Disclosure Form

- Susan Tinsley, MA, LMFT
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- BA in Sociology from Louisiana State University, Baton Rouge, LA (2000)
  MA in Counseling Psychology from Regis University, Denver, CO (2009)
  Marriage and Family Therapy Certification from Regis University, Denver, CO (2009)
  Certificate in Sex Therapy from Colorado Family Counseling, Aurora, CO (2011)
  Certified Professional Coach from Grow Training Institute (2016)

- The Florida Department of Health has the general responsibility of regulating the practice of licensed psychologists, licensed social works, licensed mental health counselors, licensed marriage and family therapists, licensed school psychologists practicing outside the school setting, licensed or certified addiction counselors, and unlicensed interns who practice psychotherapy. Susan Tinsley's LMFT number with the state of Florida is **MT 2666**.

  The board within the Department that has specific responsibility is the BOARD OF CLINICAL SOCIAL WORK, MARRIAGE AND FAMILY THERPAY AND MENTAL HEALTH COUNSELING 4052 BALD CYPRESS WAY, BIN #C08, TALLAHASSEE, FL 32399-3258 (850) 245-4474 * (850) 921-5389, FAX http://www.doh.state.fl.us/mqa/491

- Client Rights and Important Information:

  a) You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy (if I can determine it), and my fee structure. If you would like a copy of this document, it is located on my website www.susantinsleytherapist.com under Forms.

  b) You can seek a second opinion from another therapist or terminate therapy at any time. I have a 24-hour cancellation policy for all appointments. If you do not cancel 24 hours in advance of your scheduled appointment you will be charged for the missed session.

  c) In a professional relationship (such as ours), sexual intimacy between the therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the Department of Health.

  d) In couples therapy, your psychotherapist holds a "NO SECRETS" policy. Both members of the couple are treated equally and "secrets" are not kept by the psychotherapist that would require differential or discriminatory treatment of either client. Any information shared in individual therapy must be also shared in couples therapy to insure this "NO SECRETS" policy. Signing this disclosure statement affirms permission to share this confidential information.

  e) In **WALK** therapy, your psychotherapist cannot guarantee confidentiality due to the lack of privacy in the neighborhood or park chosen for the session. Signing this disclosure statement affirms that the client understands this information.

f) **<u>Any information sent electronically through email or text is not guaranteed confidential and will be printed/ filed in client's records. Your psychotherapist is not liable for any breeches of confidentiality caused by the client or any third party</u>.**

g) **EMERGENCIES-** Your psychotherapist provides non-emergency psychotherapeutic services by scheduled appointment only. If your psychotherapist believes your issues are above her level of competence, or outside of her scope of practice, she is required to refer, terminate, or consult. If, for any reason you are having an emergency, you will need to call <u>911</u> or check yourself into the nearest hospital emergency room.

h) I understand that the psychotherapist will keep a record about the sessions and all interactions between the psychotherapist and the client including voicemails and text messages. I understand that if I fail to set up a follow up session or contact my therapist giving a reason why I have not been consistent with sessions, our therapeutic relationship will be terminated after 30 days of no contact and/or sessions.

i) I understand that my psychotherapist is required by law to report any suspected child or elder abuse, or serious threats of harm to myself or another person, to the proper authorities.

j) Generally speaking, the information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed psychologist, licensed social worker, licensed mental health counselor, licensed marriage and family therapist, licensed or certified addiction counselor or an unlicensed intern. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent.

Information disclosed to a licensed psychologist, licensed social worker, licensed mental health counselor, licensed marriage and family therapist, licensed or certified addiction counselor or an unlicensed intern is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Florida without the consent of the person to whom the testimony sought relates.

There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Florida statutes 491.0147. You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 491.0147 (3) . There are exceptions that I will identify to you as the situations arise during therapy.

k) Fees for court appearances, depositions, telephone consultation, travel, and out of office services are billed on an actual time and expense basis ($125/hour). You are solely responsible for their payment. In the event that a summary report is requested on your behalf, the fee is based on the preparation time needed at the rate of $125/hour. Copies of documents are provided at $5 per page.

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

I have been informed of the Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I have been give the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at their address to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Before signing this document, please make sure that if you have any questions or would like additional information to ask me in person, by phone 561-252-1871 or by email* at info@susantinsleytherapist.com

By signing below, I am affirming I have read the preceding information and understand my rights as a client.

_____ _____

_____ _____

Client Signatures Date

_____ _____

Therapist Signature Date