Heather N. Lettow, MA, LPC, LMFT
Licensed Professional Counselor
Licensed Marriage & Family Therapist

PROFESSIONAL DISCLOSURE STATEMENT

Description of Counseling Services
Counseling services provided include individual, couple and family counseling.

Professional Education and Experience:
I completed my Master's degree in Marriage, Couple and Family Counseling at Western Michigan University in April 2011. I am licensed in the state of Michigan as a Licensed Professional Counselor and Licensed Marriage and Family Therapist. In 2007 I began to devote time to volunteering at Gryphon Place as a Volunteer Crisis Worker on various crisis and suicide lines for the state of Michigan. Upon completion of my Bachelor's degree I began employment as a Crisis Worker and soon afterwards became a Shift Team Leader. In October 2010, I began my employment at Woodlands Behavioral Healthcare Network as a Wraparound Coordinator and later a Home-Based Therapist, working with at risk children and their families.

Nature of Counseling:
I believe that the therapeutic process of counseling helps guide individuals to self-exploration change. Through the counseling process, you may be asked questions about your past, family of origin, and other experiences that may have influenced your life and the present. Counseling will focus on helping you gain an understanding of your thought and behavior processes. This is essential in order to see how thoughts impact behavior and to be able to change. I believe that the counseling process is a combination of efforts between the individual and therapist.

Informed Consent

Counseling Relationship:
During the time that we work together, we will meet weekly for 45-50 minute sessions. Counseling will take place at 5104 Lovers Lane, in Portage, MI. Contact outside of therapy will be limited to the arrangement of counseling sessions. If you are experiencing an emergency you may contact Gryphon Place 24 hours a day at 269-381-HELP. To keep our relationship professional, please do not invite me to social gatherings, offer me gifts, ask me to write references for you, add me on social media sites or ask me to relate to you other than in the professional manner of our counseling sessions. You will be best served it sessions focus on your concerns.

Effects of Counseling
You may discontinue counseling at any time. You may indicate discussion of possible negative effects of entering or not entering counseling at any time. While benefits are expected, specific outcomes of counseling are not guaranteed. While counseling is a growth and exploration process that may lead to major life changes, these changes may affect relationships with others, your job, and your understanding of yourself. Additionally, some changes may cause temporary distress but the amount cannot be predicted. Throughout our sessions together we will work to bring about the best outcome for you.

Client Rights:
As a client, you are in control over how many sessions we will have together. For some clients counseling may only be a few sessions and for others it may require a longer period of time. You have the right to end the counseling relationship at any time, although I do ask for you to participate in a final session. If I make suggestions that you feel could be harmful, you have the right to refuse or modify them, I guarantee that my services will be provided in a professional manner in accordance with the ethical standards of the American Counseling Association and American Association of Marriage and Family Therapy. If at any time you are dissatisfied with my services, please inform me. If I am unable to resolve your concerns, you may file a report to the Michigan Department of Community Health.

Referrals:
Should you or I believe that a referral is needed; I will provide some alternatives including programs and people who may be able to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals.

Fees:
Individual psychotherapy fees are $120 and Family/Couple therapy fees are $120 per 45-50 minute session. The initial consultation and assessment is $120. If your insurance company has contracted with the therapist for an 'adjusted rate', then that rate would apply. For clients who are receiving services on a self-pay basis, we will discuss and agree to a fee prior to the beginning of counseling.

PLEASE NOTE: Client is responsible for any fees billed related to legal or court proceedings, if they should occur. Insurance will not apply. Such fees might include, but not be limited to, written reports, phone calls, or depositions (in-office: $200 per hour; minimum fee is $200) or court appearances ($250 per hour including travel time; minimum fee is $300).

Phone Consultations: Phone consultations are available for a fee and can be pre-arranged for an appointed time; insurance will not cover. However, if there is an emergency, please just call. If the therapist is not immediately available to respond to emergencies, clients should go to the nearest emergency room or call 911, and keep the therapist informed of what is happening, by leaving messages if necessary.

Insurance Billing: Please verify coverage in your benefit handbook as clients are ultimately responsible for payment of services. The therapist's billing service will file client insurance claims at no extra charge. As a courtesy to clients, I will also inquire about benefit information.

Co-Payments & Deductibles: Co-payment (or entire payment, if you do not have insurance) is due at the time of service. If there are extenuating circumstances, or special financial needs, clients can discuss this with the therapist before the appointment. Clients are responsible for their insurance deductible.

Missed Appointments:
Please call at least 24 hours in advance if you must re-schedule an appointment. The therapist will make reasonable attempts to accommodate the scheduling needs of clients. Clients will be billed $60 for the first missed appointment with less than 24 hours notice. The charge for missed appointments after the first time will be $120/full fee. (Note: Insurance coverage does not usually apply for missed appointments.) Also, please know that repeated missed appointments can be a cause for termination of therapy.

Non-payment: Failure to pay co-pays, deductibles, no show/late cancellation fees, or other services received will result in:
1. You will be requested to give credit/debit card information to have on file to pay for services when they are due.
2. You will be given and/or mailed a bill of the outstanding balance, and given 14 calendar days to pay the amount due.
3. Continued failure to make payment will result in $25 fee added to the account balance each month until the balance is paid off in full.
4. Failure to make payments as designated on Payment Plan Agreement can result in termination of the agreement with the account balance being due in full within in 14 calendar days.
5. Outstanding balance can be turned over to a collection agency in order to collect funds that are owed.
6. Services can be terminated/refused if there is an on-going account balance in which the client/family is not making reasonable efforts to pay for services received.

Office Hours, client/family contact outside of session and Emergencies:

- Sessions are generally scheduled by appointment Tuesday through Thursday between 9am and 7:00pm.
- I appreciate emails and phone calls from clients, family and medical providers related to coordination of care. I am available to respond Tuesday through Thursday in between sessions and during non-client hours. To ensure confidentiality, I only utilize email to send initial paperwork, to schedule, cancel, and confirm appointments as I cannot guarantee that it not be violated by unauthorized third parties; please be aware and not send sensitive information over the web. My office line -269-743-7360 ext 1.
- If you email or call me any time after 5pm on Thursday or Friday through Sunday, your message or call will be replied/returned the following week. **Emergencies are an exception.**
- Client related emergencies include active suicidal ideation (inability to keep self safe), self -harm that requires medical treatment, active homicidal or violent behavior, domestic violence, and any behaviors that warrant police and/or mobile Crisis involvement.
- ******* **In the event of an emergency, I should <u>not</u> be your 1st contact. Instead, please go to your nearest emergency room, call 911, or dial 269-381-HELP to reach the Gryphon Place 24 hour crisis-help line. Then contact me as previously discussed.** ******

Records of Confidentiality:

Counseling is considered as confidential information, with the following clarification:

1. If you are an adult, anything you do or say in the context of therapy is privileged. However, if you behave in a way that poses a physical threat to another person or to self, privilege is waived. Your counselor is required by law to contact the person(s) involved and warn them of possible danger.
2. Parents or guardians of minor are entitled to general information regarding information communicated by their children in therapy. However, our policy and professional ethics require the counselor to communicate such information only in ways that will be helpful and in the interest of maintaining the consumer-counselor relationship. Such information is usually communicated first with the minor consumer.
3. Michigan Law requires your counselor to report suspected or known incidents of child abuse and neglect.
4. Release of Information forms provide a way for your counselor to obtain and share information with others (therapy providers, agencies, schools, doctors, etc.). You may be asked to sign a Release of Information form.
5. In some instances, your counselor may be required to testify at court hearings. Although every effort is made to protect each consumer's right to confidentiality, you counselor may be required to testify in court hearings. Although every effort is made to protect each customer's rights to confidentiality, your counselor may be required to release information if a judge orders her to.

   You are encouraged to discuss any questions or concerns you have about the counseling process with me. In the event a client would like to file a complaint regarding my counseling services, have the right to report your complaints to the State of Michigan Licensed Professional Counselors Board of Examiners. A written complaint should be sent to the following address:

   Michigan Department of Licensing and Regulatory Affairs
   Health Professions Division
   Enforcement Section
   P.O. Box 30670
   Lansing, MI 48909
   (517) 373-9196

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability and Accountability Act of 1966 (HIPAA) is a federal program that requires keeping your health information private and notifying you about how this office uses and discloses your medical records and your other individually identifiable health information. Under HIPAA you have new rights to determine how your information will be used. HIPAA also provides penalties for organizations that misuse your personal health information.

You should be aware that, pursuant to HIPAA, this office keeps information about you in two sets of professional records: (1) the Clinical Record/Protected Health Information and (2) Psychotherapy Notes.

(1) The Clinical Record/Protected Health Information includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

This office may use and disclose your Clinical Record/Protected Health Information for treatment, payment, and health care operations. Definitions of these three services follow. The therapist typically asks you to sign a consent for release of information regarding these purposes at your first session.

Treatment means providing or directing your health services provided by one or more health providers. Examples of this would include sharing your medical information with your primary care physician, or in the cases of potential danger to yourself or others.

Payment includes seeking reimbursements for services, verifying your coverage, billing and collecting payment for services. Examples of this include: billing your insurance plan, billing you for deductibles and co-payments, determining eligibility for insurance coverage, and follow-up on unpaid services.

Health care operations include the business of running this practice, such as the quality assessment and improvement activities of your insurance or EAP payment plan. We may also be required to disclose your health information by federal, state or local laws, including compliance with a court order or in the case of mandatory reporting of any suspicion of child or elder abuse. Other examples of these disclosures could include: Medical Transcription Services, Workers Compensation or similar programs.

Other uses and disclosures of your health information will be made only with your written authorization. You may revoke that authorization in writing and this office will honor your request, except for the actions already taken relying on your original authorization.

You have the following rights to your Protected Health Information. When you present a written request, you may:

- Place restrictions on disclosure of your Protected Health Information to any person identified by you. The therapist may disagree with such a restriction, but if she does agree, your limitation or disclosure will be honored.
- See and copy your Protected Health Information. Except in unusual circumstances that disclosure would physically endanger you and/or others, or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person [or where information has been supplied to me confidentially by others], you may examine and/or receive a copy of your Protected Health Information/Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence [I am sometimes willing to conduct this review meeting without charge], or you can have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of $0.25 per page.
- Request an amendment to your health information
- Receive an accounting of the disclosures of your Protected Health Information

(2) In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me, or information from others provided to me confidentially, that is not required to be included in your Clinical Record/Protected Health Information. These Psychotherapy Notes are kept separate from your Clinical Record/Protected Health Information. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies, without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage, nor penalize you in any way for your refusal to provide it.

This Notice is effective from the date indicated below. The therapist reserves the right to change the terms of this Notice and will provide you with a copy of the new Notice of Privacy Practices upon request. A copy of the current Notice may be given to you each year when you complete the annual Client Information form.

If you would like to discuss these procedures further, please let the therapist know. Thank you for your understanding.

Effective Date 04-14-2003

Disclosure Signature Page

Please circle one:

Yes **No** I acknowledge that I have read and understand Heather Lettow's Professional Disclosure Statement information and that my signature below indicates my agreement to abide by the stated conditions.

Yes **No** I have received a copy of client information and a copy of the therapist's 'Privacy Practices.'

Yes **No** I authorize the release of any medical information necessary to process my insurance claims.

Yes **No** I authorize benefits to be paid directly to Heather N. Lettow, MA, LPC, LMFT.

Yes **No** I consent to psychological treatment based on the goals and methods we discuss & agree upon.

Yes **No** I acknowledge the therapist's obligation to professional peer consultation, as needed, in accordance with Michigan licensing of psychologists and counselors.

Yes **No** I agree with the release of information to my family physician regarding my treatment.

To: Physician/ Clinic Name:_____

Address:_____

City, State, ZIP _____

Phone # of Physician or Clinic:_____

_____ _____ _____

Client (or Parent/Guardian) signature Witness Date

Relative or Friend in case of Emergency Relationship Phone #