JEFFREYCIOLINO

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Statement of Understanding/ Informed Consent

The words "your counselor" in this document mean Jeffrey Ciolino M.A., LCPC.

This statement of understanding contains important information about my professional services, business policies, and Health Insurance Portability and Accountability Act (HIPAA). Under the HIPAA law, I am required to provide you with a Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI). After reviewing the statement of understanding, informed consent, and the Notice of Privacy Practices forms, please sign below, which will then represent an agreement between us. You have the right to revoke this agreement at any time in writing. I will honor the revocation unless I have already acted upon your previous authorization, or if there are obligations imposed on me by your health insurer in order to process or substantiate claims, or if you have not satisfied any financial obligations you incurred from my services.

Training and Approach to Therapy
I received my graduate degree in clinical psychology from Roosevelt University in Chicago in 2001 and became a Licensed Clinical Professional Counselor in 2006. I have worked in clinical settings since 1991 and have been in private practice since 2006.

I use a client-centered, strength-based, solution focused approaches to psychotherapy with a primary focus on empowering the client and helping the client be their own rescuer. I utilize empathy, empowerment, validation, insight, and humor in my therapy. I also focus on multiculturalism, gender roles/identity, developmental psychology, overcoming limiting social factors, solidifying life meaning, and striving for genuineness. At times, I may also use role plays, the empty chair technique, and utilize others in therapy if appropriate. Often in the course of treatment, I ask clients to complete therapy-based homework outside of the sessions.

Psychological Services I Provide
The purpose of psychotherapy is to help clients address various problems or issues within a supportive, comfortable, and private environment. I provide talk therapy with clients. Successful psychotherapy requires clients to make a honest active effort. This entails working on issues that are talked about during sessions, outside the office during everyday activities. Psychotherapy is a process that frequently requires time for changes to occur. The initial process of psychotherapy involves an assessment period that usually lasts for approximately 2-5 sessions. This period of time allows me to gain an understanding of your issues and to develop a treatment plan to address therapeutic issues most effectively.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. Please inform me if you experience these issues and I will do my best to address them. On the other hand, psychotherapy has also been shown to have benefits for people, including better relationships, solutions to specific problems, and significant reductions in feelings of distress. Often, during the course of counseling, additional problems may become identified which were not known by your counselor or by you at the onset of counseling and I will do my best to address these as they arise. However, there are no guarantees of what you will experience. Most clinicians, including myself, believe the benefits of psychotherapy outweigh the risks. If you have questions or concerns regarding your treatment or my procedures, we should discuss them during counseling. I will take such criticism seriously, and with care and respect. I will also provide you with referral information if appropriate.

Limits of Confidentiality
Your counselor will keep your counseling records and everything you discuss strictly confidential, except for matters pertaining to:

- Suicide or self-harm
- Harm to another person
- Physical/sexual abuse or neglect of minors, persons with disabilities, and the elderly
- Information about your diagnosis, dates of treatment, procedure codes, and office notes requested by your insurance company to process your claims
- Consultations with other appropriate mental health professionals regarding treatment decisions on your behalf. Your confidentiality is still protected during consultations by your counselor and such professionals.
- Court ordered disclosures
- In accordance with the law, I am required to report to the Department of Human Services (http://foid.dhs.illinois,gov/foidpublic/foid/) if you are determined to be a "clear and present danger," developmentally disabled, or intellectually disabled in order to regulate your access to firearms.
- Anything else required by law.

If a government agency requests the information for health oversight activities, I may be required to provide it to them. Additionally, if a client files a complaint or lawsuit against me, I may disclose relevant information regarding the client in order to defend myself. Finally, if you file a worker's compensation claim and I am rendering treatment in accordance with the provisions of Illinois Worker's Compensation law, I must, upon appropriate request, provide a copy of your records to your employer or the appropriate designee.

For individuals residing in a nursing home or residential facility, this consent permits me to consult with those directly involved in your care (i.e. attending physician, facility staff, family, etc.). Additionally, it allows me to review your medical records for pertinent information. These disclosures/access ensure comprehensive care and safety. I will note these disclosures in your Clinical Record. You have a right to revoke this consent, but it may limit my ability to work with you.

Confidentiality for Couples and Families
In relationship/couples/family/collateral counseling, participants will agree that there will be no confidentiality between parties in conjoint treatment and the counselor unless predetermined. This includes any contact made with counselor outside of the sessions. If requested and appropriate, individual members may also attend private sessions alone. Whenever a member attends a private session that is pre-defined as confidential, his or her disclosures are respected as confidential and every effort will be made by your counselor to keep confidentiality during subsequent conjoint sessions. However, keep in mind that inadvertent breeches in this type of confidentiality are possible during conjoint sessions and that you agree to the risk.

Billing and Payment
My hourly fee is $200 for individual counseling and for couples counseling. Each session is a 45-minute session with 15 minutes allotted for preparation and writing clinical notes. You will be expected to pay for each session at the time services are rendered, unless we agree to other arrangements. I charge this amount for other professional services you may need, though I break down the hourly cost if I work for periods of less then one hour. Other services may include telephone conversations, consulting with other professionals with your permission, preparation of treatment summaries, and the time spent performing other services you may request of me. Acceptable forms of payment include cash, check, Square Cash App, Apple pay, Chase Quickpay/Zelle, and Credit Cards. I require a credit card authorization be put on file to be used for any outstanding payments. I also charge a $50 fee for any checks that are returned or unable to be processed.

Payment schedules for unusual financial hardship are available upon request. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment and terminating treatment. When legal means are used to secure payment, I only release the client's name, nature of services provided, and the amount due.

Insurance Claims
If you have insurance coverage, it will usually provide some coverage for mental health services. I will fill out forms and be of whatever assistance I can to help you receive the benefits to which you are entitled; however, you are responsible for full payment of my fees. You should also be aware that the contract with your

insurance company requires that you authorize me to provide it with information such as diagnostics, treatment plans, or copies of your Clinical Record. I attempt to release the minimum information necessary for the purpose requested. Some insurance companies will not allow me to provide services after your benefits have ended. In such cases, I will assist you in finding another provider who can help you continue your treatment. By signing this informed consent for treatment you agree to allow therapist to release information to insurance companies as required for billing including electronic billing / data submission if appropriate. You also agree to authorize payment directly to the provider by your insurance carrier unless otherwise agreed upon and documented by therapist.

Communications, Cancellations and Missed Sessions
In order to coordinate treatment it is often necessary for me to leave you a message on your designated voicemail, email you on your designated email, or call/text you on your designated cell phone. I do my best to protect your confidentiality when leaving a verbal or written message. Signing this consent gives me permission to leave voice, text, and e-mail messages. If you do not want messages left for you, please notify me in writing. I would prefer to only use text messaging and email for scheduling, billing, or care coordination issues. A return text or e-mail is the only indication of me receiving the message. No therapeutic treatment will be provided via text messaging or email and a phone call is necessary to cancel an appointment.

Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advanced notice of cancellation. Most insurance plans will not pay for missed sessions so you will be responsible for paying $200 for every missed session. After two consecutive "no show' sessions, your relationship with your counselor may be discontinued. There may be exceptions if we both agree that you were unable to attend due to circumstances beyond your control.

On very rare occasions, an unforeseen circumstance beyond my control may cause me to have to cancel your appointment abruptly. In such case, I will contact you as soon as possible to reschedule or discuss appropriate action.

Professional Records
I am required by law and the standards of my profession to maintain Clinical Records, which contain Protected Health Information. All clinical records will be kept in a secure and locked manner and every effort will be made to keep records secure. These records include information about your reasons for seeking treatment, a description of ways your issues/problems impact your life, your diagnosis, treatment goals, progress towards goals, medical and social history, treatment history, past treatment records I receive from other providers, billing records, and reports to others such as your insurance carrier. Additionally, I will also keep Psychotherapy Notes. These notes are important for effective treatment and may include sensitive information that may be unnecessary to include in your Clinical Record. Insurance companies do not have access to Psychotherapy Notes without your authorization and cannot require you to provide such authorization as a condition of coverage or penalize you for your refusal.

Client Access to Records
You may access your records by submitting a request in writing. A separate request is needed for access to psychotherapy notes. I will charge you $1.00 per page to compile a copy of your record. Due to the professional nature of your treatment records, the contents may be misinterpreted or upsetting to untrained readers. To address this, my general policy is to prepare a treatment summary and recommend you review your summary/ records in my presence so we can discuss the contents. If you choose, I can also send them to another mental health professional of your choice. In cases where there is compelling evidence that access to your records would cause harm to you, I can limit the access you have to your records or portions of your record. I will document your request of records and the rationale for withholding some or all of the records in the file. In situations involving multiple clients, I will only provide individual clients with those parts of the records that relate directly to them and do not include confidential information related to any other client.

Closing Your File
As a client your file will be considered active and will remain open for 30 days following your last date of service. If there are no services provided after the 30th day, your file will be closed and your case will be considered terminated. Of course, you are welcome to again request services from your counselor at any time in the future. However, I do not have an obligation to provide services to you and if appropriate, referrals may

be made. I will retain your file for a period of seven years following the last date of service provided to you. After that seven-year period, your file will be destroyed in a professional and confidential manner.

Crisis Intervention
I do not provide crisis intervention as part of my private practice. If you experience an emergency or crisis, including but not limited to risk of harm to self or others, increased psychiatric or medical symptoms, unstable substance use, or feeling unsafe, please call 911 or go to the emergency room of the nearest hospital. If appropriate, you may also utilize crisis services such as the Advocate Illinois Crisis Line at (773) 296-5380. If you utilize crisis services, please notify me at an appropriate time.

Termination
Ideally, termination occurs when you have achieved all of your counseling goals and a therapeutic closure of your treatment was completed in the last session. However, should you miss a session and not contact me within 10 business days, your counselor will assume you are discontinuing therapy, will close your file, and consider you as a termination without closure. Termination can also occur if you would like referrals to receive other psychological services or if you or I believe you would benefit more from working with another professional. In these cases, I will provide you with referral information to the best of my ability and we can discuss any questions or concerns you may have.

Client Rights
Under HIPAA provisions, you are entitled to several rights. These rights include requesting I amend your record, requesting restrictions on what information from your Clinical Record is disclosed to others, requesting an accounting of most disclosures of Protected Health Information you have neither consented to nor authorized, determining the location to which protected information disclosures are sent, and having any complaints you make about my policies and procedures recorded in your records.

Client Informed Consent for Counseling Services

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release that information and other information necessary to complete the billing process. I agree to pay the fee per session. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me including providing information about referrals. I agree to undertake therapy with Jeffrey Ciolino, LCPC and know I can end therapy at any time. I understand I can refuse any requests or suggestions made by Jeffrey Ciolino, LCPC but that this may result in termination.

Your signature below indicates you read the information in this contract and agree to (individual/ couples/ relationship/ family/ group) therapy once a week or as scheduled with the initial sessions of therapy serving as an assessment period lasting approximately 2-5 sessions in order to develop a treatment plan. Your signature also serves as an acknowledgement that you received the HIPAA Notice form described above.

Name: _____ Date: _____

Witness: _____ Date: _____

Guardian or Parent: _____ Date: _____

Guardian or Parent (both signatures required if Client is between 12 and 17 years old.)
Guardian or Parent only (if client is under age 12).