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(913) 677-3553 · Fax (913) 677-3282  
[www.clinical-assoc.com](http://www.clinical-assoc.com)

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**Licensed Psychiatrists**

Teresa M. Varanka, M.D., F.A.A.C.A.P.  
Peter Mehta, M.D.

**Nurse Practitioners**

Valerie Jansen, APRN, B.C.  
Julie Al-Azzeh, APRN, B.C.  
Julie Owens, APRN, B.C.  
Chika Okafor, DNP, APRN, PMHNP-B.C.

**Licensed Psychologists**

Bruce Michael Cappel, Ph.D., ABPP  
Marc A. Schlosberg, Ph.D.  
Lynn Lieberman, Ph.D., ABPP  
Mitchell R. Flesher, Ph.D., J.D.  
Robert L. McRoberts, Ph.D.  
Lindsay N. Dees, Psy.D.  
Kathy Pearce, Ph.D.  
Darren Higginbotham, Psy.D.

**Postdoctoral Fellows**

Laura Sue Elias, Ph.D., LCAC  
Gladys Mwangi, Ph.D.

**Licensed Masters Level Psychologists**

Seth Wescott, LMLP  
Samantha Ciani, LMLP  
Cassandra Thompson, LMLP  
Ajibade Adebayo, LMLP  
Alaina Rhoad, LMLP

**Licensed Clinical Marriage & Family Therapists**

John Myers, LCMFT

**Licensed Clinical Psychotherapists**

Kim Kosmala, LCP  
Joe Wilner, LCP  
Jana Bremenkamp, LCP

**Licensed Specialist Clinical Social Workers**

Mike Crowley, LSCSW, LCAC  
Gary Christ, LSCSW, LCAC  
Stuart Waldman, LSCSW  
Sandie Currie, LSCSW  
Linda Lynch, LSCSW  
Alex Gianikas, LSCSW, LMAC  
Ariel Ludwig, LSCSW, LCAC  
Karen Smith, LSCSW, LCSW

**Licensed Clinical Professional Counselors**

Laura Thornton, LCPC, LMAC, LAC  
Katie Grier, LCPC  
Lisa Bozzoli, LCPC  
Jillian Johns, MS, LCPC  
Erin Kincannon Emler, MS, LCPC

**Licensed Clinical Addiction Counselor**

Laura Sue Elias, Ph.D., LCAC

**Licensed Professional Counselors**

Lauren Roberts, LPC  
Katie Stilwell, LPC  
Nicolette Zeller, LPC  
David Walter, LPC  
Heather Bloomcamp, LPC  
Marie Schulte, LPC  
Mary Pitman, LPC  
Marissa Harris, LPC  
Katie Hebbert, LPC

**Licensed Addiction Counselor**

Robin Rouse, LAC



## **OTHER LOCATIONS**

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**[www.clinical-assoc.com](http://www.clinical-assoc.com)**

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Wyatt Ezechiels, LPC

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Megan Lowe, LMLP, LMAC

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## *Welcome to Our Practice ...*

We are pleased to have the opportunity to serve you and hope that this booklet will provide information helpful in making an informed decision concerning our services.

The Health Insurance Portability and Accountability Act (HIPAA) requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of Personal Health Information (PHI) for treatment, payment and health care operations. The Notice, which is provided for you later in this document, explains HIPAA and its application to your PHI in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully if you have not already done so. We can discuss any questions you have about the procedures at that time. When you sign the document acknowledging that you have read this booklet, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on Clinical Associates, P.A. (CA) unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

# *Office Policies*

## **APPOINTMENTS**

Services are by appointment only. The length of the appointment time varies on the basis of services provided. Individual therapy is generally scheduled for 45 to 50 minutes and this is known as the "clinical hour." Because the appointment is reserved for you, it is necessary to charge \$85.00 for appointments which are not canceled 24 hours in advance, unless in fact they are occasioned by circumstances which we would both define as an emergency. Failure to provide a 24-hour notice of cancellation generally means that some other person is not able to use that appointment time.

## **CONFIDENTIALITY**

The law protects the privacy of all communications between a patient and a provider, psychiatrist and psychologist. In most situations, information can only be released about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent.

- Occasionally it may be helpful to consult other health and mental health professionals about a case. During a consultation, every effort will be made to avoid revealing the identity of a patient. The other professionals are also legally bound to keep the information confidential. If you don't object, you will not be told about these consultations unless it is felt that it is important to our work together. Also, you should be aware that privilege and confidentiality apply only to the identified patient. If you are seen in an adjunct or collateral fashion, then you do not have these rights as outlined. An example would be a patient's spouse who is not an identified patient but who is seen in session for the benefit and progress of the patient.
- You should be aware that we practice with other mental health professionals and that we employ an administrative staff. In most cases, protected information is shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees as discussed elsewhere in this booklet.
- If a patient threatens to harm himself/herself, our office 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 we are 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 the professional services provided, such information may be protected by patient privilege law. We cannot provide any information without your (or your legal representative's) written

authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order our office to disclose information.

- If a government agency is requesting the information for health oversight activities or related to national security, our office may be required to provide it for them.
- If a patient files a complaint or lawsuit against our office, we may disclose relevant information regarding that patient in order to defend the practice.
- If you file a worker's compensation claim, and we have examined or treated you in regard to such claim, we must, upon appropriate request, provide a report to the patient's employer or the employer's insurance company.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment.

- If we have reason to suspect that a child under 18 has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, or that an adult has been or is being abused, neglected or exploited or is in need of protective services, the law requires that we file a report with the appropriate government agency, usually the Department of Social and Rehabilitation Services. Once such a report is filed, we may be required to provide additional information.
- If a patient communicates an imminent, specific threat of harm against a specific individual and we believe that there is a substantial risk that the patient will act on that threat in the foreseeable future, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

A law in Kansas may allow, under certain circumstances, disclosure of records to the Behavioral Sciences Regulatory Board under subpoena if there were to be serious misbehavior or illegal activity by anyone in our group. You should be aware that we will always try to preserve your confidentiality rights and specific questions can be addressed with your provider or Dr. Cappo in this regard. This information is provided to keep you as fully informed as possible of any potential limitations of confidentiality. 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. In situations where specific advice is required, formal legal advice may be needed.

I understand that my treatment provider generally may not condition mental health services upon my signing an authorization unless the mental health services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to a release authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Our building uses video surveillance for security. Some images are viewable by our staff and employees and are not recorded in any form. Some images are stored electronically on a hard disk that is then overwritten when full. Only in the case of an incident of some type are the stored images reviewed. If you have any questions or concerns in this area please talk to Dr. Cappo.

### **MESSAGES**

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During regular office hours, calls are answered by the receptionists in the office. In the evening, calls are answered by an answering service and if there is an emergency, they will contact your practitioner. If it is a life-threatening emergency, go to the nearest hospital emergency room. Please be aware that if you subscribe to certain telephone features, this may affect confidentiality or our ability to contact you. If you have Caller-ID services and we phone from the office, then our practice name may show up on your Caller ID and be available to others in the household. We do not block the Caller ID signal in outgoing calls from our office. Also, please be aware that should your telephone not accept any blocked calls, then it may limit our ability to contact you at times. There are times when only blocked calls may be available from specific locations. If we are calling from one of those locations and your telephone does not accept blocked calls, there will be a delay in eventually contacting you. If you have concerns along these lines, please discuss this with your practitioner. Unless you tell us otherwise, we may attempt to contact you at any of the numbers you have provided us. Please do not email your provider unless your provider has agreed to this with you. Emails are not read timely by all providers and time sensitive information should not be conveyed in an email.

### **INITIAL CONTACT**

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Your initial appointment is often called an "initial evaluation." This appointment is scheduled for you to discuss your concerns and problems from your point of view. There may be time during this appointment to obtain historical and other background data or this information may be gathered at subsequent sessions. In situations of crisis, the usual format of an "initial evaluation" is not followed in the hope that the time might be used to resolve or relieve the immediate crisis. As part of the "initial evaluation" new patients are sometimes requested to complete at least one questionnaire concerning their beliefs, experiences, thoughts and feelings which will then be scored using statistical norms. The results of this "psychological test" will allow us to "measure" your concerns and problems. This booklet contains a copy of our *Policies and Practices to Protect the Privacy of Your Health Information*. You should review this information and ask any questions of your provider or Dr. Cappo. Under certain conditions a provider-patient relationship may not exist. This may include some forensic evaluations or evaluations/treatment at the request of a third party such as an employer, state or federal agency, court or insurer. The agency will pay for the service and may control access to reports or records. In such cases, the relationship actually exists between our practice and the referring agency rather than between you and your provider.

### **EMOTIONAL SUPPORT ANIMAL DOCUMENTATION REQUESTS**

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It is our policy **not** to complete paperwork or write letters related to emotional support animals.

# *Treatments*

We expect and encourage you to obtain knowledge of the procedures, goals, and possible side effects of psychotherapy. We expect to make our professional contact one where you receive the maximum benefit, and we will also keep you informed about alternatives to psychotherapy. Psychotherapy may be tremendously beneficial for some individuals while, at the same time, there are some risks. The risks may include the experience of intense and unwanted feelings, including: sadness, anger, fear, guilt or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the therapy process. Other risks of therapy might include: recalling unpleasant life events, facing unpleasant thoughts and beliefs, increased awareness of feelings, values and experiences, alteration of an individual's ability or desire to deal effectively and harmoniously with others in relationships, changing employment settings and changing lifestyles. These decisions are a legitimate outcome of the therapy experience as a result of an individual's calling into question many of their beliefs and values. Your provider will be available to discuss any of your assumptions, problems, or possible negative side effects of your work together.

## **MEDICATION TREATMENT AND MEDICATION REFILL PROTOCOL**

Allow 48 hours for refills to be processed. No refill will be provided between 5:00 p.m. and 8:00 a.m., Monday through Friday or on weekends. In order to continue to receive medication services, you **must** be seen a minimum of once every **six** months.

## **INDIVIDUAL, FAMILY AND COUPLES TREATMENT**

CA offers individual, family and couples psychotherapy focusing on depression, anxiety, stress, anger, self-esteem, communication, substance abuse and other issues. This treatment starts with an initial diagnostic and treatment planning session. The treatment provider and the patient(s) will decide together in that session how to proceed with the course of treatment and will regularly re-evaluate this throughout the treatment process.

## **GROUP THERAPY**

All of our groups are open which means that individuals can begin their attendance in group at any time.

## **ADULT ANGER CONTROL GROUP**

The Adult Anger Control Group is offered on a weekly basis. We ask participants to make a commitment for a minimum of twelve (12) weekly sessions and recommended aftercare sessions. The emphasis is on issues of identifying and dealing with anger and violence, as well as dealing with these issues in conjunction with substance abuse. This group meets the criteria for the Johnson County Domestic Violence Diversion Program as well as some other local court programs. Please check with the Court of Jurisdiction if other than Johnson County.



### **ADULT SUBSTANCE ABUSE GROUP**

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CA is a Kansas Department for Aging and Disability Services State Certified agency for outpatient substance abuse. We are also approved through the Johnson County Courts, as well as some other courts and municipalities, to provide evaluation and diagnosis, psychoeducational intervention, brief treatment and intensive treatment including family sessions. We do not offer inpatient, residential or detoxification treatment.

### **AFTERCARE FOR ADULT ANGER GROUP AND ADULT SUBSTANCE ABUSE GROUPS**

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Aftercare for Adult Anger Control Group and Adult Substance Abuse Group is recommended once a month for the duration of probation or diversion program.

### **ADOLESCENT GROUPS**

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These are weekly coeducational and/or therapy groups for teens ages 12 to 18. Issues concerning behavior, family, relationships, substance use, self-esteem, anger, communication and other general topics are addressed in an environment that is supportive yet can also be confrontive. Peer feedback is an important aspect of the group process.

- "COPING" is an Adolescent Group for teens ranging in age from 12 to 18 who are experiencing some difficulties with their emotions. The group focuses on developing positive coping strategies to more effectively deal with the day-to-day stressors that occur in a teen's life. Teens suffering from depression, anxiety, low self-esteem, difficulty in interpersonal relationships, school stress or grief and loss, benefit from a group setting where support and feedback is offered.
- "DECISION-MAKING" is an Adolescent Group for teens ranging in age from 12 to 18 who are faced with past choices that have had a negative impact on their lives. The group uses the setting of a supportive, yet confrontive atmosphere to address issues such as alcohol and/or drug use, anger, poor communication, school difficulties, family conflict or behavioral difficulties. Some teens may be involved in the juvenile legal system and are desiring to address the behaviors/choices that led to the legal consequences.

### **ANGER CONTROL GROUP FOR ADOLESCENTS**

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The primary goal of this group is to prevent physical, sexual, property and or psychological violence by helping adolescents learn to cope with anger, stress, frustration and anxiety in positive and constructive ways. A secondary goal is to work on the related issues of substance use/abuse which facilitate such violence as well as self-esteem issues.

### **ADOLESCENT SUBSTANCE ABUSE GROUP**

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CA is a Kansas Department for Aging and Disability Services State Certified agency for outpatient substance abuse. We are also approved to offer Options 1, 2, 3 and 4 through the Johnson County Courts, which address evaluation and diagnosis, psychoeducational intervention, brief treatment and intensive treatment including family sessions. We do not offer inpatient, residential or detoxification treatment.

### **ADOLESCENT SUBSTANCE ABUSE AFTERCARE GROUP**

Aftercare for Adolescent Substance Abuse Group is recommended once a month for six months or for the duration of probation or diversion program.

### **IMMIGRATION EVALUATIONS**

The U.S. Citizenship and Immigration Services (USCIS) require that applicants for naturalization demonstrate the ability to read, write and speak basic English and to answer basic questions about the history and government of the United States. This evaluation determines whether an individual meets specific criteria based on developmental or mental impairment. The required forms: N-648, Part II-2, 3, 4 & 5 will be completed as part of the assessment but USCIS will determine whether to grant the waiver.

### **SEX OFFENDER GROUP**

The Sex Offender Group is offered on a weekly basis to persons 18 years of age and older. Participants are both court ordered and self-referred. This interactional program is empirically based and has a cognitive-behavioral focus. The curriculum examines and treats the root causes of offending as well as presenting relapse prevention skills.

### **SEX OFFENDER TREATMENT PROGRAM**

Clinical Associates, P.A. offers evidence-based sex offender evaluation and treatment services throughout the State of Kansas. Clinical Associates is the contracted provider for sex offender treatment for the Kansas Department of Corrections. We offer evaluation, assessment, and treatment at correctional facilities, parole and probation offices, and at Clinical Associates' offices within the state. Clinical Associates' sex offender treatment program utilizes evidence-based measures to assess the risk, needs, and responsibility issues of clients. Treatment is focused on a decrease in client risk to the community, and an increase in pro-social behaviors. At the conclusion of services, we want clients to have developed the ability to intervene prior to potential problematic behaviors, and be better able to display appropriate responses to stressful life events. Clinical Associates believes that patient success depends on the successful interaction between the referral source, the client, and the treatment team. We understand the importance of providing high-quality, evidence-based services to clients and make available to those with whom we work our collective experience in a professional manner.

### **OTHER AREAS OF EMPHASIS**

CA offers Attention-Deficit Disorder evaluations and treatment, intellectual functioning and achievement, court-involved domestic violence and sex offender evaluations and treatments, and forensic and court ordered evaluations. CA is a Kansas Department for Aging and Disability Services licensed outpatient treatment, diagnostic and referral service as well as Juvenile Court Services and Johnson County Drug/Alcohol Board service provider.

### **OTHER PSYCHOLOGICAL SERVICES**

Infrequently, a patient's distress remains or becomes so high that hospitalization or the use of medication must be considered. CA has several prescribing practitioners (psychiatrists & nurse practitioners) although psychologists and social workers are not physicians, and consequently do not prescribe medication; however, at times psychologists and social workers may treat patients in hospitals. In cases where

medications or hospitalization may be required, this will be discussed in advance with the patient and, if necessary, with other responsible individuals. LMLPs and LPCs are licensed professionals who practice under direction of our Clinical Director.

### **TERMINATION**

Termination of psychotherapy may occur at any time and may be initiated by either the patient or the provider. We request that if a decision is being made to terminate, that a final termination session be scheduled to explore the reasons for termination. Termination itself can be a constructive, useful process. If any referral is warranted, it will be made at that time.

### **PATIENTS WHO ARE DEPENDENTS**

If you are requesting our services as the guardian or parent of a child, or the guardian of a dependent adult, the same general practice as outlined above will apply. However, as your child's provider, it is important that your child is able to completely trust us. As such, we keep confidential what your child says in the same way that we keep confidential what an adult says. As the parent or guardian, you have the right and responsibility to question and understand the nature of our activities and progress with your child, and we must use our clinical discretion as to what is an appropriate disclosure. In general, we will not release specific information that the child provides. However, we may deem it appropriate to discuss with you, the parent or guardian, your child's progress and your participation in their treatment. Children over the age of 13 have specific rights and should sign pertinent forms in addition to their parent or guardian.

## *Patient's Rights*

HIPAA provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your files is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; and, having any complaints you make about our policies and procedures recorded in your file. At any time, our patients may question and/or refuse therapeutic or diagnostic procedures or methods, or gain whatever information they wish to know about the process and course of therapy. You may examine and/or receive a copy of your 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, we recommend that you initially review them in the presence of your provider, or have them forwarded to another mental health professional so you can discuss the contents. You should also be aware that some of these rights may be limited in specific situations or that invoking some of these rights could result in other consequences (such as refusing to participate in a court ordered or employer required visit which might bring about legal or work consequences). If your request for access to your records is refused, you have a right of review (except in specific cases where information has been supplied to CA confidentially by others), which will be discussed with you upon request.

Patients are also assured of confidentiality which is protected by both ethical practice and by state law. There are, however, important exceptions to confidentiality that are legally mandated. In general terms, these exceptions include: (1) Possible notification of relevant others if we judge that a patient has an intention to harm another individual or themselves. (2) We are also obliged by the law to report any incidence of suspected child abuse, neglect, or molestation in order to protect the children involved. (3) In legal cases, we or our records may be subpoenaed by the court. Confidentiality will be respected in all cases, except as noted above, and in those additional cases where in our clinical judgment the maintenance of confidentiality is, in fact, destructive to the individual. In those situations, we will inform our patients of our judgment and they will have the final decision as to whether we maintain confidentiality. Please understand that all files are kept confidential in their use by the staff of CA. Your written consent is required for any release of information by CA staff to other persons, organizations or agencies except in the rare cases of court orders, child abuse, life threatening situations and national security issues. If you provide us a fax number with instructions to fax information to you, we cannot assure confidentiality or security at the receiving end. Also, be aware that while your provider may be available to you by e-mail, this also is not a secure or confidential form of communication. If you receive a response by e-mail, then such information should not be forwarded to others and should be considered specific to your private use.

Additionally, a Kansas Department for Aging and Disability Services you are entitled to the following rights and privileges without limitations:

1. To be treated with dignity and respect,
2. To be free from:
  - a. Abuse,
  - b. Neglect,
  - c. Exploitation,
  - d. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation,
3. To a safe, sanitary, and humane living environment that:
  - a. Provides privacy, and
  - b. Promotes dignity,
4. To receive treatment services free of discrimination based on the client's race, religion, ethnic origin, age, disabling or a medical condition, and ability to pay for the services,
5. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without consent, except for:
  - a. Photographing for identification and administrative purposes, as provided by R03-602, or
  - b. Video recordings used for security purposes that are maintained only on a temporary basis,
6. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights,
7. To confidential, uncensored, private communication that includes letters, telephone calls, and personal visits with:
  - a. An attorney,
  - b. Personal physician,
  - c. Clergy,
  - d. Department of Social and Rehabilitation Services Staff, or
  - e. Other individuals unless restriction of such communication is clinically indicated and is documented in the client record,
8. To practice individual religious beliefs including the opportunity for religious worship and fellowship as outlined in program policy,
9. To be free from coercion in engaging in or refraining from individual religious or spiritual activity, practice, or belief,
10. To receive an individualized treatment plan that includes the following:
  - a. Client participation in the development of the plan,
  - b. Periodic review and revision of the client's written treatment plan,
11. To refuse treatment or withdraw consent to treatment unless such treatment is ordered by a court or is necessary to save the client's life or physical health,
12. To receive a referral to another program if the licensee is unable to provide a treatment service that the client requests or that is indicated in the client's assessment or treatment plan,
13. To have the client's information and records kept confidential and released according to R03-602,
14. To be treated in the least restrictive environment consistent with the client's clinical condition and legal status,

15. To consent in writing, refuse to consent, or withdraw written consent to participate in research, experimentation, or a clinical trial that is not a professionally recognized treatment without affecting the services available to the client,
16. To exercise the licensee's grievance procedures,
17. To receive a response to a grievance in a timely and impartial manner,
18. To be free from retaliation for submitting a grievance to a licensee, the Department of Social and Rehabilitation Services, or another entity,
19. To receive one's own information regarding:
  - a. Medical and psychiatric conditions,
  - b. Prescribed medications including the risks, benefits, and side effects,
  - c. Whether medication compliance is a condition of treatment, and
  - d. Discharge plans for medications,
20. To obtain a copy of the client's clinical record at the client's own expense,
21. To be informed at the time of admission and before receiving treatment services, except for a treatment service provided to a client experiencing a crisis situation, of the:
  - a. Fees the client is required to pay, and
  - b. Refund policies and procedures, and
22. To receive treatment recommendations and referrals, if applicable, when the client is to be discharged or transferred.

#### **SUBSTANCE ABUSE GRIEVANCE PROCEDURE**

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If there are any concerns or complaints regarding substance abuse treatment and/or services received, they can be directed to:

Bruce Michael Cappo, Ph.D., APBB  
Director  
Clinical Associates, P.A.  
8629 Bluejacket Street, Suite 100  
Lenexa, Kansas 66214-1700  
913-677-3553  
913-677-3282 (Fax)

Kansas Department for Aging and Disability Services  
Behavioral Health Services Commission  
503 S. Kansas Avenue  
Topeka, Kansas 66603-3404  
785-296-6807

A review will be completed within 30 days

There may be other relevant exceptions to confidentiality which are not included here or that arise following printing of this document. Please ask your provider or Dr. Cappo any questions you may have in this area.

You have the right to discontinue treatment at any time, except in cases where the treatment or assessment has been ordered by the court. CA may discontinue treatment if it becomes reasonably clear that you are not benefiting from treatment.

Disclosing information received from other agencies or doctors is subject to the Drug Abuse Office and Treatment Act of 1972 (21 USC 1175) Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 USC 4582) as follows:

Prohibition on Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates such provision of this law shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

# ***Financial Obligations and Responsibilities***

**Prices subject to change. Please call office to confirm pricing.**

Fees are charged differently for specific groups of providers as follows:

## **EVALUATION AND TREATMENT**

<b>CPT</b>	<b>Description</b>	<b>Med Provider Charge</b>	<b>Psychologist/ Therapist Charge</b>
90791	Initial Session	N/A	\$250.00
90792	Initial Intake	\$325.00	N/A
90832	Psychotherapy 20-30 minutes	N/A	\$125.00
90834	Psychotherapy 45-50 minutes	N/A	\$210.00
90837	Psychotherapy 51-60 minutes	N/A	\$240.00
90846	Family Counseling w/Patient	N/A	\$230.00
90847	Family Counseling	N/A	\$230.00
90853	Group Psychotherapy	N/A	\$160.00
96101	Psych Testing	N/A	\$450.00
96103	Computer Testing	N/A	\$60.00
99204	Initial Session – Med Management	\$425.00	N/A
99213	Indiv. Med Management	\$225.00	N/A
99214	Indiv. Med Management	\$250.00	N/A
99215	Indiv. Med Management	\$275.00	N/A



**TESTING AND FORENSICS (Psychologists/Therapists)**

<b>Description</b>	<b>Charge</b>
Psych Testing per hour	\$450.00
Consultation per hour	\$450.00
Court/Forensic Time per hour	\$450.00
Level I Evaluation	\$250.00
Level II Evaluation	\$2,000.00
Level III Evaluation	\$2,300.00
Competency to Stand Trial	\$700.00
Bariatric Evaluation	\$1,600.00
Parenting Evaluation	\$2,300.00
Sex Offender Evaluation	\$2,400.00
Juvenile Waive to Adult	\$2,300.00
Attorney-Referred Psychosexual (Ph.D.) Eval	\$2,500.00
Community Corrections/Court Services Psychosexual Eval	\$400.00
Adult Substance Abuse	\$150.00
Juvenile Substance Abuse	\$150.00
Juvenile Substance Abuse Advance	\$150.00
Mental Status at time of Offense (MSO)	\$2,500 to \$4,000.00
Attorney-Referred Psychosexual (Masters Level) Eval	\$1,750.00
Federal (USPO/BOP) Psychosexual Eval	\$825.00
Board of Indigent Defense Services (BIDS) Psychosexual	\$600.00
Community Corrections Sex Offender Treatment	\$40.00 per session

**SCHOLARSHIP FEES (Psychologists/Therapists)**

<b>Description</b>	<b>Charge</b>
WJ-III or WIAT-II	\$550.00
WISC-IV or WAIS-IV	\$550.00
IQ & Achievement	\$1,050.00
Group Fee	\$40.00
Aftercare (adult and teen)	\$23.00
Aftercare (adult)	\$23.00

- **For any appointment not canceled 24-hours in advance \$85.00.**
- **FMLA paperwork completed first time by provider \$50.00...renewal \$35.00**

For particular services, some individuals may qualify for a scholarship agreement as noted above. We also sometimes have available particular programs offering services to persons who meet particular qualifications (such as deaf or hard of hearing persons with substance abuse issues) at reduced fees or fees paid by grant or subsidy. Court-related travel, preparation time and appearances are \$360.00 per hour. The fee includes our time on your behalf for record keeping and preparation. There will be a charge for filling out special forms such as FMLA forms, disability letters and forms, etc. Allow five (5) business days for completion of all forms and letters. We encourage you to discuss fees at any time, and our patients are expected to pay for services when provided unless arrangements have been made in advance. With limited exceptions, when our psychological reports are sent to a third party, payment in full is necessary prior to release of our findings. For your convenience, we accept cash, personal check, Mastercard, Visa, Discover, and American Express. Please feel free to discuss any concerns about fees with your provider directly.

In certain situations such as a forensic, court ordered, mandated, or recommended evaluation or treatment, the services requested may not meet the eligibility requirements of medical necessity as defined by your insurance company. At times, CA may have an agreement with specific insurance companies to not require payment for services deemed not medically necessary. Our agreement allows us to inform you that we will not provide such services to you under these conditions. If you choose to have such services performed, even if they are not found to be of medical necessity, you agree to be responsible for the charges involved. CA will be happy to bill your insurance company as a courtesy although such action would not constitute a change in the above agreement.

Payment is expected at the time services are rendered unless other specific arrangements have been made. Payment of fees is an important part of our work together. Please discuss fee issues with your provider directly should you have difficulties or concerns. Dr. Cappo is always available to discuss fees with you personally.

Please understand that failure to pay your bill may result in specific information being disclosed to a collection agency to facilitate payment. This information would include demographic information including your name, how you might be contacted, the amount you owe and for what specific services. Specific clinical information about your problems will remain confidential. You will receive written notification that this will happen at the address supplied to CA. You will be notified of a date by which you must contact the office to make arrangements for payment or have your account turned over to collection. It is your responsibility to maintain accurate phone and mailing contact information with our office.

#### **RESTRICTIVE LEGENDS**

We are not required to honor any restrictive legend on checks you write unless we have agreed in writing to the restriction. Examples of restrictive legends are “must be presented within 90 days” or “constitutes agreement for payment in full.”

## **BILLING AND TRANSCRIPTION**

Our office contracts with reputable third parties at times to provide various support services and, as required by HIPAA, we have formal business associate contracts with these businesses. Such services could include, but are not limited to, transcription or billing. Any vendor who provides such services to us is committed to the same levels of confidentiality that we apply here in our practice.

## **INSURANCE**

If you have a health insurance plan, your visits may be reimbursed by your insurance company. Your signature on the appropriate form allows our office to release relevant information to facilitate reimbursement. In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Many individuals are members of preferred provider plans or health maintenance organizations with whom we have contractual obligations. Please inform us in advance should you be eligible for these contracted services. It is the patient's responsibility to obtain insurance preauthorization for all office visits. Failure to do so may result in out-of-pocket expense. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear any confusion, we will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed care plans will not allow us to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire file. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company

files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report submitted, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above [unless prohibited by contract]. If you prefer that we do not release information to your insurance carrier for reimbursement purposes, or if your insurance carrier fails to reimburse you in a manner which you expected, you will remain responsible for the fee for services.

# Reference Forms

*The following forms are provided for you here for your reference. You may be asked to complete some or all of them for our records. These will be provided for you as separate sheets to sign.*

## GENERAL CONSENT FOR TREATMENT

Name (printed): \_\_\_\_\_

- I understand that all files are kept confidential in their use by the staff of Clinical Associates, P.A. My written consent is required for any release of information by Clinical Associates, P.A.'s staff to other persons, organizations or agencies except in the rare cases of court orders, child abuse, life threatening situations and national security issues. There may be other occasions where a third party is responsible for contracting with CA and they are actually the client and control access to the information.
- I consent to participate in the necessary psychological testing, therapy, medication management, recommended medical tests or follow up, or other procedures in the course of assessment and treatment regarding my concerns by the staff of Clinical Associates, P.A.
- I am aware that I have the right to discontinue at any time, except in cases where the treatment or assessment has been ordered by the court. There are also times when discontinuation of services may result in negative consequences related to employment or other areas of life. My provider may discontinue treatment if it becomes reasonably clear that I am not benefiting from treatment.
- I am aware that the practice of psychotherapy, medication management and related disciplines is not an exact science and I acknowledge that no guarantees have been made to me as a result of assessment, consultation or treatment.

Exceptions or additions to the above are as follows: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
Your own effort will play an important role in determining how much benefit you receive from coming here. Another important part of treatment is honest communication between you and your provider. If you have concerns about any items on this page, you should feel free to discuss them with your provider. Thank you.

# FORENSIC INFORMED CONSENT CONTRACT

This Forensic Psychological Evaluation is being conducted at the request of:

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and is therefore somewhat different than other psychological services. It is important for you to understand how a forensic evaluation differs from more tradition psychological evaluations.

While the results of this evaluation may or may not be helpful to you personally, the goal of this evaluation is to provide information about how you are functioning psychologically to the individual or agency requesting the evaluation. In most cases, this evaluation is intended for use in some type of a legal proceeding. As such, the confidentiality of the evaluation and the results are determined by the rules of that legal system. If your attorney has requested this evaluation, he/she will receive a copy of my report and will control how it is to be used and who has access to it. Normally, the results of this evaluation are protected by the attorney-client privilege. Exceptions to this might include a determination on my part that you are dangerous to another person or if you reveal information that a child has been abused. I would also have to release this information if a court orders me to do so. There may be other examples where the laws require me to release the information obtained during the evaluation. We will discuss these situations on a case-by-case basis.

Once a decision has been made to use the report in a legal proceeding, the report and any information pertaining to it will probably be admissible into evidence as well as any other information that was provided concerning your mental health and functioning. If you have any concerns about the use or distribution of my report, you should discuss these issues carefully with your attorney. If someone other than your attorney requested the evaluation, that individual is my client and he/she has complete authority over the results, including whether or not any information will be released to you or to anyone else. In addition, because the evaluation was requested by another party, and is not for the purpose of treatment or counseling, the confidentiality may have fewer legal protections. I will not release the information unless instructed to do so by the person or entity that hired me or when I am legally required to do so.

Your participation in this evaluation is voluntary. I will not conduct the evaluation without your signature on this document. You also have the right to stop the evaluation at anytime. There may be legal consequences if you stop the evaluation; therefore, it would be in your best interest to consult with an attorney before doing so. In addition, if appointments are not kept or are canceled within 24 hours of the appointment time, the person requesting the evaluation will incur charges for the unused time that has been set aside for these services. The evaluation itself consists of two separate parts: an oral interview and psychological testing. In addition, it may be necessary for me to review other related materials such as court records, depositions, transcripts, medical records, etc. If at any time you have a question about any aspect of the evaluation or these procedures, please feel free to ask me. In addition, if at any time you need a break from the evaluation, please let me know and we will stop. Once the evaluation is completed, and with the permission of the requesting party, I may be able to have a meeting with you to explain the results and answer any questions you might have.

I have read and agree to the above: \_\_\_\_\_  
(Signature) (Date)

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

## CONSENT TO RELEASE INFORMATION

I, \_\_\_\_\_ authorize \_\_\_\_\_

to disclose to Clinical Associates, P.A. progress notes, medication records, treatment plan, laboratory results, evaluation and status of treatment from my records. The purpose or need for such disclosure is to facilitate treatment, assessment and case disposition.

I further authorize Clinical Associates, P.A. to disclose to:

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

medication records, psychiatric evaluation and treatment records, laboratory results and other medical tests, progress notes, treatment plan, evaluation and status of treatment from my records. The purpose or need for such disclosure is to facilitate treatment, assessment, and case disposition.

I understand that my medical records (including any alcohol, drug or psychiatric information) may be protected by Federal Regulations. This consent to disclose may be revoked by me in writing at any time except to the extent that action has already been taken in reliance thereon. This consent expires one year following termination of the case.

I indemnify and hold Clinical Associates, P.A. harmless from any and all damages or prejudice which might result to myself, relatives or heirs from the use or misuse of the information furnished by the agency pursuant to this authorization.

***THIS IS YOUR COPY. YOU MAY BE ASKED TO SIGN A DUPLICATE FORM FOR OUR RECORDS.***

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent, Guardian or legal representative (specify relationship)

\_\_\_\_\_ Date \_\_\_\_\_

**PROHIBITION ON REDISCLOSURE:** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates such provision of this law shall be fined not more than \$500, in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense. Drug Abuse Office and Treatment Act of 1972 (21 USC 1175) Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 USC 4582)

## **CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS**

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

- (1) The patient consents in writing;
- (2) The disclosure is allowed by court order; or
- (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States attorney in your district or SRS/Alcohol and Drug Abuse Services.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate state or local authorities.

See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR, Part 2 for Federal regulations.

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My signature on the agreement form certifies I have been given a copy of this information on confidentiality.



## **GROUP THERAPY POLICIES**

1. Meeting Time: The group begins and ends on time. You are expected to stay for the entire session.
2. Attendance: You are encouraged to attend on a weekly basis and stay in the group until the problems that brought you into treatment are dealt with. Vacation plans that prevent attendance at a session(s) should be brought to the group's attention prior to your vacation. If sickness occurs, please contact or leave a message for one of the group therapists before the session; otherwise you will be billed for that session. If you miss sessions and you are court ordered to attend, the courts will be notified of your missed attendance. Group sessions may be canceled for the following reasons: (a) bad weather, (b) official holidays, or (c) if the therapist is on vacation or unavailable. Every effort is made to have another practitioner cover the group if a therapist is absent for vacation or illness. If the weather conditions are uncertain or threatening, please check to see if evening classes at Johnson County Community College (JCCC) are cancelled. CA closes for weather when JCCC cancels for weather. If JCCC classes are held then CA is open.
3. Primary Therapist: You may be engaged in individual psychotherapy, in addition to this group. If you see someone outside of our practice, you are expected to sign a "release of information" form to allow us to communicate with your individual psychotherapist for purposes of coordinating treatment. If you terminate or change individual therapists, notify the group leader immediately.
4. Group Discussions: The group's focus is on verbal interactions. You are encouraged to express your feelings openly and freely. Interruptions not usually acceptable in social gatherings are often desirable.
5. Confidentiality: Strict group confidentiality must be maintained. This means that group issues, conversations, and membership identities are not to be conveyed by members to people outside of the group. There are times when the group leaders may discuss group-related information with other persons. This includes the following situations: (a) sharing information about your progress in group therapy with your individual psychotherapist, and (b) if it is believed that you are harmful or potentially harmful to yourself or someone else, appropriate people need to be informed.
6. Violence: Violence of any kind in the group is forbidden. You may say anything. However, physical contact that is sexual, aggressive and/or threatening is prohibited in the group.
7. Termination: Reasons for termination vary and include completion of group therapy or violation of group policies. If you are leaving the group for reasons other than having to do with violation of policies, it is requested that you plan to attend at least one additional session following announcement of your intent to terminate. The purpose of this additional session is for you and the group to address issues related to your leaving.
8. Smoking, Eating, and Drinking: Smoking and eating (including chewing gum) are not allowed during group. Drinking of nonalcoholic beverages is permissible.
9. Homework: On occasion, therapeutic "homework" projects may be assigned.
10. Substance Abuse: Arriving to group under the influence of any non-prescribed substance, including alcohol, is grounds for termination and/or referral.
11. Individual Sessions: There are times when it may be necessary for you to meet individually with the group therapist. Either you or a group leader may request an individual session. Individual session(s) may be appropriate for group-related situations that do not lend themselves to group discussion. Whenever possible, issues pertaining to group will be dealt with in group. Individual sessions are billed at the individual therapy rate.
12. Breaches of Group Policy: Not abiding by these policies may lead to termination or referral.
13. Fees: Fees are due at each group session. You may pay either in cash or by check (payable to Clinical Associates, P.A.) or credit card.

My signature on the agreement form certifies that I have read the above GROUP THERAPY POLICIES and agree to abide by them. This information is supplied to patients as a public service and meets part of our education requirements as a participating agency in Substance Abuse Treatment & Recovery.

## INFECTIOUS DISEASES

**What is HIV/AIDS?** The human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS), is a virus that lives and multiplies primarily in white blood cells, which are part of the immune system. HIV ultimately causes severe depletion of these cells. An HIV-infected person may look and feel fine for many years and may therefore be unaware of the infection. However, as the immune system weakens, the individual becomes more vulnerable to illnesses and common infections. Over time, a person with untreated HIV is likely to develop AIDS and succumb to multiple, concurrent illnesses.

**How Is HIV/AIDS Spread?** HIV can be transmitted by contact with the blood or other body fluids of an infected person. In addition, infected pregnant women can pass HIV to their infants during pregnancy, delivery, and breastfeeding. Among drug users, HIV transmission can occur through sharing needles and other injection paraphernalia such as cotton swabs, rinse water, and cookers. However, another way people are at risk for HIV is simply by using drugs, regardless of whether a needle and syringe is involved. Drugs and alcohol can interfere with judgment and can lead to risky sexual behaviors that put people in danger of contracting or transmitting HIV.

**What Other Infectious Diseases are Associated with HIV/AIDS?** Besides increasing their risk of HIV infection, individuals who take drugs or engage in high-risk behaviors associated with drug use also put themselves and others at risk for contracting or transmitting hepatitis C (HCV), hepatitis B (HBV), tuberculosis (TB), as well as a number of sexually transmitted diseases, including syphilis, chlamydia, trichomoniasis, gonorrhea, and genital herpes. Injecting drug users (IDUs) are also commonly susceptible to skin infections at the site of injection and to bacterial and viral infections, such as bacterial pneumonia and endocarditis, which, if left untreated, can lead to serious health problems.

*HCV, HBV, and HIV/AIDS* HCV, the leading cause of liver disease, is highly prevalent among IDUs and often co-occurs with HIV; HBV is also common among drug abusers. These are two of several viruses that cause inflammation of the liver. Chronic infection with HCV or HBV can result in cirrhosis (liver scarring) or primary liver cancer. A vaccine does not yet exist for HCV; however, HBV infection can be prevented by an effective vaccine. HCV is highly transmissible through blood-borne exposure. NIDA-funded studies have found that, within 3 years of beginning injection drug use, most IDUs contract HCV—and up to 90 percent of HIV-infected IDUs may also be infected with HCV. The effects of HCV infection on HIV disease are not well understood; however, the course of HCV infection is accelerated in dually infected individuals, with higher rates of progressive liver disease and death in those with both HIV and HCV than in those with HCV alone. While treatment can be effective, management of co-occurring HIV and HCV presents certain challenges. HIV therapy can slow progression of liver disease in co-infected persons, but treatment response rates to HCV therapy in these individuals are reduced. Assessment of stage of disease is important to the timing of therapy initiation for both infections, as is long-term medical follow up in order to improve quality of life.

*TB and HIV/AIDS* TB is a chronic and infectious lung disease. Through major public health detection and treatment initiatives, its prevalence declined in the United States for several years—in 2005, 14,000 cases were reported, the lowest number since surveillance began in 1953. However, the decline of TB prevalence has slowed by half in recent years, and TB infection remains intertwined with HIV/AIDS and drug abuse.

People with latent TB infection do not have symptoms, may not develop active disease, and cannot spread TB. However, if such individuals do not receive preventive therapy, they may develop active TB, which is contagious. NIDA research has shown that IDUs have high rates of latent TB infection. Because HIV infection severely weakens the immune system, people infected with both HIV and latent TB are at increased risk of developing active TB and becoming highly infectious. Effective treatment for HIV and TB can reduce TB/HIV-associated disease and the risk of transmission to others.

*To learn more about these infectious diseases go to [www.drugabuse.gov](http://www.drugabuse.gov)*

## **Child Therapy Agreement**

- If you decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship.
- You are waiving your right to access to your child's treatment records.
- I will inform you if your child does not attend the treatment sessions.
- At the end of treatment, I will provide you with a summary that includes a general description of goals, progress made, and potential areas that may require intervention in the future.
- If necessary to protect the life of your child or another person, I have the option of disclosing information to you without your child's consent.
- You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).
- You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.
- If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will not include recommendations concerning custody or custody arrangements.
- If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of \$250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.
- Should you have concerns about any of the above please discuss this with your child's therapist or with Dr. Cappo.

Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

## OUTPATIENT SERVICES AGREEMENT FOR COLLATERALS

### INTRODUCTION

I want to thank you for accepting the invitation to assist in \_\_\_\_\_'s psychotherapeutic treatment. Your participation is important, and is sometimes essential to the success of the treatment. This document is to inform you about the risks, rights and responsibilities of your participation as a collateral participant.

### WHO IS A COLLATERAL?

A collateral is usually a spouse, family member, or friend, who participates in therapy to assist the identified patient. The collateral is not considered to be a patient and is not the subject of the treatment. Psychiatrists, psychologists & therapists have certain legal and ethical responsibilities to patients, and the privacy of the relationship is given legal protection. Your practitioner's primary responsibility is to the patient and their interests are placed first. You also have less privacy protection.

### THE ROLE OF COLLATERALS IN THERAPY

The role of a collateral will vary greatly. For example, a collateral might attend only one session, either alone or with the patient, to provide information to the therapist and never attend another session. In another case a collateral might attend all of the patient's therapy sessions and his/her relationship with the patient may be a focus of the treatment. We will discuss your specific role in the treatment at our first meeting and other appropriate times.

### BENEFITS AND RISKS

Psychotherapy often engenders intense emotional experiences, and your participation may engender strong anxiety or emotional distress. It may also expose or create tension in your relationship with the patient. While your participation can result in better understanding of the patient or an improved relationship, or may even help in your own growth and development, there is no guarantee that this will be the case. Psychotherapy is a positive experience for many, but it is not helpful to all people.

### MEDICAL RECORDS

No record or chart will be maintained on you in your role as a collateral. Notes about you may be entered into the identified patient's chart. The patient has a right to access the chart and the material contained therein. It is sometimes possible to maintain the privacy of our communications. If that is your wish, we should discuss it before any information is communicated. You have no right to access that chart without the written consent of the identified patient. You will not carry a diagnosis, and there is no individualized treatment plan for you.

### FEES

As a collateral you are not responsible for paying for professional services unless you are financially responsible for the patient.

### CONFIDENTIALITY

The confidentiality of information in the patient's chart, including the information that you provide me, is protected by both federal and state law. It can only be released if the identified patient specifically authorizes this happen. There are some exceptions to this general rule:

- If there is a suspicion that you are abusing or neglecting a child or a vulnerable adult, your practitioner is required to file a report with the appropriate agency.
- If your practitioner believes that you are a danger to yourself (suicidal) then actions will be taken to protect your life even if your identity must be revealed to do so.
- If you threaten serious bodily harm to another your practitioner will take necessary actions to protect that person even if your identity must be revealed to do so.
- If you, or the patient, is involved in a lawsuit, and a court requires that information or testimony be provided then your practitioner will comply.
- If insurance is used to pay for the treatment, the patient's insurance company may require submission of information about the treatment for claims processing purposes or for utilization review.

You are expected to maintain the confidentiality of the identified patient (your spouse, friend, or child) in your role as a collateral.

## **DO COLLATERALS EVER BECOME A FORMAL PATIENT?**

Collaterals may discuss their own problems in therapy, especially problems that interact with issues of the identified patient. The therapist may recommend formal therapy for a collateral. These are some examples of when this might occur.

- It becomes evident that a collateral is in need of mental health services. In this circumstance the collateral needs to have a clinician, diagnosis, and chart records kept.
- Parents, being seen as collaterals as their child is being treated, need couples therapy to improve their relationship so they can function effectively as parents.

Most often, but not always, your clinician will refer you to another clinician for treatment in these situations. There are two reasons the referral may be necessary:

- Seeing two members of the same family, or close friends, may result in a dual role, and potentially cloud the clinician's judgment. Making a referral helps prevent this from happening.
- The clinician must keep a focus on the original primary task of treatment for the identified patient. For example, if the clinician started treating a child's behavioral problem, then takes on couples therapy with mom and dad to address their relationship problems, the original focus of therapy with the child may be lost. A referral helps the clinician to stay focused.

One exception to these guidelines is when a family therapy approach can be effectively and ethically used to treat all members of the family, or each of the couple.

## **RELEASE OF INFORMATION**

The identified patient is not required to sign an authorization to release information to the collateral when a collateral participates in therapy. The presence of the collateral with the consent of the patient is adequate. This provides some assurance that full consent has been given to the clinician for the patient's confidential information to be discussed with the collateral in therapy. The Release of Information Form is also helpful to the clinician on those occasions when receiving a telephone call from a collateral or when the clinician calls a collateral for one reason or another. In most instances the clinician cannot take a call from a collateral without a Release of Information Form.

## **PARENTS AS COLLATERALS**

Clinicians specializing in the treatment of children have long recognized the need to treat children in the context of their family. Participation of parents, siblings, and sometimes extended family members, is common and often recommended. Parents in particular have more rights and responsibilities in their role as a collateral than in other treatment situations where the identified patient is not a minor.

- In treatment involving children and their parents, access to information is an important and sometimes contentious topic. Particularly for older children, trust and privacy are crucial to treatment success. But parents also need to know certain information about the treatment. For this reason, we need to discuss and agree about what information will be shared and what information will remain private. Your clinician generally requires a written contract signed by both you and your child/children concerning access to a child's record and once that contract is made, it is legally binding, although it sometimes may be overridden by a judge. In general, parents should be informed about the goals of treatment and how the treatment is going and whether the child comes to his/her appointments. Your clinician will always inform you if he/she thinks that your child is in danger or if he/she is endangering others. One of your first tasks is to discuss this shared definition of dangerousness if you choose, so that everyone is clear about what will be disclosed.
- If you are participating in therapy with your child, you should expect the clinician to request that you examine your own attitudes and behaviors to determine if you can make positive changes that will be of benefit to your child.

## **SUMMARY**

If you have questions about therapy, procedures, or your role in this process, please discuss them with your therapist. Remember that the best way to assure quality and ethical treatment is to keep communication open and direct with your clinician. By signing below, you indicate that you have read and understood this document.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# *Acknowledgement of Receipt and Agreement*

I have received and read the New Patient Welcome materials (version 16.21) that describes the practice and CA policies as well as the Health Insurance Portability and Accountability Act (HIPAA) and its application to my personal health information. I have discussed any questions I had and agree to abide by the terms as stated.

My signature below indicates that I, \_\_\_\_\_  
have received a written copy and a verbal explanation of the following documents from  
Clinical Associates, P.A.

1. Written summary of the Federal Regulations on confidentiality
2. Client's Rights
3. Grievance Policy and Procedure
4. Client responsibilities
5. Treatment Service Fees
6. Infectious Diseases to include AIDS, HIV, STI and HCV
7. Group Therapy Policies

\_\_\_\_\_(initial) I authorize Clinical Associates, P.A. (CA) to leave me messages regarding my appointment times or other relevant information that may contain protected health care information on my voice mail, answering machine or with any person answering the phone numbers I have provide to CA.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# NOTES

# NOTES