Counseling Agreement for Clients of Wavecrest, a Counseling Ministry of Fellowship of the Inner Light
(Professional Disclosure Statement/Client Agreement/Consent for Treatment/HIPPAA Notice, and General Information)
Instructions: Please keep pages 1-5 for your records and bring your completed form on page 6 to your first session.

About Emily Bura, LPC, CSAC, CPSC

Counselor Qualifications and Areas of Practice

Emily Bura received professional training in Counseling and Psychotherapy through Old Dominion University, earning a Masters' Degree in Mental Health Counseling. She is a Licensed Professional Counselor in Virginia (LPC). Emily is a Certified Substance Abuse Counselor (CSAC), a Certified Pre-Admission Screening Clinician (CPSC) in the Commonwealth of Virginia. She is a member of the Master Clinicians' Group (MCG), a peer consultation and support organization serving licensed mental health clinicians in Virginia and North Carolina. Treatment at Wavecrest addresses the needs of individuals, couples, and families. Emily Bura practices as a generalist with areas of particular clinical interest in anger management, obsessive compulsive disorder, and relationships. She is accepting all ages, problems in living, and mental health diagnoses as described in the Diagnostic and Statistical Manual of the American Psychiatric Association

Theoretical Orientation

In order to appropriately address the needs of all clients, varied theoretical orientations (frameworks for practice) will be applied. Each approach will be selected on the basis of client presenting concern, symptomology, and evidence base supporting it as maximally beneficial to the client. Each approach that will be implemented is well established, researched, and respected therapeutic orientation.

What You Can Expect as a Client at Wavecrest Counseling

Counselor and Client Responsibilities and Expectations

Counseling /psychotherapy is most effective when it is a collaborative process. Within the first few sessions, we establish goals for your counseling and therapy and will use these goals to guide the course of our work. Part of this plan may include referral to another mental health or medical professional if there is a need for interventions we cannot provide. We will work diligently to provide you with compassionate and effective counseling and psychotherapy that are respectful of your life experiences and individual perspectives.

Your commitment includes consistently coming to your sessions, being fully engaged in the process, completing agreed upon tasks, being honest and forthcoming to the best of your ability, completing work both in and outside of our sessions, doing your best to explore your insights, problems, and needs in productive ways, and communicating concerns you may have about the counseling process. Together, we will strive to make each session a "safe place" to share thoughts and feelings, try new behaviors, and plan for the future. As you progress through counseling, you may find that you experience rapid relief of symptoms, or that your pain intensifies as you work through it. You may feel that you've made good progress, and then later feel that nothing has been resolved. Each of these experiences are normal and even likely as we work together to resolve problems and facilitate your growth. We ask that you commit to working through the difficult moments even as we celebrate those filled with success and hope. Our ultimate goal is that your counseling experience will provide you with an opportunity for growth and healing.

Role of Diagnosis

Your counselor uses the Diagnostic and Statistical Manual (5th Edition) published by the American Psychiatric Association (2013) to assist in defining any diagnosis we may determine to be appropriate to your situation. Diagnosis serves to provide a framework upon which we can view your situation and plan treatment. However, unless you authorize it, we do not disclose any information about you, (including your diagnoses) to anyone at any time.

Emergencies vs Urgent Services Requests

An Emergency is a life threatening event or need that may qualify for immediate intervention and/or hospitalization. If you have an Emergency, call 911 and have an emergency services unit respond to your location. If possible, call your counselor afterwards to advise of the circumstances and that the unit is on the way, or is on scene. In these circumstances, immediate medical intervention must be accessed to resolve the crisis. Afterward, a follow up appointment should be made with your counselor to address needs.
In contrast, an Urgent Services Request is prompted by events or circumstance that leads a client to believe that the counselor's services are needed in the short term. It is <u>not</u> an instance in which immediate intervention and/or hospitalization is required. If you have an Urgent Services Request, please call to request your counselor's next available appointment. Please be advised that this appointment may require you to be available during your work or school hours if there are no available appointments times that fit your schedule.

Phone Consultations

I do not provide on demand counseling over the telephone. If you are in need of immediate services, please call 627-LIFE or 911.

If You Have a Complaint
We believe in professional responsibility. If you think you have been treated unethically and cannot resolve this problem with us, we encourage you to contact the Virginia Board of Health Professions (800-533-1560) to lodge a complaint.

Parking, Wavecrest's Office Spaces, and Boundaries
Please park on the street in front of the Fellowship of the Inner Light with respect to driveways. If there is a need to park in the driveway (e.g. to preserve privacy), please inform us ahead of time so we can work with you to meet your needs. There are publicly posted schedules for on street parking requiring a permit. It is your responsibility to review this, and if necessary request a temporary parking permit at the start of your appointment. Please be sure to return the permit at the end of your session, another one will not be provided. You are welcome to enter via the main entrance, and sit anywhere in the lobby area. The Restroom is located on the first floor, second door on the left from the main entrance. We strive to create a peaceful environment that is conducive to our work. We will make every effort to accommodate your needs.

Scheduling, Cancellation, Communication Policies, and General Information

Scheduling, Length of Sessions, Cancellations
We schedule sessions with our mutual agreement. Sessions are 45-55 minutes in length unless otherwise agreed upon. If you are unable to keep an appointment, please cancel or reschedule at least 24 hours in advance to avoid being charged a missed appointment/late cancellation fee.

No Show/Cancellation Policy
Our goal is to manage our time wisely to serve our clients better. When timely (24 hours' or more notice) cancellations occur, it is possible to offer open appointment times to clients on the appointment waiting list. We sincerely appreciate your cooperation and understanding of the following policy, which is in effect to encourage timely notice of cancellations:
POLICY: Each No Show/ Late Cancel (with less than 24 hours' notice) has a specific related charge and outcome.

Instance	Charge	Notes
1	$35 weekday, $50 weekend*	At the next meeting there will be a verbal review of the No Show/ Cancellation Policy
2	$80 / $105*	Full review of No Show/ Cancelation Policy as written in this agreement.
3	$80 / $105*	The client will be automatically discharged from the practice, which will be classified as a *voluntary discharge elected by the client.* As a result of the client's voluntary discharge, Wavecrest is absolved of any responsibility to the client(s), including but not limited to agreements previously established in this document. Any scheduled services or appointments are cancelled.

The client agrees to having these charges made to their registered credit/debit card at the time of the missed appointment or thereafter. These charges may be appealed if extenuating circumstances exist that prevent timely notification of cancellation.

Inclement Weather/Community Emergency Closing Policy
In an effort to prioritize client safety, we close our office whenever Virginia Beach Public Schools close due to inclement weather or other community emergencies. If a weather or emergency event falls on a Saturday, we follow the closing schedule of Tidewater Community College. There may be alternatives available such as telehealth appointments, please contact Emily prior to your appointment if you desire to keep your appointment despite inclement weather.

Electronic Communications
Messages may be left on our voicemail or texted to our phone at any time. We respond texts and voicemails as soon as possible after they are received. Please indicate your preferred method of return communication in your message.
We do use both phone calls and text messages for scheduling and cancellation purposes. You may elect to text requests for appointments and cancellation notices (please understand that cancellations must be received by our office at least 24 hours before your appointment time, and that message delivery times can be affected by many factors).
Email and text messages are not useful methods of communication for counseling purposes. *Please do not send private or personal information to us via email or text. We cannot guarantee the confidentiality of any communication sent to us in these ways, nor can we guarantee that emails and texts will be received or read.* Likewise, we can't respond to questions or counseling needs described in emails or texts (ethical concerns and severe limitations created by security issues, time lapses, and potential technological problems make this problematic). Email is checked infrequently and is not a method for communicating needs.
Please, never use email or texting to communicate an Emergency, call 911.

Telehealth
Telehealth sessions are offered via doxy.me/wavecrest, a HIPAA compliant, secure internet-based platform. In case of technology failure, telephone call will be the alternate method of communication. Upon client preference, other methods may be used although clients opting to use other methods (facetime, whatsapp) understand and agree to accept any privacy risks this may create. Clients are responsible for maintaining a private space to participate in telehealth services. Clients will be required to disclose their current location and verify their identity at the start of every telehealth session. Wavecrest retains the right to refuse to offer telehealth

sessions to any client at any time based upon clinical judgement and will, in such cases, provide services in office or assist in linking the client with alternative treatment options.

Fee and Payment Policies at Wavecrest Counseling

Non-billing of Insurance
Wavecrest does not bill insurance for services rendered.

Inability to Pay at Time of Service
Payment is required in full at the time services are provided (unless other arrangements have been made in advance). However, we understand that there may be instances when a client is not able to pay at the time of service. Therefore, we have developed a simple means of helping clients receive services without incurring mounting debt or requiring debt collection protocols. In the event that you cannot make your payment at the time of your session, we offer you two options:

(1) Be seen at your scheduled appointment time after you agree to all of the following:
- a) Provide a valid credit card before or during your first appointment. (Please complete the authorization form your will find below)
- b) Agree to deliver to our office the full payment of the amount due within 7 days of your appointment date,
- c) Authorize us to charge the unpaid fee to your card if payment is not received within 7 days of any appointment,
- d) Authorize us to charge missed appointment fees to your card to avoid disruption of your counseling services.

OR

(2) Reschedule your appointment (at least 24 hours in advance of your appointment date and time) to a date when you can have your payment available at the time services are provided.

Defaulted Payments
We believe in the fairness and honesty of our clients and expect that we will be paid outstanding balances in timely ways. However, those few clients who default on payment of fees for services rendered are responsible for all legal and administrative fees related to collection on defaulted accounts. Your signature on this document signifies your agreement to this policy.

Wavecrest's Counseling and Related Services Fee Schedule (December 2020)

Counseling and Psychotherapy (for a standard appointment of 1-55 minutes)*	$80 / $105* weekends
Couples Therapy (for a standard appointment of 1-55 minutes)*	$80 / $105*
Family Therapy (for a standard appointment of 1-55 minutes)*	$80 / $105*
Off Site/In Home Counseling Services (for a standard appointment of 1-55 minutes)*	$180 / $250*

Legal proceedings (for example, court testimony) has a cost of $1050 per day or part thereof that the therapist is required to be present. Review page 5 for additional information. Document Requests : Letters, Record Requests, Record Summaries, Work, School, or FMLA Forms, Recommendations, Subpoena Duces Tecum Compliance, and other document requests $105 per hour or fraction thereof as required to create, compile, deliver or otherwise process the requested documentation.

In the event that we cannot complete any needed documentation during your scheduled appointment time, I will be required to do so outside of your regular session. Your credit/Debit card will be charged $105 per hour or fraction thereof for all documentation completed outside of your sessions. If you need me to complete documentation for you to assist you (letters to the court or to an employer, FMLA paperwork, documents required by your employer, etc.) Please request it at the beginning of your session so that we can attempt to complete the paperwork during your session time to avoid additional cost to you.

Records
Practitioners must maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:
1. Records of a minor child must be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child;
2. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or
3. Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION (HIPAA Notice)

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

As an LPC, I create and maintain treatment records that contain individually identifiable health information about you. This notice, among other things, concerns the privacy and confidentiality of those records and the information they contain.

Uses and Disclosures of Information without Your Authorization

Federal privacy rules and regulations allow me to use or disclose your personal health information (without your written authorization) to enable me to provide treatment to you, for related business purposes, to conduct health care operations, and to disclose your protected health information to any health care provider to facilitate their treatment activities.

Notice of privacy practices

This may include consultations or referrals with other licensed health care providers about your condition, the coordination and management of your health care among health care providers or a third party, and oversight organizations that work to ensure that services are provided in a manner that complies with applicable laws, regulations and professional ethics.

I may be required or permitted to disclose your personal health information without your written authorization in other circumstances including, *but not limited to the following*:

- When compelled by a court, board, commission, administrative agency, arbitration panel, or search warrant as long as the request is lawful and follows the guideless established by law and the regulations of the requesting entity.
- For the purpose of reporting the abuse of a protected population (child, elder, etc.), neglect or domestic violence to appropriate authorities.
- To report, in good faith, the need for additional services if I believe you have become a danger to your own safety or to the safety of other persons.
- To contact you to provide appointment reminders or information about alternatives or other health-related benefits and services that may be of interest to you.

Uses or disclosures of your personal health information (without your authorization) will be limited to the minimum necessary to accomplish the intended purpose of the use or disclosure.

Other Uses and Disclosures Requiring Your Authorization

In those instances when I am asked for information for purposes outside of the situations described above, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each revocation is in writing. Any revocation applies to only that information for which an authorization is required, and is not retroactive to any time prior to the date of the revocation.

Client's Rights and Therapist's Duties

You Have The Right To:

- Request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request. We will discuss this issue if this occurs.
- Request and receive confidential communications of your private health information by alternative means and at alternative locations.
- Inspect and/or obtain a copy of protected health information and billing records used to make decisions about you for as long as the protected health information is maintained in the record. I may deny your access to protected health information under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Request an amendment of protected health information for as long as the protected health information is maintained in the record. If requested, I will discuss with you the details of the amendment process. Please understand, however, that I am not required to amend the information in the record.
- Generally have the right to receive an accounting of any disclosures of your protected health information. On your request, I will discuss with you the details of the accounting process.
- Obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

My Duties:

I am required by law to maintain the privacy of your Personal Health Information and to provide you with a notice of my legal duties and privacy practices with respect to Personal Health Information. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you a copy of these revisions at the next appointment.

Complaints:

If you have a concern about the privacy of your records or any other element of this policy, you may complain to me, or to the Secretary of the U.S. Department of Health and Human Services. Please submit complaints in writing, to me or to the Secretary of the U.S. Department of Health and Human Services at the following address: U.S. Department of Health & Human Services 150 S. Independence Mall West - Suite 372 Philadelphia, PA 19106-3499 (215) 861-4441; (215) 861-4440 (TDD) (215) 861-4431 FAX

Policies Related to Court Appearances

(Subpoenas, And Other Requests for Your Therapist's Participation in Legal Proceedings of Any Kind)

The patient, by virtue of their signature below, acknowledges receipt of this policy and agrees to comply with the conditions stated herein.

I. The patient agrees that he/she has reviewed the Wavecrest Counseling Fee Schedule located in its Professional Disclosure statement and Implied Consent and authorizes payment for services as describe therein.

II. The patient agrees that he/she is responsible for and agrees to the following:
A)The patient authorizes the therapist to process payment in full via the Square Credit Card Processing application and the patient's "on file" credit card for:
-any charges resulting from any Subpoena for Witness or Subpoena Ducus Tecum naming the therapist.
-any charges resulting from involvement in proceedings involving the patient or his or her interests.
-any charges associated with the therapist being called uponin any other manner by the patient and/or any attorney, guardian ad litum, judge, or other officer of the court) to appear for any court or other legal proceeding.
-Any charges related to the above actions regardless of who requested the subpoena.

B)The patient acknowledges that if he/she did not request the subpoena and does not desire to have the therapist present in court, he or she should consider contacting his/her attorney to request that a Motion to Quash the subpoena be initiated.

III. The patient agrees that, if the therapist is required to deviate from her standard daily practice in any manner in response to a subpoena issued in a case involving the patient, the fees and permissions described herein apply.

IV. The patient agrees that the fees described herein are for any part of a day for each day that the therapist is required to be available for court or other legal proceedings whether the case is continued, dismissed, or otherwise disposed of, and whether the therapist testifies, does not testify, or is excused from the case.

V. The patient agrees to ensure that the initial $1050 payment for the first day of legal proceedings is received by the therapist at least three days prior to the date of the proceeding. The patient acknowledges that if this payment is not received as described, the therapist will be unable to appear on the patient's behalf.

VI. The patient authorizes the therapist to charge the patient's credit card an additional $1050 per day fee for any part of each additional day that the therapist is expected/required to be available for legal proceedings.

VII. The patient agrees that, if for any reason his/her payment cannot be processed or is otherwise not received by the therapist when it is due, the patient will accept full responsibility for all fees, damages, lost income, and legal costs associated with the therapist's absence from her practice and her efforts to recoup her compensation.

VIII. The patient agrees to ensure that any attorney or other Officer of the Court who is associated with his/her case is aware of these conditions so informed decisions can be made and the creation of unnecessary financial hardship is avoided.

IX. The patient authorizes the therapist to process payment for her participation in the patient's case if an attorney attempts to require the therapist's appearance when payment has not been received in advance as described herein,

X. In the event that the therapist is unsuccessful in recouping her fees for her involvement in any court or other legal proceeding, she will avail herself of all appropriate legal remedies to rectify the lack of payment. In the event that she must take legal action to receive payment, the patient agrees to pay all legal fees and other expenses related to recovering these funds.

If you have questions or concerns related to this Notice or its contents, please contact me. We are pleased to be of service to you.

I look forward to meeting you.

Credit/Debit Card Registration Form and Acknowledgment of Payment Policies

Client(s) Name(s): _____

Payment is expected in full at the time services are provided (unless other arrangements have been made in advance). Each client is required to submit a completed credit card registration form before services can be provided. To facilitate credit card processing, Ms. Bura will mark the letter "E" on the signature line on the Processing application's payment page in lieu of your signature. You agree to maintain an up to date, valid card in your file. Updates are automatically entered onto your existing credit card sheet. Your original authorization for use of your "on file" card immediately transfers to the new card information. Your signature below authorizes all actions described herein and signifies your agreement with the policies described in this and related documents. This permission can be revoked at any time upon your written request as long you have a "zero" balance owed or provides an alternate method of payment. Thank you very much for your understanding and cooperation.

Credit Card Information and Permission

Directions: Please complete this form and submit it to Wavecrest Counseling at your first session.

Cardholder's Name as listed on card: _____

Credit/Debit Card #: _____-_____-_____-_____ Expiration: mm/yy_____/_____

CVV Code: _____ (3-4# code/back of card) Billing Zip Code: _____ Type of Card: _____

Billing Address: _____ Phone: _____

Guarantor/ Cardholder Payment Authorization/Acknowledgements:
I understand that I am responsible for all fees for services provided to the client(s) at this practice. I have reviewed the Wavecrest Counseling Fee Schedule on page 3. I agree to pay fees as stated in this document at the time services are rendered. I understand that the card on file with be automatically charged for all document requests, and additional services, including but not limited to Releases of Information, court related services, as well as in events outlined in "No Show/ Cancellation Policy." It is the cardholder's duty to ensure that the card on file is valid and up to date, or to provide card information to the client so that they may ensure the same.

By my signature below, I certify that I have read, understand, and agree to abide by the payment policies of Wavecrest Counseling and authorize Emily Bura, LPC or her agent to charge outstanding fees as they occur (in accordance with the payment policies described herein) to the credit or debit card provided by me in this document.

Client/Parent/Guarantor Signature: _____ Date: _____

Client Options, Permissions, Acknowledgements

Client Attestation: I have read, understand, and agree to comply with the Wavecrest Counseling policies, and the No Show/Cancellation Policy and, the requirement to provide accurate and valid payment/ card information to Wavecrest. I also acknowledge receipt of a copy of the Wavecrest Counseling Notice of Privacy Practices for Protected Health Information (HIPAA Notice).

Acknowledgement of Policies and Signatures

By signing below, I certify that I:
(1) Have reviewed, understand, and agree to comply with all the policies found on pages 1-5 and of this disclosure statement/counseling agreement,
(2) Have reviewed the practice Payment Policies and have completed the associated credit card registration form and signature sheet on page 6 of this document. I am submitting my completed Page 6 at or before my first session,
(3) Have reviewed Wavecrest's Counseling and Related Services Fee Schedule on page 3. I agree to pay the fees as stated in this document at the time services are rendered,
(4) Have reviewed the Policies Related to Court Appearances on page 5. I agree to the conditions described therein, when applicable,
(5) Acknowledge Receipt of a copy of the Wavecrest Counseling HIPAA Notice on pages 3-4, and consent to treatment for myself or my minor child.

_____

Signature Client 1 Date

_____

Signature Client 2 Date