of-network, I am happy to provide you with a receipt to submit to your insurance provider for reimbursement to you after each session. You will be responsible for payment in full in advance. Often times you are reimbursed more, or come out better, than if you

were to pay your copay. If you have Medicaid/Husky or Medicare, you will need to contact them to see if you are allowed to pay out-of-pocket. Please be aware that insurance providers often require an update on how counseling is going, any concerns or stressors you may have, as well as your general level of functioning. They also require a diagnosis for reimbursement of any counseling services. A diagnosis is a term used to describe the nature of your problem, and indicates if the problem is considered long-term or short-term. All diagnoses come from the DSM V. I am happy to show you a copy of this book, and discuss any diagnostic impressions I have made.

Paying out-of-pocket helps avoid a diagnosis altogether, thus further ensuring your privacy. There are many benefits to paying out-of-pocket for counseling services. Confidentiality is lessened when protected health information (PHI) must be reported to your insurance provider. When this information is reported, it becomes a part of your mental health record and a national databank. Certain diagnoses may hinder your ability to receive disability, health insurance, life insurance, or even certain employment opportunities. Furthermore, insurance providers often dictate who you may see, the number of sessions you may have, and the length sessions may be. Struggling with one of life's many challenges, such as divorce or grief, may not meet your insurance provider's criteria as being medically necessary to receive counseling services. For example, most insurance providers do not recognize couples counseling. Such struggles are common, and do not necessarily mean you are suffering from a mental illness. Additional benefits to paying out-of-pocket are the ability to keep costs down. Insurance providers contract with Counselors for a percentage of their customary rates, causing Counselors to have higher rates in order to keep their practices open and services flowing. Paying out-of-pocket means less paperwork is required of the Counselor, thus freeing up their resources, time, and energy to devote to the direct care of each client. Overall, care is more personalized, treatment options are more flexible, sudden rate increases are prevented, certain costs may be waived should you face a hardship, labels may be avoided, any stigma associated with counseling may be removed, and true privacy may be maintained. The costs of this practice are kept below fair market value for the area, as I do not want anyone to be discouraged from seeking counseling due to financial concerns. If you wish to decline, and thus forego the use of insurance, please let me know. You may make this decision at any time, making you responsible for payment in full at the beginning

Initial____

of each session. Insurance companies normally do not pay for telephone emergencies, court testimony, the fee for marriage/couples or family therapy, or additional time spent in session or no shows. Your co-payment and any services not covered by your insurance benefits are your personal responsibility and must be paid at the time of service.

Your signature below indicates that you have read this Insurance Informed Consent Addendum and agree to their terms. Your signature also denotes your understanding and agreement that if your insurance company fails to pay for any reason, including bankruptcy of the insurance company, you are responsible for any unpaid balances and upon notification will pay what is due. Your signature authorizes the release of additional information to process insurance claims and request payment of benefits to Paolo Morena, LLC.

_____

Client Signature or Personal Representative, *(Parent/Guardian if client is under 18)*

_____

Printed Client Name or Personal Representative, *(Parent/Guardian if client is under 18)*

Date _____

Initial____