

Counseling Agreement for Clients of

Joanne M. Moore, LPC, NCC, BCETS, CCH

**(Professional Disclosure Statement/Client Agreement/Consent for Treatment/HIPPA Notice, and General Information)**

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About Stillwaters Counseling and Psychotherapy

**Counselor Qualifications and Areas of Practice**

Joanne (Jodi) M. Moore received professional training in Counseling and Psychotherapy through Old Dominion University and the University of Virginia; ultimately earning a Masters' Degree in Counseling. After completion of a multi-year counseling/psychotherapy Residency and comprehensive examination process, she earned her License to practice Professional Counseling in the State of Virginia. In addition to her LPC credential, Ms. Moore has earned several other credentials as follows: National Certified Counselor (NCC), Board Certified Expert in Traumatic Stress (BCETS), Diplomate status with the American Academy of Experts in Traumatic Stress, certification as a Clinical Hypnotherapist (CCH), and certification in Critical Incident Stress Management (CISM). She is also an active member of several professional organizations. She is a counselor educator who provides training and clinical supervision services to counseling students and Residents. She is the founder and facilitator for the Master Clinicians' Group (MCG), a peer consultation and support organization serving licensed mental health clinicians in Virginia and North Carolina. She is the former facilitator of The Parents' Group, a support group for bereaved parents. Her practice addresses the needs of individuals, couples, and families. Her practice is limited to clients who are age 18 and over and to adolescent clients ages 13 to 17 who have specific needs within Ms. Moore's areas of expertise and specialization.

Ms. Moore has particular interest and expertise in Complicated Grief, Complex Trauma Syndromes and Disorders, Military Life, Wounded Warrior, and Deployment related concerns, Sexual Disorders, Sexual Compulsivity, Anxiety Disorders, Mood Disorders, Adjustment Disorders, Relationship Counseling, Eating Disorders, Assertiveness, Identity, and Self-Concept Development, Non-Suicidal Self Injury, Career Counseling, and diagnosis and treatment of other mental health disorders and problems in living as described in the Diagnostic and Statistical Manual of the American Psychiatric Association.

**Theoretical Orientation**

Ms. Moore's primary theoretical orientation (her primary framework for practice) is Integrative. This theoretical orientation allows the counselor/therapist to apply components of several major counseling and psychological theories including Cognitive-Behavioral, Existential, Time-limited Dynamic, and traditional Psychodynamic Theory and other disciplines within the field of psychology and counseling to allow for maximal results based upon the specific needs of the client. Each of these approaches is a well established, researched, and respected therapeutic orientation.

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What You Can Expect as a Client at Stillwaters Counseling and Psychotherapy

**Counselor and Client Responsibilities and Expectations**

Counseling /psychotherapy is most effective when it is a collaborative process. Within the first few sessions, we establish goals for your counseling and therapy and will use these goals to guide the course of our work. Part of this plan may include referral to another mental health or medical professional if there is a need for interventions we cannot provide. We will work diligently to provide you with compassionate and effective counseling and psychotherapy that are respectful of your life experiences and individual perspectives.

Your commitment includes consistently coming to your sessions, being fully engaged in the process, completing tasks we've agreed upon, being honest and forthcoming to the best of your ability, completing work both in and outside of our sessions, doing your best to explore your insights, problems, and needs in productive ways, and communicating concerns you may have about the counseling process. Together, we will strive to make each session a "safe place" to share thoughts and feelings, try new behaviors, and plan for the future.

As you progress through counseling/psychotherapy, you may find that you experience rapid relief of symptoms, or that your pain intensifies as you work through it. You may feel that you've made good progress, and then later feel that nothing has been resolved. Each of these experiences are normal and even likely as we work together to resolve problems and facilitate your growth. We ask that you commit to working through the difficult moments even as we celebrate those filled with success and hope. Our ultimate goal is that your counseling experience will provide you with an opportunity for growth and healing.

**Role of Diagnosis**

Your counselor uses the Diagnostic and Statistical Manual-Text Revision (4<sup>th</sup> Edition) published by the American Psychiatric Association (2000) to assist in coding any diagnosis we may determine to be appropriate to your situation. Diagnosis serves the purpose of providing a framework upon which we can view your situation and plan treatment. Also, your health insurance provider requires this information to determine your eligibility to receive services.

### **Emergencies**

In the event that you need emergency services and cannot contact us, please call the Crisis Hotline at 627-LIFE or your local Fire-Police-Rescue at 911.

### **If You Have A Complaint**

We believe in professional responsibility. If you think you have been treated unethically and cannot resolve this problem with us, we encourage you to contact the National Board of Certified Counselors (336-547-0607) and/or the Virginia Board of Health Professions (800-533-1560) to lodge a complaint.

### **Parking, Stillwaters' Office Spaces, and Boundaries**

Please park **on the street** in front of our home/office in an area that is clear of the mail box. If there is a need to park in the driveway (e.g. to preserve privacy), please inform us ahead of time so we can work with you to meet your needs.

You will see a small sign on our front door asking you to come in and have a seat. (Please do not knock or ring the door bell). You are welcome to enter, sit anywhere (including at the dining table), and enjoy the reading materials available to you. The Restroom is located the wall on the right side of the foyer.

We strive to create a peaceful and conducive environment for our work. For this purpose, privacy screens partition off the private areas of our home from the office/treatment area. This helps us maintain good professional and physical boundaries between our public areas and private living space. Please let us know if anything in the environment becomes distracting or affects your ability to work. We will make every effort to accommodate your needs.

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## **Scheduling, Cancellation, Communication Policies, and General Information**

### **Scheduling, Length of Sessions, Cancellations**

We schedule sessions with our mutual agreement. Sessions are 50-70 minutes in length unless otherwise agreed upon. If you are unable to keep an appointment, please cancel or reschedule at least 24 hours in advance to avoid being charged a missed appointment/late cancellation fee.

### **No Show/ Late Show /Cancellation Policies**

*Our goal is to manage our time wisely to serve our clients better. When timely (24 hours or more notice) cancellations occur, it is possible to offer open appointment times to clients on the **appointment waiting list**. We sincerely appreciate your cooperation and understanding of the following policy, which is in effect to encourage timely notice of cancellations:*

*POLICY: Clients are responsible for a \$50 charge for each No Show/No Call event, and when an appointment is cancelled with less than 24 hours prior notice. The client agrees to pay this charge **at or before** the next appointment. **These charges also apply in the event that a client comes to his or her appointment so late that there is not sufficient time remaining to engage in a therapeutic process.** (This will not apply in those instances when the Counselor is also running late due to an emergency or other unforeseen circumstance).*

*These charges may be appealed if extenuating circumstances exist that prevent timely notification of cancellation.*

### **Inclement Weather/Community Emergency Closing Policy**

In an effort to protect client safety, we close our office whenever Virginia Beach Public Schools close due to inclement weather or other community emergencies. If a weather or emergency event falls on a Saturday, we follow the closing schedule of Tidewater Community College.

### **Messages**

Messages may be left on our voice mail at any time. Voice mail is checked regularly between 8am and 8pm seven days a week. We will return your calls as soon as possible. Please indicate your preferred method of communication on your **New Client Form or in your message**.

### **Phone Calls**

Your counselor is available for phone consultation **only in the event of an emergency**. An emergency is **a life threatening need or when immediate hospitalization is indicated**. Unfortunately, the demands of our practice prevent the provision of any other form of unscheduled counseling services via telephone. If you need or want to speak to our counselor before your next scheduled session, please call for an earlier appointment time. We will strive to set this appointment within as brief a period of time as possible, and your needs will be relayed to the counselor.

### **Emails and Text Messages**

Email and text messages are not useful methods of communication for counseling purposes. Please do not send private or personal information to us via email or text. We cannot guarantee the confidentiality of any communication sent to us in these ways, nor can we guarantee that emails and texts will be received or read. Likewise, we can't respond to questions or counseling needs described in emails or texts (ethical concerns and severe limitations created by security issues, time lapses, and potential technological problems make this problematic). You may elect, at your own discretion, to email or text requests for appointments and cancellation notices (please understand that cancellations must be **received** by our office at least 24 hours before your appointment time, and that email/text delivery times can be affected by many factors). Please do not include personal information about your status or case in these emails/texts.

***Please, never use email or texting to communicate an emergency or crisis.***

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## Fee and Payment Policies at Stillwaters Counseling and Psychotherapy

### **Health Insurance**

We file health insurance claims as a courtesy to our clients. Please understand that you are responsible for knowing the number of sessions you have available to you under your insurance plan and for charges for any services or sessions that are not covered. Please contact your insurance company prior to our first session to ensure they will cover the services you are seeking, and determine if you need preauthorization.

***If your health care plan ultimately denies coverage for any service provided to you, you are responsible for paying for services rendered. These charges are billed at the standard Stillwaters Counseling and Psychotherapy rates and are due within 15 days of the billing date.***

### **Payments and Co-Pays**

Please submit your payment for co-pays and fees at the beginning of each session unless we make other arrangements in advance.

### **Inability to Pay at Time of Service**

We are a small practice with limited staff and are unable to dedicate resources to billing, client account management, and debt collection. Therefore, payment is required in full at the time services are provided (unless other arrangements have been made in advance). However, we understand that there may be instances when a client is not able to pay at the time of service. Therefore, we have developed a simple means of helping clients receive services without incurring mounting debt or requiring debt collection protocols. Our policy is as follows:

**In the event that you cannot make your payment at the time of your session, we offer you two options:**

- (1) Be seen at your scheduled appointment time **after you agree to all of the following:**
  - a) Agree to deliver to our office the full payment of the amount due within **7 days** of your appointment date,
  - b) Provide us with a valid credit card at the time of your appointment,
  - c) Give your permission for us to charge your outstanding balance to this credit card **if your payment is not received in our office within 7 days of your appointment date.**
- OR**
- (2) Reschedule your appointment (at least 24 hours in advance of your appointment date and time) to a date when you can have your payment available at the time services are provided.

### **Payment of Outstanding Balances/Missed Appointment Fees and Scheduling**

We are committed to helping people find healing and growth and work hard to facilitate that process. A growing account balance can create significant stress for the client and compromise our work. What appears to be helpful (e.g. allowing a client to pay later) can actually sabotage our progress. Likewise, research repeatedly bears out the fact that clients who don't pay for services don't engage as fully in the process and receive less benefit in the end. Therefore, we do not bill clients for balances, use payment plans, or provide sliding scale fee schedules. If you need this kind of accommodation, please let us know. We can refer you to a competent clinician in a subsidized setting where these options are offered.

To prevent the accumulation of outstanding balances, it is our policy that clients must have a "zero" balance (owe no outstanding fees) before they can schedule an appointment. This policy includes payment of fee balances and any **Missed Appointment Fees**. We do not want fees to become a hardship or hindrance to progress and hope you can understand the need to comply with these policies so our work can be more productive.

**If you accrue an outstanding balance or Missed Appointment Fee, please submit your payment via cash, check, credit card, e-check, or PayPal before or at the time you schedule your next appointment.**

**Defaulted Payments**

We believe in the fairness and honesty of our clients and expect that we will be paid outstanding balances in timely ways. However, those few clients who default on payment of fees for services rendered are responsible for all legal and administrative fees related to collection on defaulted accounts. Your signature on this document signifies your agreement to this policy

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**Payment and Insurance Methods Selection and Agreement**

**Please carefully read the statements below and check statement that applies to you:**

**I will use my medical insurance.** I understand that I am responsible for all co-insurance, co-pays, and any regular fees for services provided to me in the event that my insurance company denies coverage. I have read, understand, and agree to comply with the Stillwaters Counseling and Psychotherapy fee policies, and the No Show/Cancellation Policy. I also acknowledge receipt of the **Notice of Privacy Practices for Protected Health Information.**

**I will not be using medical insurance, and will pay for services out of pocket.** I understand that I am responsible for all fees for services provided to me. I have read, understand, and agree to comply with the Stillwaters Counseling and Psychotherapy fee policies, and the No Show/Cancellation Policy. I also acknowledge receipt of the **Notice of Privacy Practices for Protected Health Information.**

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**Acknowledgement of Policies and Signatures**

**By signing this document, I indicate that I (1) Have reviewed, understand, and agree to comply with the policies on Pages 1, 2, 3, and 4 of this disclosure statement/agreement, (2) Acknowledge Receipt of a copy of the Stillwaters Counseling and Psychotherapy HIPAA Notice and (3) Consent to treatment for myself or my minor child. My signature also serves as a release to allow Stillwaters Counseling and Psychotherapy to communicate relevant information to my insurance company (if applicable).**

\_\_\_\_\_  
Signature client 1 Date

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Signature Client 2/ Guarantor/ Parent / Guardian Date

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**NOTICE OF PRIVACY PRACTICES  
FOR PROTECTED HEALTH INFORMATION (HIPAA Notice)**

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

As a Licensed **Professional Counselor licensed by the State of Virginia**, I create and maintain treatment records that contain individually identifiable health information about you. This notice, among other things, concerns the privacy and confidentiality of those records and the information they contain.

**Uses and Disclosures of Information without Your Authorization**

Federal privacy rules and regulations allow me to use or disclose your personal health information (without your written authorization) to enable me to provide treatment to you, for billing and related business purposes, to conduct health care operations, and to disclose your protected health information to any health care provider to facilitate their treatment activities.

**Notice of privacy practices**

This may include consultations or referrals with other licensed health care providers about your condition, the coordination and management of your health care among health care providers or a third party, communications with insurance carriers and billing agents, and oversight organizations that work to ensure that services are provided in a manner that complies with applicable laws, regulations and professional ethics.

I may be required or permitted to disclose your personal health information without your written authorization in other circumstances including, but not limited to the following:

- When compelled by a court, board, commission, administrative agency, arbitration panel, or search warrant as long as the request is lawful and follows the guideless established by law and the regulations of the requesting entity.
- For the purpose of Reporting Child or Elder Abuse, Neglect or Domestic Violence to appropriate authorities.
- To report the need for additional services if I believe you have become a danger to your own safety or to the safety of other persons.
- To contact you to provide appointment reminders or information about alternatives or other health-related benefits and services that may be of interest to you.

**Uses or disclosures of your personal health information (without your authorization) will be limited to the minimum necessary to accomplish the intended purpose of the use or disclosure.**

S T I L L W A T E R S  
Counseling and Psychotherapy

**Other Uses and Disclosures Requiring Your Authorization**

In those instances when I am asked for information for purposes outside of the situations described above, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each revocation is in writing. Any revocation applies to only that information for which an authorization is required, and is not retroactive to any time prior to the date of the revocation.

**Client's Rights and Therapist's Duties**

**You Have The Right To:**

- Request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request. We will discuss this issue if this occurs.
- Request and receive confidential communications of your private health information by alternative means and at alternative locations.
- Inspect and/or obtain a copy of protected health information and billing records used to make decisions about you for as long as the protected health information is maintained in the record. I may deny your access to protected health information under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Request an amendment of protected health information for as long as the protected health information is maintained in the record. If requested, I will discuss with you the details of the amendment process. Please understand, however, that I am not required to amend the information in the record.
- Generally have the right to receive an accounting of any disclosures of your protected health information. On your request, I will discuss with you the details of the accounting process.
- Obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

**My Duties:**

I am required by law to maintain the privacy of your Personal Health Information and to provide you with a notice of my legal duties and privacy practices with respect to Personal Health Information. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you a copy of these revisions at the next appointment.

**Complaints:**

If you have a concern about the privacy of your records or any other element of this policy, you may complain to my Business Manager, Mr. Jesse Moore, me, or to the Secretary of the U.S. Department of Health and Human Services. Please submit complaints in writing, to me or my Business manager at the office, or to the Secretary of the U.S. Department of Health and Human Services at the following address:

U .S. Department of Health & Human Services  
150 S. Independence Mall West - Suite 372  
Philadelphia, PA 19106-3499  
(215) 861-4441; (215) 861-4440 (TDD)  
(215) 861-4431 FAX

If you have questions or concerns related to this Notice or its contents, please contact me. We are pleased to be of service to you.

**This notice first became effective on April 14, 2003**