Jo Ann Kaminsky, MEd, LPC, ATR-BC, RPT-S
2227 N College
Fayetteville, AR. 72701

Office Policy

Appointments

Welcome to my care. I will do my best to treat our time with respect. If I need to cancel an appointment, I will give you 24 hours' notice, unless there is an emergency. Your therapy time is reserved for you. If you need to make a change, please make rescheduling arrangements before 24 hours of your appointment. Late notification will result in your being charged a $130. fee. Unexpected illness and emergencies sometimes do occur and exceptions will be made.

Office Information

Please enter through the middle door and turn to your right where the waiting room is. Parking is in the gravel drive and parking spots in front and on the side of the building. There is a large parking spot in the front that can accommodate a van with a wheelchair. For your child's safety please do not allow your child to play on the playground unattended. In case of inclement weather, the office will be closed when the local schools are closed.

Emergencies You may reach me at (479) 587-1387 (message machine available), or my cell at 479-283-2449.Texting is through Signal. If you have an emergency and cannot reach me call the Crisis Center, adult Hotline 1-888-274-7472. Teen Hotline 1-800-798-8336. If I should be out of town at any time, I will leave the name and number of another therapist who will be available to you in case of emergency.

Payment of Fees

All fees are payable in full at the end of each therapy session. Payment of fees is your responsibility, not the insurance company's. By special arrangement, you may pay your co-pay at the time of treatment and I will file for the remainder. In either case, you are ultimately responsible for payment of all fees. If you or your family member is a victim of a crime your bill will be submitted to the Arkansas Crime Victims Reparations Board and you will not be required to pay for services unless your claim is not approved. Your counseling services will begin immediately with the assumption that your case will be approved. There may be occasions when your insurance company or managed care facility refuses to authorize additional treatment. In such situations we will discuss your ability to pay for therapy on your own and explore options for continuing your treatment. These options may

include, but are not limited to, decreasing of treatment, utilizing peer support groups, moving you into a group therapy setting or providing referrals to sliding scale facilities. You may pay through square, Paypal, Venmo personal check or cash. Please make all payments payable to Jo Ann Kaminsky. One hour of individual therapy is $ 130.

Telehealth

Although most counseling will be provided in person, there is an option to have sessions through telehealth or distance counseling. Services will be provided through a secure platform used by the counselor, either Zoom or vptherapy360. Both are comfortable and easy to use. With zoom you will be invited to join a meeting and with vptherapy you will be sent a link through text or email. You will need to have a computer with Chrome or Firefox to be able to receive the information. For safety I will need to verify your whereabouts at each session and begin with a coded question to make sure it is a safe time for counseling. Examples of verification means include the use of code words, phrases or inquiries. (For example, “Is this a good time to proceed?”)

If you travel out of the state, distance counseling may not be available, depending on state laws.

Occasionally technology breaks down and in that case we will be in contact by phone. I will attempt to help work out the issues, but session may need be conducted by phone for the short term.

Despite the use of reasonable security safeguards, distance service recipients need to know that there are potential risks of distance communications. Not the least of these considerations is about entering private information when using a public access or computer that is on a shared network. Don’t use “auto-remember” user names and passwords. You should also consider employers’ policies relating to the use of work computers for personal communications.

Before telehealth begins there will be a screening process to determine if it is an appropriate option. Potential problems may be technological or may have to do with the specific mental health issues we are working with, or lack of safety to conduct distance therapy. In some cases counseling over the phone will be done also.

Communications

Text communications will be through Signal, You will be invited to Join free. Special codes will be implemented to be sure the right people are connecting. Email communications will

be to joannkaminsky@joannkaminsky.com. This is a secure encrypted email. Any written communications will be part of your record.

Social Media Policy

For your protection, it is a goal for counselors to avoid a relationship outside of a counseling relationship with clients. That is an ethical policy that keeps clients form being taken advantage of in any way and helps keep the therapeutic relationship separate. That means that I don't try to sell you a truck or a piece of property, unfortunately it also means that it's better not to spend time socially. In a small town that is sometimes unavoidable but that's the general rule. This also means that I will not be able to accept your friend request on Facebook or linked-in. I don't tweet or use other social media. I will have a professional Facebook page and you are welcome to connect in that way.

Confidentiality

Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled bylaw. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosures of your records or testimony is required by law you will be responsible for and shall pay the costs involved in producing the records and the therapist's fee for the time involved in giving testimony, travel, and reviewing records. Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: Child abuse, abuse of the elderly or disabled, abuse of patients in mental health facilities, sexual exploitation, child custody cases, suits in which the mental health of a party is in issue, situations where the therapist has a duty to warn or disclose, fee disputes between the therapist and the client, and in a negligence suit brought by the client against the therapist. By signing this information and consent form you are further giving your consent to the undersigned therapist to contact any person the therapist deems reasonably necessary to protect you or a third party from harm including but not limited to the following person(s).

Name	Address	Phone Number

Notice of Privacy Policy-As required by the Federal Regulations

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

Policy: This information is provided to you in response to federal regulations that took effect April 14, 2003. These regulations were issued by the Department of Health and Human Services of the U.S. Government in response to a law called "HIPAA" which was passed in 1996. I care about your privacy and will always do whatever is necessary to protect it. These regulations are about the privacy of your health and personal information know in the regulations as "Protected Health Information", or PHI. In the process of providing you with proper counseling care and services, I will collect, use, and share certain information you have provided. This policy explains how I collect and how I use your information. It also describes your rights as they relate to your PHI, and states how I protect the security and confidentiality of your information. Collecting Information: I can disclose PHI without an authorization from you under these circumstances:

- For treatment purposes, such as to your physician, a hospital, or another therapist who may be involved in treatment.
- For payment purposes, such as to your insurance company or other third party-payer.
- For health-care operations, such as to set-up or confirm appointments, or share your PHI with my employees if they are directly involved in your care or if they otherwise have a business need to know about your PHI.
- To communicate with family members or friends who you designate as being allowed to receive this information, for public health reporting purposes,
- In cases of suspected abuse, neglect and domestic violence
- To avert a serious threat to health or safety
- For health oversight activities
- For workers compensation purposes
- To business associates-there are times I do business with other organizations called business associates such as answering services, collection agencies, etc. These organizations are required to sign agreements with us to safeguard and protect your PHI.

In all other cases, I will disclose your PHI only upon receipt of a proper authorization signed by you or your legal representative.

Your rights regarding your PHI: Although your PHI is the legal property of JoAnn Kaminsky. You have certain rights regarding PHI.
You have the right to:

- Obtain a paper copy of this notice of information practices upon request

- Inspect and copy your counseling record
- Amend your counseling record
- Obtain an accounting of disclosures of your counseling information made in the previous six years
- Request a restriction on certain uses and disclosures of your information
- Authorize individuals, including family and friends, access to your counseling information as it pertains to treatment, payment and/or health care operations
- Revoke your authorization to use or disclose counseling information except to the extent that it has already been disclosed

My responsibilities: I have the following responsibilities regarding your PHI:

- Maintain the privacy of your counseling information
- Provide you with this notice of my legal duties and privacy practices with respect to information I collect and maintain about you
- Abide by the terms of this notice
- Notify you if I am unable to agree to a requested restriction

I reserve the right to change my practices and to make new provisions effective for all PHI I maintain. Should my information practices change, I will prominently post the revised notice in my office and make additional copies available upon request.I will not use or disclose your counseling information without your authorization, except as described in this notice. I will also discontinue to use or disclose your counseling information after I have received a written revocation of the authorization according to the procedure included in the authorization.

There is also the possibility that even if we use only encrypted emails and secure texts and video services, we can't absolutely guarantee that things will work perfectly. Confidential information might be disclosed. If that happens I agree to do everything I can to mitigate the situation as soon as I know and tell you.

For more information or to report a problem: If you have a question, you may contact me at my office .If you believe your rights have been violated, you can file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.Room 509F
,HHH Building
Washington, D.C. 20201

If you have any questions regarding confidentiality, you should bring them to the attention of JoAnn Kaminsky when you discuss the matter further. By signing this information and

consent form you are giving your consent to the undersigned therapist to share confidential information with all persons giving your mental care services and payment for those services and you are also releasing and holding harmless the undersigned therapist from any departures from your right of confidentiality that may result.

I have read, understand, and agree to the policies above. I consent to treatment by Jo Ann Kaminsky. Should I decide to not undertake treatment by Jo Ann Kaminsky I may contact any of the referrals she provides me or give notice that I decide not to participate in any treatment at this time.

Client Signature_____ Date_____

Therapist Signature_____ Date_____

Parent if client is a minor_____Date_____