Professional Disclosure Statement

Information for Clients, Informed Consent and Agreement to
Enter into Mental Health/Substance Abuse Treatment Services with

Kimberly Skelton, LPCS, LCAS
Licensed Professional Counselor & Licensed Clinical Addiction Specialist
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Kimberly Skelton, LPCS, LCAS is an independently licensed clinician. Kim sees individual clients through her professional Limited Liability Company, Kimberly Skelton, PLLC; buprenorphine program clients through Willow Wellness and Recovery, PC; and intensive outpatient program clients through Widening Circles, LLC. I am a co-owner of both Willow Wellness and Widening Circles.

Provider Qualifications: Kim received her Bachelor of Arts degree in Psychology in 2003 and her Master of Arts degree in Community Counseling in 2005 from the University of Alabama. Additionally, she completed a post-master's addiction certificate program sponsored by the state of Georgia in 2009. In North Carolina, she is board certified as a Licensed Professional Counselor Supervisor (LPCS#9497) and a Licensed Clinical Addiction Specialist (#1862). Kim has worked as a therapist since 2005 and has been working in the helping profession since 2000. She is a member of the American Counseling Association and the Association for Creativity in Counseling.

Counseling Background: Kim is trained to provide professional, relevant and effective counseling services for adolescents, adults and families. Kim's areas of special interest include mood disorders, trauma and traumatic grief, addictions, gender and orientation concerns and spirituality. Kim has completed extensive training in Eye Movement Desensitization and Processing (EMDR), an evidence-based treatment for trauma. Kim's theoretical orientation is integrative in nature, drawing from a range of theories and practices. She has special training in expressive arts therapy and often incorporates the creative process as a tool for meaningful self-exploration and understanding.

Regarding addictions work, she is heavily influenced by Mindfulness Based Relapse Prevention and often weaves together education, support and experiential activities to facilitate learning and change. She often utilizes techniques from Dialectical Behavior Therapy (DBT) to teach mindfulness and distress tolerance skills. DBT combines standard cognitive-behavioral techniques for emotion regulation and reality-testing with concepts of mindful awareness, distress tolerance, and acceptance largely derived from Buddhist meditative practice.

Session Fees and Length of Service: It is important that you are informed and aware of all financial responsibilities regarding appointments. The Affordable Care Act as well as new laws regarding mental health and substance abuse treatment parity have impacted access to care for many.

Insurance Coverage: At this time, I am paneled with **Blue Cross Blue Shield.** For other insurance plans, I am happy to provide a "superbill" that you can submit to your insurance company for out-of-network benefits. Because insurance plans vary widely, you will need to consult with your policy to determine coverage and benefits.

Use of Diagnosis: Most insurance companies require a diagnosis of a mental-health or substance use disorder condition before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Fees:

Initial Appointment (60 minutes):	$100.00
Individual Therapy/EMDR/Couples Therapy	$100.00

Social Media/ Electronic Communication Policy: Email, texting, and other social media platforms are features of 21st century life. Cellular phone and internet communication provide quick and effective ways to communicate. However, it is very important to be aware of the risks of these types of communication, particularly the difficulty of maintaining the confidentiality of electronically transmitted communications, including email, texting, and other social media formats, and that using these technologies could risk your privacy. Social media pages are not intended for clinical interaction with current or prospective clients. Professional ethics explicitly prohibit me from "friending" or interacting with clients on any personal social media accounts.

Scheduling and Cancellations: Sessions available by appointment. There is no charge for cancellations made at least 24 hours before your appointment time). Late cancellations (less than 24 hrs) will be billed at half the session fee - $50 and no-shows are billed the full appointment fee.

Confidentiality: Pursuant to HIPAA and Federal Law 42 CFR, all of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our treatment relationship, with the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information.

Client 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 I amend your record; requesting restrictions on what information from your Clinical Records 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; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. I am happy to discuss any of these rights with you. In the case of my death or major medical incapacitation, all records will be accessed by Ilona Csapo, MD.

After Hours Support and Emergencies: If you are in need of emergency services, you have the following options:

- Go to the closest ER or call 911. Misson Hospital is located at 509 Biltmore Avenue, Asheville, NC and Pardee Hospital is located at 800 N. Justice Street Hendersonville, NC
- Contact RHA Mobile Crisis Vaya Health/ LMEat 1-800-849-6127 at any time.
- Detox units are available at the following locations:
  ARP-Phoenix/Neil Dobbins: 277 Biltmore Avenue, Asheville, NC / 828-253-6306
  Julian F. Keith Alcohol and Drug Abuse Treatment Center (ADATC): 201 Tabernacle Road, Black Mountain, NC / 828- 257-6200

When I will be away from the office for extended time, my voicemail message will reflect when I will return. If you have a life threatening emergency you should call 911 or go to the hospital of your choice. I check voicemails daily M-F and return calls within 24-48 hours, excluding weekends.

Complaints : Although clients are encouraged to discuss any treatment concerns with me, you may file a complaint with the organization below should you feel your provider has been in violation of any of these codes of ethics. Kim abides by the American Counseling Association Code of Ethics (http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx).

North Carolina Board of Licensed Professional Counselors
P.O. Box 77819 Greensboro, NC 27417
Telephone: 844-622-3572 or 336-217-6007 |Fax: 336-217-9450

Acceptance of Terms: We agree to these terms and will abide by these guidelines.

Print Client or Guardian Name: _____

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

Signature of Parent/Guardian if Client is a Minor:_____ Date: _____

New Client and History | Kimberly Skelton, LPCS, LCAS

Today's Date:_____/_____/_____

DEMOGRAPHICS

Name:_____Soc Sec #:_____-_____-_____

Sex/Gender:_____ Race: _____Marital Status:_____ Birth Date: _____/_____/_____

Employment:_____Height:_____ Weight:_____Hair Color: _____ Eye Color: _____

Spiritual/Religious Background:_____Sexual Preference:_____

Address:_____ City:_____ State:_____ Zip:_____

CONTACT INFORMATION PREFERNCES

Home phone #: _____Approval to leave voicemail?_____

Cell phone #: _____Approval to leave voicemail?_____ Text?_____

Email address:_____Approval to send email?_____

Primary Physician and contact information:_____

Emergency Contact Name and phone number:_____

Insurance Carrier: _____Subscriber Name:_____Relationship to you:_____

Subscriber ID:_____Group #:_____Date Issued:____/_____/_____

How did you hear about my counseling practice?_____

FAMILY BACKGROUND

Current living arrangement: _____You were raised by:_____

Family members you are close to now:_____

Children and their ages:_____

Describe your relationship with your parental figures while growing up:_____

If alive, describe them currently:_____

Please list any siblings, their ages and describe your current relationship with them:_____

_____

Briefly describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse/mental health: _____

Sexual/physical/emotional abuse:_____

MARITAL/SIGNIFICANT PARTNERSHIP HISTORY

Marital status: ___Single/never married ___Married ___Partnered ___Separated ___Divorced ___Widowed ___Living with someone

If currently married/partnered, when were you married/partnered? _____ If living w/someone, how long? _____

Describe your current relationship with your significant other:_____

EDUCATION

Last grade or degree completed:_____ Have a learning difficulty? If yes, specify:_____

Desire to continue education? _____Yes _____No In school now?_____If so, where?_____

EMPLOYMENT

Employer:_____Years on job:_____

If no job, when and where did you last work?_____Looking for work now? _____Yes _____No

Any job problems now? _____Yes _____No Explain:_____

Ever been fired? _____Yes _____No How many times:_____Reason:_____

Special Abilities or Competencies? _____Yes _____No Describe:_____

LEGAL HISTORY

Arrest Date	Charge	Convicted?	Sentence

Are you currently on Probation or Parole? _____Yes _____No Ending Date:_____

Are you involved in any lawsuits or have any upcoming Court dates? _____Yes _____No When?_____

MILITARY SERVICE ____N/A

Type:_____When:_____ Honorable discharge? _____Yes _____No

If not, why?_____ Describe any combat experience:_____

Are you troubled now by your experience in the military? _____Yes _____No

INTERESTS/ACTIVITIES/SUPPORTS/STRENGTHS

What are your interests and activities?_____

Do you feel you spend enough time on your interests or non-work activity? _____Yes _____No

Do you have adequate supports in your life? _____Yes _____No Who?_____

What do you consider your strengths? _____

MEDICAL HISTORY

How is your general health? ___Excellent ___Good ___Fair ___Poor

Any significant illnesses, injuries or major medical issues? ___Yes ___No Describe:_____

Current Medications Taken (List All):

Name Dosage Reason Prescribed and Date

_____

_____

_____

_____

_____

FOR WOMEN Number of pregnancies?_____Live births:_____Adoptions:_____Normal menstrual cycle? _____

Are you pregnant?_____Premenstrual syndrome?_____Menopause?_____Hormone therapy?_____

MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING AND TREATMENT HISTORY

Please circle any of the following that apply to you now or within the past month:

Depression	Increased alcohol use	Nervous/Anxious
Crying spells	Increased drug usage	Panic attacks
Hopelessness	Blackouts/memory loss	Can't concentrate
Relationship breakup	Withdrawal symptoms	Confusion
Loneliness	Financial worries	Mood swings
Emptiness	Loss of control in:	Racing thoughts
Loss of appetite	- alcohol/drug use	Fear of dying
Sleep disturbance	- overeating/bingeing	Job stress
Nightmares	- purging	Decreased activity
Thoughts of harming self	- yelling/breaking	Not seeing friends
Thoughts of harming others	- hitting people	Feel controlled
Suicide attempts/injuries	- endangering self	Feel talked about
Hearing voices	- endangering others	Guilt/shame
Seeing things others don't	- spending	Sexual problems
Unusual thoughts	- gambling	School problems

TREATMENT HISTORY

Types of Treatment Experiences	Total # of times	Date of Most Recent Time or Session	Location	Outcome
Medical Hospitalization (surgeries, etc)		_____/_____/_____		
Alcohol/Drug Treatment Inpatient and/or Outpatient (circle)		_____/_____/_____		
Mental Health Treatment Inpatient and/or Outpatient (circle)		_____/_____/_____		
AA/12 Step Meetings/ Support Groups		_____/_____/_____		

Have you ever attempted suicide or seriously harmed yourself? When?_____Describe:_____
Has anyone in your family attempted suicide?_____Completed suicide?_____Who/When?_____

Have you ever attempted to kill or seriously harm someone else? _____Who and when?_____
Describe:_____

Have you ever been the victim of physical, sexual or verbal abuse? Any other trauma?_____
Describe: _____

Have any family members had a history of mental illness or addiction? ___Yes ___No If so, describe illness (give diagnosis if known):_____

Family History of Criminal Activity or Violent Behavior?_____

Family History of Medical Problems?_____

ALCOHOL AND SUBSTANCE HISTORY: Please fill in the chart according to your past substance usage.

TYPE OF DRUG If certain type, please circle. Ex: cigarettes under nicotine or beer under alcohol	AGE OF 1ST USE	WHAT AGE WERE YOU USING IT REGULARLY	AVERAGE # OF DAYS USED EACH WEEK	AVERAGE AMOUNT USED DAILY	# DAYS USED IN PAST 30 DAYS	DATE LAST USED
Tobacco						
Nicotine (Cigarettes, Dip, Cigars, etc.)						
Alcohol						
Alcohol (beer/wine/liquor/moonshine)						
Cannabinoids						
Marijuana/Hashish						
Opioids						
Heroin (IV?_____)						
Opium						
Opioid Pain Pills Types_____						
Stimulants						
Cocaine						
Amphetamine (diet pills, ADHD meds such as Adderall, Ritalin, Concerta)						
Methamphetamine						
Benzodiazepines						
Ex: Xanax, Klonopin, Ativan Types_____						
Club Drugs						
GHB						
MDMA (Ecstasy or Molly)						
Rohypnol						
Dissociative						
Ketamine						
PCP and analongs						
Salvia Divinorum						
Dextromethorphan (DXM)						
Hallucinogens						
LSD						
Mescaline						
Psilocybin (mushrooms)						
Other Compounds						
Anabolic steroids						
Inhalants						
Other:_____						

Have alcohol and/or drugs ever caused problems in any of the following areas? family _____ employment _____
legal _____ emotional _____ social _____ financial _____ behavior _____ physical _____

Does a relative, loved one, friend, court or employer think so? ___Yes ___No Explain:_____

Are there other things not covered that you would like your mental health provider to know?_____

_____

What are your hopes for treatment?_____

Kimberly Skelton, LPCS, LCAS

25 Orange Street, Asheville, NC 28801

PRIVACY PROTECTION NOTICE

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This notice shall go into effect January 1, 2013 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

I. Preamble

A recent United State Supreme Court decision held that communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. **PHI consists of three (3) components: treatment, payment, and health care operations.**

Treatment refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you.

Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The **use** of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks within my office related to your care. **Disclosures** refer to activities you authorize which occur outside my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might by your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate form the overall "designated medical record."

"Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are my notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record."

"Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy

notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes.

Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of you care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your "designated mental health record."

You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service for my practice and refers to these people as "Business Associates." I do employ business associates to assist with my administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

I never release any information of any sort for marketing purposes.

V. Client's Rights and My Duties

You have a right to the following:

- The right to request restrictions on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;
- The right to inspect and receive a copy of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- The right to amend material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- The right to an accounting of non-authorized disclosures of your protected health information;
- The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). My duties as a Licensed Professional Counselor on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

VI. Complaints

I am the appointed "Privacy Officer" for my practice per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Kimberly Skelton, LPCS, LCAS, Privacy Officer

I, _____, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____

Client or Parent Signature (if client is a minor) Date

_____ _____

Provider Date

Authorization for Release of Protected Health Information

Patient Name:_____ DOB:_____ SSN: _____

I am either the person named above or someone who can legally act for the person. I hereby authorize Kimberly Skelton, PLLC to disclose to, receive from and communicate with the following person or facility in written, verbal and/or electronic format:

Person or Facility to Disclose/Receive to or from: _____

Address:_____

Phone Number:_____ Fax Number:_____

INFORMATION THAT MAY BE RELEASED/SHARED:

___Complete Health Record which may include demographic information, reason for referral, alcohol/drug and legal history, urinalysis and breathalyzer results, psychiatric evaluations, medication records, progress notes, attendance and progress in treatment, assessment results or diagnoses, service or treatment plan, discharge information) including information about communicable diseases such as HIV or other sexually transmitted diseases

OR

___**My health information** about the following treatment or condition:_____

Please check ONE: My health information for ____**ALL DATES** or _____**ONLY THE FOLOWING DATES:** _____

Reason:___Provide continuity of care ___Compliance with program ___Personal Use ___Legal Purposes
___Social security/disability ___Insurance/Managed care

- I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.
- If I elect to use insurance, I understand that my provider will communicate with my insurance company to provide information needed for me to utilize my insurance benefits.
- I understand that I may revoke this authorization at any time by notifying my treatment provider in writing, but if I do, it will not have any effect on any actions providers took before it received the revocation. Otherwise, this release of information is valid for one year from the signed date.

Patient Signature:_____Print Name:_____Date:_____
If you are not the patient, please state your authority to act for the patient:_____
Staff Signature:_____Date:_____
Date this authorization was revoked, if applicable_____