Colin O'Grady, M.Ed, LPC, LLC

Psychotherapist

6301 Forbes Ave. Suite 240, Squirrel Hill, PA. 15217
412-818-1276 | colin.lpc@ogradycounseling.com | www.ogradycounseling.com

Professional Disclosure Statement and Informed Consent

Welcome to Colin O'Grady, Licensed Professional Counseling, LLC. This document contains important information related to our professional services and business policies. Please take the time to read this carefully and please bring any questions to my attention at your next session. Signing this document represents an agreement between you and Colin O'Grady, LPC to move forward in the process of counseling.

Qualifications and Experience

I am a practicing Licensed Professional Counselor (LPC PC#006161) in Pennsylvania for 7 plus years and a former school counselor for 12 years (PA K-12 Certificate #1062783). I earned my Masters of Education in School Counseling Grades 7-12 in 2007 and received my K-6 certification and Licensure Certification in 2010. I have been working in the helping professions since 2003, and providing counseling since 2004. I have counseling experience in private practice, as a School Counselor in grades 7-12 and in community agency settings.

Counseling Approach and Client/Counselor Roles

I provide individual, couples, family, and group counseling services to adults, adolescents and children while integrating techniques from various therapies including (not limited to) Cognitive Behavioral, Gestalt, and Person Centered therapy. I take a person-centered, strengths-based approach, collaborating with clients to cultivate skills and resources designed to improve the quality of life. We will explore your experiences and relationships and work toward your goals. My role is to listen in a non-judgmental way, ask questions, and provide feedback. You are the expert on your life and have the ability to work to change your experience. We may agree to "homework" to help you achieve your goals. Psychotherapy is not like a medical doctor appointment. It differs in that you will need to actively work on aspects of your life, in session and in the world, that are in need of improvement.

Practice Fees (per session), Billing and Payments

Initial Evaluation	**$150**
Individual Psychotherapy	**$125**
Family Therapy	**$125**
Group Therapy	**$80**
Late/Cancelation Fee	**$60**

Payment for all services will be due at the time services are rendered. This includes insurance co-payments and deductibles and private payment. Individual sessions are 60 minutes in duration. All new clients in the practice will have an initial assessment to explore needs, goals, and fit with counselor. I do accept some health insurance products. Should your insurance change at any time and does not cover the cost of psychotherapy, you will be financially responsible for the associated fees. It is your responsibility to be aware of the mental health coverage associated with your health insurance plan. This can be completed by contacting the customer service department at your insurance provider. We would be more than willing to assist you in understanding this information, should the need arise.

Any telephone call, report preparation, clinical evaluations, treatment summaries, FMLA, Disability and letter writing requests will be billed at a fee of *$150 per hour*. Please be advised that insurance companies do not cover any expense for the therapist time necessary to complete these special reports. In the event that you become involved in legal proceedings that require your therapist's participation or attendance, you will be expected to pay for the time even if your therapist is called to testify by another party. Due to the complexities of legal involvement, we will charge *$300 per hour* for

preparation and attendance at any legal proceedings. When attending, fees will apply from the time I leave my office to the time I complete my testimony and return to my office. If 24 hour notice is not provided for cancelled or rescheduled court dates, there will be a *cancellation fee of $300*.

Risks and Benefits of Counseling

The counseling process can be difficult at times as we grapple with certain issues and feelings, but it also has the potential to be very rewarding. The process of making change can involve risks such as dealing with traumatic events, painful emotions, and the unpredictable impacts of change on our lives. Counseling is a process that takes time, self-assessment, commitment, and an openness to change and self-growth. While counseling is beneficial for most, I am unable to provide any guarantees. I look forward to collaborating with you on your journey. You may ask questions about the process or end counseling at any time. We will regularly assess your goals and the effectiveness of our sessions. During our work together, you may be assessed for a diagnosis, which becomes a permanent part of your client record. Please review your rights under HIPAA regulations. Feel free to ask questions at any time.

Ethics and Competency

As a Licensed Professional Counselor in the Commonwealth of Pennsylvania, I am obligated by the ethical codes and laws relevant to counseling. Part of my ethical obligation is to only provide services to clients who I am competent to serve. If I determine that your needs are outside of my expertise or scope of practice, or at your request, I can make referrals to other mental health providers. All counseling comes to an end at some point, which is called termination. Should ongoing therapy be needed at that time, we will work together to find appropriate services to meet your needs. Please see ethical codes at http://www.counseling.org/ethics.

Dual Relationships

I will not enter into personal (dual) relationships with clients outside of professional counseling services. This boundary continues even after counseling is terminated. This is an ethical obligation that benefits you by allowing me to serve as a counselor rather than a friend. I do not initiate contact with clients in public places or communicate online or through social networking sites to protect this boundary and your confidentiality. Occasionally, I may share some of my experiences in sessions when it may be beneficial, but our focus will be on your experiences.

Confidentiality

Information discussed in our counseling sessions will remain confidential, except in the circumstances below that are mandated by law or by the ethical guidelines of the Pennsylvania Board of Licensed Professional Counselors and the American Counseling Association. I may break confidentiality:

1. If you make written request for the release of information. Also, if you request for diagnosis information (if applicable) to be released on a receipt for payment purposes to an insurance company.
2. If there is a risk of serious or foreseeable harm to any person (yourself or another person).
3. If you disclose a life-threatening, communicable disease, I may be obligated to alert an at-risk third party.
4. If I have reason to suspect that a minor-aged, developmentally disabled, or an elderly person is in danger of being abused or neglected. I am legally obligated to report this to the Department of Social Services.
5. If I am ordered to release confidential information by a court of law via subpoena.
6. If I need to share information with another professional for consultation, with a health care provider treating you in an emergency, or with other mental health professionals when necessary to coordinate your care. These professionals are also obligated to maintain confidentiality.

Emergencies, Phone Sessions, and Email

In the event of an emergency, please dial 911 or go to the emergency room. If you cannot reach me immediately by telephone during a crisis, you or your family should contact the **Resolve Crisis Network at 1-888-796-8226**. As a private practitioner, I am not on call or available 24 hours a day. Often, I am with clients or away from my phone. I generally try to return messages within 24 hours with the exception of weekends and holidays/vacations. If you need a higher level of services than I am able to provide as a private practitioner, I can offer a referral to a more appropriate

agency. I generally do not offer phone sessions except in crisis situations, teleconferencing is a preferred method. Teleconferencing sessions, if necessary, will be billed to you at the same rate as your regular session. Communication via email will be brief and not contain confidential information as this method of communication offers limited appropriate dialogue in an emergency situation.

Emergency Contact Information

If there is an emergency during the time we are working together, or if I become concerned about your personal safety, I am required by law and the ethics of my profession to contact someone close to you. By completing this section, I authorize Colin O'Grady, LPC to contact my designated emergency contact person in the event of an emergency or if he suspects threat of harm to self or others. Please write the name and contact information of your chosen contact person in the space provided below:

Emergency Contact Name:_____

Address: _____

Phone: _____

Relationship to you: _____

Request for Services

I understand I may ask questions about this disclosure and the counseling process at any time. I may also discontinue services at any time. By signing below, I acknowledge I have read (or have had it read to me) and understand this disclosure and I am requesting counseling services from Colin O'Grady, LPC.

_____ _____

Client Signature (14 and older) Date

_____ _____

Counselor Signature Date

Consent for Treatment of Children or Adolescents (If Applicable)

I/We consent that _____may be treated as a client under the care of Colin O'Grady, LPC. At times, it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children.

Signature(s)_____

Date_____

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Adult Intake Form

Today's date: _____

A. Identification

Your name: _____ Date of birth: _____Age: _____

Social Security #: _____Sex:_____

Home street address: _____Apt.: _____

City: _____State: _____ Zip: _____

Home/evening phone: _____Cell Phone:_____

Work Phone:_____Other:_____

e-mail: _____

- By including your email address, you are granting permission that I communicate with you by email. Because email is not a secure form of communication, I am unable to ensure the confidentiality of information transmitted by email.
  Calls or e-mail will be discreet, but please indicate any restrictions:

Preferred method of communication (Please circle one): Home Work Cell Email

Marital status (Circle): Married Single Divorced Separated

Employment Status (Circle one): Full Time Part Time Retired Disabled Other_____

B. Insurance Information

Name of company**:**_____ Group number:_____

ID#:_____

Name and DOB of subscriber (if different from you):_____

Your current employer: _____

What level of education have you completed? _____

Emergency Contact Information:

Name:_____Telephone Numbers:_____

Relationship:_____

C. Medical History

1. Starting with your childhood and extending to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/Diagnosis	Treatment Received	Treated by	Result

2. Describe any allergies you have. Please list the allergy and related physical reaction.

_____

_____

3. List *all* medications, drugs, or other substances you take or have taken in the last year—prescribed, over-the-counter vitamins, herbs, and others.

Medication/drug	Dose (how much?)	Purpose of Medication	Prescribed and Supervised by

D. Medical Providers

Has a medical doctor treated you within the last 6 months? ❑ Yes ❑ No

If yes, for what condition?_____

Has your physician referred you? ❑ Yes ❑ No

Primary Care Physician:_____ Phone_____

Psychiatrist:_____ Phone _____

(if applicable)

Other Physicians:_____

E. Mental Health History

Have you ever participated in therapy? ❑ Yes ❑ No

If Yes, for how long?_____ Which years?_____

Names of former Therapist/s:_____

Have you ever been hospitalized for a mental health related concern? ❑ Yes ❑ No

If yes, at what hospital?_____ When?_____

Are you currently having suicidal thoughts? ❑ Yes ❑ No

If yes, please
explain_____

Have you had suicidal thoughts in the past? ❑ Yes ❑ No

If yes, please
explain?_____

Are you currently having homicidal thoughts? ❑ Yes ❑ No

If yes, please
explain_____

Have you had homicidal thoughts in the past? ❑ Yes ❑ No

If yes, please
explain_____

Do you currently drink alcohol? ❑ Yes ❑ No Amount:_____ Frequency:_____

Do you use tobacco products? ❑ Yes ❑ No Type(s):_____Frequency:_____

Do you use other substances? ❑ Yes ❑ No Type(s):_____Frequency:_____

Please list all medications and supplements that are currently taking. Include dosages:

_____
_____
_____
_____

What are the current stressors and related concerns affecting your mental health at this time?

_____
_____
_____
_____
_____
_____

Is there a history of depression, anxiety or other mental health concerns in your family? ❑ Yes ❑ No

Family member:	Condition:
_____	_____
_____	_____
_____	_____

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

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Client's Right and Responsibilities Statement

You have the right to: (please check each box)

❑ be treated with dignity and respect.
❑ fair treatment regardless of race, gender, ethnicity, age, disability or source of income.
❑ have treatment and other member information kept private only to be disclosed in an emergency or required by law.
❑ information from staff/providers in a language that you can understand.
❑ have an easy to understand explanation of your condition and treatment.
❑ share in the formulation of your plan of care.
❑ be informed of all treatment options regardless of cost or if they are covered or not.
❑ information about providers.
❑ know the clinical guidelines used in providing and/or managing your care.
❑ know about the complaint, grievance and appeal process.
❑ know about the State and Federal laws that relate to your rights and responsibilities as a client.

You have the responsibility to:

❑ give providers the information needed to provide the best possible care.
❑ let the provider know when the treatment plan is no longer working for you.
❑ follow your medication plan. You are expected to tell your provider about medication changes.
❑ treat those providing you care with dignity and respect.
❑ keep your scheduled appointments (Please see cancellation policy for further details).
❑ ask your providers questions regarding your care. This is so you can understand your care as well as your role in that care.
❑ inform your provider about any problems with paying fees.
❑ follow the plans and instructions for your care. The care that is to be developed and agreed upon by you and your provider.

I read the above statement and a copy was given to me.

Signature

_____Date_____

_

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Notice of Practice's Policies and Procedures to Protect the Privacy of your Health Information

I. THIS NOTICE DESCRIBES HOW TREATMENT INFORMATION ABOUT YOU:

A. MAY BE USED AND DISCLOSED AND

B. HOW YOU CAN GET ACCESS TO THIS INFORMATION SHOULD YOU SO DESIRE.

*** PLEASE REVIEW IT CAREFULLY.**

II. IT IS OUR LEGAL DUTY TO SAFEGUARD YOUR "PROTECTED HEALTH INFORMATION" ("PHI").

A. By law we are required to insure that your PHI is kept private.

B. The PHI constitutes information created or noted by us that can be used to identify you. It contains data about your past, present, or future health (including mental health) or condition, the provision on health care (including counseling) services to you, or the payment for such health care.

C. We are required to provide you with this Notice about our privacy procedures. This Notice must explain when, why, and how we would use and/or disclose your PHI.

- Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice;
- PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside our practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practice described in this Notice. Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Should we make any significant changes to our policies, we will immediately change this Notice and your therapist will have it available for your viewing. You may also request a copy of this Notice from us at any time.

III. HOW WE WILL USE AND DISCLOSE YOUR PHI.

We will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of our uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations that *Do Not* Require Your Prior Written Consent. We may use and disclose your PHI without your consent for the following reasons:

- **For treatment.** PHI can be shared with this practice (Colin O'Grady, LPC) to provide you with mental health treatment, including discussing or sharing your PHI with Oakmont Psychotherapy therapists, staff and supervisors, trainees and interns. Example: We may discuss your treatment with a supervisor or consult with another Oakmont Psychotherapy Associates therapist in order to facilitate your care.
- **To obtain payment for treatment.** We may use and disclose your PHI to bill and collect payment for the treatment and services we provide you. Example: We might send your PHI to your insurance company or health plan in order to get payment for the health care services that we have provided to you. We could also provide your PHI to business associates, such as an office manager/administrative assistant, billing companies/billing specialists or collection companies.

- **Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that we attempt to get your consent after treatment is rendered. In the event that we try to get your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) but we think that you would consent to such treatment if you could, we may disclose your PHI.

B. Certain Other Uses and Disclosures that *Do Not* Require Your Consent. We may use and/or disclose your PHI without your consent or authorization for the following reasons:

- **Serious Threat to Health and Safety:**
  If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or others, and if we determine that disclosure is necessary to prevent the threatened danger. If you express a serious threat to kill or seriously injure yourself or a readily identified person or group of people and we determine that you are likely to carry out this plan/threat we are required to take reasonable measures to prevent harm and assure safety. This may include directly advising a potential victim of the threat or associated intent.
- **Child abuse:** If we have reasonable cause to believe, based on our professional judgment, that a child with whom we have contact in a professional capacity is being abused. In these cases, we are required, by law, to report this to the Pennsylvania Department of Welfare.
- **Adult or Domestic Abuse**
  If we have reason to believe that an older adult is in need of protective services due to abuse, neglect, exploitation, or abandonment, we may report the information to the Allegheny County Area on Aging.
- **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.**
  Should you be involved in a court proceeding and a request is made for your protected health information, this information will not be disclosed without your written consent or a court order as this information is privileged under Pennsylvania state law. The privilege does not apply to when being evaluated for a third party or the evaluation is court ordered. Should these concerns be applicable, they will be discussed with you in advance of services being provided.
- **For Workers' Compensation purposes.** We may provide PHI in order to comply with Workers' Compensation laws. This may include periodic reports to your employer which may include history, diagnosis, treatment details and progress.
- **If disclosure is otherwise specifically required by law.** Example: If compelled by U.S.Secretary of Health and Human Services to investigate or assess our compliance with HIPAA regulations, or compelled to comply with a lawful subpoena.
  There are additional disclosures of PHI that we are required and permitted by law to make without your consent or authorization. The ones listed above are the most common.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. While we will consider your request, we are not legally bound to agree. If we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.

B. The Right to Amend Your PHI.

You have the right to request that your PHI information be amended for as long as the PHI information is maintained in the record. Your request and the reason for the request must be made in writing. We may deny the request. At your request, we will discuss with you the details of the amendment process.

C. The Right to Get a List of the Disclosures We Have Made. You are entitled to a list of disclosures of your PHI that we have made that did not require your consent or authorization (as described in section III). Upon your request, we will discuss the details of the accounting process.

D. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in our possession, or to get copies of it; however, you must request it in writing. Under certain circumstances, we may decide that we must deny your request, but if we do, we will give you, in writing, the reasons for the denial. We may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, in advance.

E. The Right to Choose How We Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). We are obliged to agree to your request providing that we can give you the PHI, in the format you requested, without undue inconvenience. We may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

Emergencies, Phone Sessions, and Email

- In the event of an emergency, please dial 911 or go to the emergency room. If you cannot reach me immediately by telephone during a crisis, you or your family should contact the **Resolve Crisis Network at 1-888-796-8226**. As a private practitioner, I am not on call or available 24 hours a day. Often, I am with clients or away from my phone. I generally try to return messages within 24 hours with the exception of weekends and holidays/vacations.
- If you need a higher level of services than I am able to provide as a private practitioner, I can offer a referral to a more appropriate agency. I generally do not offer phone sessions except in a crisis situation because I have found face to face interactions to be more effective. Communication via email will be brief as this method of communication offers limited protection of confidentiality.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such a change, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you at our next therapy session.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If, in your opinion, we may have violated your privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint, please send it to Colin O'Grady, LPC, Maxon Towers, 6315 Forbes Ave. Suite B-15, Squirrel Hill, PA. 15217. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about our privacy practices, we will take no retaliatory action against you.

Colin O'Grady, LPC, LLC

Acknowledge of Receipt of Notice

I acknowledge that I received the Notice of Privacy Practices

6301 Forbes Ave. Suite 240, Squirrel Hill, PA. 15217

Client name (Please Print)_____

Signature of client (14 and over)_____Date_____

Personal representative information (if applicable)

Name (Please Print)_____

Signature of client's representative:_____Date_____

Relationship to the client:_____

Email:_____

- By including your email address, you are granting permission that I communicate with you by email. Because email is not a secure form of communication, I am unable to ensure the confidentiality of information transmitted by email.

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Cancellation, Makeup and Attendance Policy

Non-emergency cancellations require 24 hours' notice. Non-emergencies include vacations, preplanned medical appointments, family events, parties, sports events, lack of babysitter or anything that is not designated as "emergency" (see below). The session must be canceled no later than 24 hours before the appointment. If non-emergency cancellations become excessive, the client may lose his or her weekly slot in the clinician's schedule. ***If the session is not canceled with 24 hours' notice, you will be billed $60*** for that missed session.

Emergency related cancellations require as much notification as possible. Emergency cancellations are accepted only for illness, illness of a family member, death in the family or inclement weather. Please do not come, or bring your child, to the office with a fever, strep, unidentified rash, diarrhea, vomiting or any highly contagious illness. You or your child must be fever-free for 24 hours prior to the session as to avoid spreading this illness to others at the practice. We offer make-up sessions, as they are in the client's best interest. Make-up slots are offered for emergency related cancelations.

Because this office holds a time for your session, you are essentially promising to fulfill that slot. We take careful attendance. **If you exceed a cancellation rate of 25 percent or higher you are at risk of losing your time slot**. This policy includes emergency, non-emergency and vacation cancellations.

By signing this statement, I am indicating that I have a clear understanding of this policy and agree to the associated terms.

Client Name **(please print)**_____

Signature _____Date_____

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, request and authorize _____

to release certain confidential information from my file to:

NAME:

ORGANIZATION:

ADDRESS:

Purpose of disclosure:

Material to be released:

My signature indicates that I have read this form and/or have had it read to me. I know what information is to be disclosed and am aware of all consequences related to disclosure of the material.

I am able to revoke this consent (in writing or verbally) at any time. This consent form expires on

_____ (date) unless revoked by me prior to this date.

Client's name (printed) _____

Client's signature _____ Date_____

Witness signature _____Date _____

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Permission to Contact Primary Care Physician (PCP).

It is important that all healthcare providers work together to best serve you. Many health insurance companies and managed care organizations request that our office have communication with your PCP for the purposes of

quality of care and effectively meeting assurance standards. Most often, this communication consists of diagnostic information and treatment recommendations. You have the right to refuse this consent for communication.

Below, please ***grant*** or ***decline*** permission for Colin O'Grady, LPC to contact your PCP's office and release health information. Should you wish to grant permission, please print and sign your name below as well as write your PCP's name, address and contact information where indicated.

PCP information

Name _____

Address _____

Telephone _____

❑ I would like to **Grant** Consent

Print Name

_____

Signature

_____Date_____

❑ I would like to **Decline** Consent for Colin O'Grady, LPC to release information to my PCP

Print Name

_____

Signature

_____Date_____