Break Free
CENTER FOR WELLNESS

Dr. Sharron Riley-Seymour
642 Hilliard Street, Suite 1316, Manchester, CT 06042
860-327-5790 ♦ Sharron@BreakFreeCenter.com

Hello,

Welcome to Break Free Center for Wellness, and thank you for allowing me to work with you. It is very important to me that you get the results you are looking for in your therapy and that your experience is a very positive one.

Before your appointment, please read the following practice policies and bring any questions you have to your appointment.

- Please review the Notice of Privacy Practices
- Please review and sign the Practice Policies
- Please review and sign the Informed Consent to Treatment Consent

Please also complete the Client Intake Form and Life Events Checklist to give me a better idea of how I can support you during our time together.

It's important these are reviewed and completed prior to your first appointment so that you can fully benefit from your scheduled time. I'm happy to discuss the details with you and answer any questions you may have before we begin our initial session.

I look forward to meeting with you!

Kind regards,

Sharron Riley-Seymour, PhD, LPC, CCTP
Break Free Center for Wellness

Notice of Privacy Practices

Effective 4/29/17

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The medical information we record and maintain is known as Protected Health Information, or PHI. We will not use or disclose your PHI without your permission, except as described in this notice. Please review it carefully.

Information regarding your healthcare, including payment for healthcare, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. §1320d et seq., 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2. Under these laws, the practice may not say to a person outside the practice that you receive services, nor can the practice disclose any information identifying you as an alcohol or drug abuser, or disclose any other PHI except as permitted by federal law. We reserve the right to change our practices and to make the new provisions effective for all medical information we maintain. Should our medical information practices change, we will amend this notice and post a notice of the changes, which will be made available to anyone upon request. This notice is effective as of March 1, 2014.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask to limit the information shared
- Get a list of those with whom your information is shared
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices You have some choices in the way that information is used and shared:

- Tell family and friends about your condition
- Provide mental health care

Other Uses and Disclosures Your information may be used and shared:

- As you are treated
- As your services are billed
- In compliance with the law
- To address workers' compensation, law enforcement, and other government requests
- In response to lawsuits and legal actions
- To avert serious threat to health or safety

Your Rights

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information by written request.
- A copy of your health information will be provided, usually within 30 days of your request, and may be charged at a reasonable fee.

Ask to correct your medical record

- You can ask to correct health information about you that you think is incorrect or incomplete. Your request may be declined, and you'll be notified as to why in writing within 60 days.

Request confidential communications

- You can ask to be contacted in a specific way (for example, home or office phone) or to send mail to a different address.

Ask to limit what is used or shared

- You can ask that certain health information for treatment, payment, or operations not be used or shared. This does not mean there will be automatic compliance to your request as it could affect your care.

Get a list of those with whom information is shared

- You can ask for a list (accounting) of the times your health information for six years prior to the date you ask was shared and who it was shared with, and why.
- All disclosures will be included except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. This appointment will be verified before actions are taken.

File a complaint if you feel your rights are violated

- You can complain if you feel your rights have been violated by contacting the office directly at (860) 327-5690 or Sharron@BreakFreeCenter.com.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- You will not be retaliated against for filing a complaint.

Your Choices

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

In these cases, your information is never shared unless you give written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes or treatment content

Other Uses and Disclosures

Treat you

- Your health information can be used and shared with other professionals who are treating you. Example: A psychiatrist is providing medications and you provide written permission to communicate with this prescriber.

Running of the practice

- Your health information can be used and shared to run the practice, improve your care, and contact you when necessary. Example: Health information about you is used to manage your treatment and services.

Bill for your services

- Your health information can be used and shared to bill and get payment from health plans or other entities. Example: Your information is given to your health insurance plan so it will pay for your services.

Address workers' compensation, law enforcement, and other government requests

- Health information about you can be used or shared for workers' compensation claims, law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law or for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

- Health information about you can be shared in response to a court or administrative order, or in response to a subpoena.

To avert serious threat to health or safety

- Your protected health information may be used and disclosed when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. Any disclosure, however, would be to someone able to help prevent the threat.

Practice Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Special Rules Regarding Disclosure of Psychiatric, Substance Abuse and HIV

For disclosures concerning PHI relating to care for psychiatric conditions, substance abuse or HIV-related testing and treatment, special restrictions may apply. For example, we generally may not disclose this specially protected information in response to a subpoena, warrant or other legal process unless you sign a special authorization or a court orders the disclosure.

Mental health information: Certain mental health information may be disclosed for treatment, payment and health care operations as permitted or required by law. Otherwise, we will only disclose such information pursuant to an authorization, court order or as otherwise required by law. For example, all communications between you and a therapist will be privileged and confidential in accordance with Connecticut and Federal law.

Substance abuse treatment information: If you are treated in a specialized substance abuse program, Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records. These records may be disclosed if:

1. You consent in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

HIV-related information: We may disclose HIV-related information as permitted or required by Connecticut law. For example, your HIV-related information, if any, may be disclosed without your authorization for treatment purposes, certain health oversight activities, pursuant to a court order, or in the event of certain exposures to HIV by personnel of the practice, another person, or a known partner.

Minors: We will comply with Connecticut law when using or disclosing protected health information of minors. For example, if you are an un-emancipated minor consenting to a health care service related to HIV/AIDS, venereal disease, abortion, outpatient mental health treatment or alcohol/drug dependence, and you have not requested that another person be treated as a personal representative, you may have the authority to consent to the use and disclosure of your health information.

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PRACTICE POLICIES AND TREATMENT CONSENT

Welcome to Break Free Center for Wellness! The decision to begin therapy can be a difficult one. By making this decision, you have made a commitment to your emotional well-being and to improving your relationships with others. Research has shown that individuals entering therapy achieve favorable results when they have a clear understanding of what to expect.

The following material will provide you with important information about professional services and business policies. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The Notice of Privacy Practices, which is attached to this agreement, explains HIPAA and its application to your personal health information. The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of the first session.

Counseling Services and Office Policies

Therapy calls for an active effort on your part. In order for treatment to be the most successful, you will have to work on things we talk about during our session at home. Additionally, your responsibilities include providing relevant, accurate, and complete information regarding your history, symptoms, complaints, medications, and current status. Please make your best efforts to make relevant information available if requested to do so (such as previous psychiatric evaluations, discharge summaries, etc.).

As your therapist, I have the responsibility to ask you questions about your family's history, as well as your thoughts, feelings, and actions. I also have the responsibility to provide you with direct information about treatment as well as clinical recommendations. If you choose to terminate treatment, I can assist you in developing appropriate options, unless you choose otherwise.

Session Fees:

- Intake (Diagnostic Assessment): $225.00
- Individual sessions (45-60 minutes): $180.00
- Couples or Family sessions (45-60 minutes): $200.00

The frequency of sessions depends on clinical need and can be discussed at your first session and re-evaluated at subsequent sessions. I require that you maintain a treatment schedule of at least one appointment per month to keep your case active.

Payments:
Co-payments and session fees are due at the start of each session. All payments for services are to be made by personal check, cash, or credit/debit/HSA cards. If your insurance company is being billed, I will make appropriate efforts to obtain payment. However, you as the client are ultimately responsible for any outstanding charges that are not covered. Please note that all clients are required to keep a card on file to ensure timely payment of co-pays and deductibles.

If you currently carry a balance that is more than 30 days old, we will discuss options to address this at the start of the next session, which may include:

1. Making a payment arrangement.
2. Pausing sessions to allow time for balances to be paid down/off (please note that I may not be able to guarantee the availability of your time slot if sessions are paused for an extended period).
3. Exploring other support options that are free or low-cost.

Late Cancellations and No-Show Policy:
If you need to cancel an appointment, please provide 24 hours' notice. Appointments canceled with less than 24 hours' notice will result in a missed appointment charge of $75.00. This fee will NOT be billed to your insurance and will be payable by you prior to the next session.

Additionally, after **three incidences** of late cancellations or no-shows, I will engage you in a conversation to assess whether this is the appropriate time for therapeutic support. While I will not terminate services, you will be released from any recurring schedule. This is to ensure consistency in treatment, which is necessary for effecting meaningful change.

Operation Adjustments:
There are certain circumstances that may result in an adjustment to operations, such as how or where sessions are conducted:

1. **Inclement Weather:** In the event of forecasted inclement weather, all sessions will be conducted virtually via the confidential client portal. Notifications will be provided as early as possible to ensure your safety and prevent any inconvenience.
2. **Health Concerns:** Public health (e.g., COVID-19) or other health concerns may also result in some or all services transitioning to telemedicine rather than in-person sessions. If you feel unwell, please utilize the ongoing privilege of virtual visits to ensure others are not impacted.
3. **Session Location Flexibility:** Clients have the benefit of alternating between virtual and in-person sessions at their convenience. However, I request 24-hour notice if you wish to change your session location to allow time for adjustments to scheduling and/or travel.

Additional Information:
Any requests for letters regarding clinical treatment or copies of records will be completed in a timely manner, no later than 30 days from the date the written request is received. The fee for copies of records is $.60 per page. Same-day requests will not be honored. Upon withdrawal from treatment or successful completion, a discharge summary will be generated, which you may obtain free of charge by written request.

If I am called to testify in court proceedings, the charge is $200 per hour, which includes travel time, as these services are outside the usual and customary practice and are not covered by insurance carriers.

Clinical topics and issues will not be discussed through text messaging or email. If you have clinical needs or concerns, please schedule an appointment. Text messaging and email communication will be limited to confirming and/or canceling appointments only. Messages are checked once daily, and I will do my best to return your call in a timely manner. If you are experiencing a clinical emergency, please utilize 211 for mobile outreach services, call 911, or go to your closest emergency department. My office does not offer on-call or after-hours services.

The therapeutic relationship is a collaborative and voluntary partnership. If at any time you feel treatment lacks direction or is not meeting your expectations, please begin a dialogue so we can address your concerns together. You have the right to be treated without regard to race, religion, sex, age, national origin, marital status, sexual orientation, and mental or physical disability. Additionally, I ask that you do not attend sessions under the influence of drugs or alcohol, or your session will be rescheduled. Furthermore, abusive language or physical aggression will not be permitted during session. These expectations reflect my highest regard for mutual respect, safety, and personal dignity. If no questions are asked by you, it will be assumed that all aspects of this contract are understood.

Limits to Confidentiality

The confidentiality of your records is highly valued. The law protects the privacy of communications between a client and therapist, though some situations are excluded by law. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets legal requirements imposed by HIPAA and/or other federal or state laws.

Limits to preserving confidentiality include the following:

- If you have a health insurance policy, it will usually provide some coverage for mental health treatment or assessment. If you choose to use this mental health coverage, your insurance company, external gatekeeper, and quality assurance committee may review your records for quality and/or appropriateness of care. Required information regarding the state of care may also be released to your insurance company to facilitate payment.
- If I know or have reason to suspect that a child under 18 years of age is being or has been abused, abandoned or neglected by a parent, legal custodian, caregiver or any other person responsible for the child's welfare, the law mandates that I file a verbal and written report with the Department of Children and Families. Once a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the client, other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim(s), and/or appropriate family member(s), and/or the police.
- If such a situation arises, I will make a reasonable effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

I HAVE READ AND I UNDERSTAND THE ABOVE INFORMATION AND BY SIGNING THIS FORM I ACCEPT AND FULLY AGREE TO BE TREATED ACCORDING TO THE ABOVE CONDITIONS AND CLIENT/THERAPIST RESPONSIBILITIES. I UNDERSTAND I HAVE THE RIGHT TO END TREATMENT AT ANY TIME.

Client Signature	Date
Therapist Signature	Date

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

In this document, "I", "me" and "my" refer to the client, and "Practitioner" refers to Sharron Riley-Seymour, LPC, CCTP.

I consent to the use or disclosure of my protected health information by Practitioner for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis, diagnosis or treatment of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Practitioner is not required to agree to the restrictions that I may request. However, if Practitioner agrees to a restriction that I request, the restriction is binding on the Practitioner.

I have the right to revoke this consent, in writing, at any time, except to the extent that Practitioner has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Practitioner and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Practitioner. This Notice of Privacy Practices also describes my rights and duties of the Practitioner with respect to my protected health information.

Practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Practitioner and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

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INTAKE FORM

GENERAL INFORMATION		
Partner 1: Full Name (Last, First, MI):		
DOB:	Age:	Gender identity:
Partner 2: Full Name (Last, First, MI):		
DOB:	Age:	Gender identity:
Partner 1: Address (street address, city, state zip):		
Partner 2 (if different): Address (street address, city, state zip):		
Partner 1 Phone #:	Phone # type? ☐ Cell ☐ Home	If cell, is it ok to text?
Partner 2 Phone #:	Phone # type? ☐ Cell ☐ Home	If cell, is it ok to text?
Initial if it is safe to contact you at the numbers above?		
Initial if it is okay for me to identify myself when calling you?		
Referral Source:		
Partner 1: Current Occupational Status (e.g. FT, PT, self-employed, student, unemployed:	Occupation:	
Partner 1: Employer/School:		
Partner 1: Emergency Contact:		
Partner 1: Emergency Contact Phone #:		
Partner 2: Current Occupational Status (e.g. FT, PT, self-employed, student, unemployed:	Occupation:	
Partner 2: Employer/School:		
Partner 2: Emergency Contact:		
Partner 2: Emergency Contact Phone #:		

PRESENTING INFORMATION
What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can?
How have you tried to alleviate or cope with the problem? How un/successful was it?

Please check any of the following you have experienced in the past 6 months. Please put "1" or "2" for the partner who experienced this symptom in the space provided.

- ☐ Increased appetite _____
- ☐ Decreased appetite _____
- ☐ Trouble concentrating _____
- ☐ Difficulty sleeping _____
- ☐ Excessive sleep _____
- ☐ Low motivation _____
- ☐ Hearing/seeing things
- ☐ Excessive drinking/smoking
- ☐ Isolation from others _____
- ☐ Fatigue/low energy _____
- ☐ Low self-esteem _____
- ☐ Depressed mood _____
- ☐ Tearful or crying spells _____
- ☐ Irritability
- ☐ Memory problems
- ☐ Substance use
- ☐ Anxiety _____
- ☐ Fear _____
- ☐ Hopelessness _____
- ☐ Panic _____
- ☐ Thoughts of hurting yourself
- ☐ Confusion
- ☐ Other: _____
- ☐ Other: _____

What are your goals for counseling?

Please check any of the following that apply. Please put "1" or "2" for the partner who experienced this symptom in the space provided.

- ☐ Headaches _____
- ☐ High blood pressure _____
- ☐ Gastritis or esophagitis _____
- ☐ Hormone-related problems ____
- ☐ Head injury _____
- ☐ Angina or chest pain _____
- ☐ Irritable bowel _____
- ☐ Chronic pain _____
- ☐ Loss of consciousness _____
- ☐ Heart attack _____
- ☐ Bone or joint problems ____
- ☐ Seizures _____
- ☐ Kidney-related issues _____
- ☐ Chronic fatigue _____
- ☐ Dizziness _____
- ☐ Faintness _____
- ☐ Heart valve problems _____
- ☐ Urinary tract problems ____
- ☐ Fibromyalgia _____
- ☐ Numbness & tingling _____
- ☐ Shortness of breath _____
- ☐ Diabetes _____
- ☐ Hepatitis _____
- ☐ Asthma _____
- ☐ Arthritis _____
- ☐ Thyroid issues _____
- ☐ HIV/AIDS _____
- ☐ Urinary tract problems ___
- ☐ Cancer _____
- ☐ Other: _____

What else would you like me to know?

MENTAL HEALTH HISTORY

Are you mandated to attend therapy? ☐ Yes ☐ No
If yes, by whom, and for what reason?

Have you seen a mental health professional before?
Partner 1:☐ Yes ☐ No
Please specify dates, reason for counseling and your experience?

Partner 2: ☐ Yes ☐ No
Please specify dates, reason for counseling and your experience?

Were you ever diagnosed with a mental health disorder?
Partner 1:☐ Yes ☐ No
Please indicate any previous diagnoses?

Partner 2:☐ Yes ☐ No
Please indicate any previous diagnoses?

Have you been hospitalized for a mental health issue?
Partner 1: ☐ Yes ☐ No
If yes, when, where, and for what reason?

Partner 2: ☐ Yes ☐ No
If yes, when, where, and for what reason?

Specify all medications and supplements you are presently taking and for what reason.
Partner 1:

Partner 2:

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.
Partner 1:

Partner 2:

Who is the primary care physician for both partners? Please include name and phone number.

Do you have suicidal thoughts?
Partner 1: ☐ Yes ☐ No
If yes, please describe.
Partner 2: ☐ Yes ☐ No
If yes, please describe.

Have you ever attempted suicide?
Partner 1: ☐ Yes ☐ No
If yes, please describe.

Partner 2: ☐ Yes ☐ No
If yes, please describe.

Do you have thoughts or urges to harm others?
Partner 1: ☐ Yes ☐ No
If yes, please describe.

Partner 2: ☐ Yes ☐ No
If yes, please describe.

Do you, or have you ever engaged in self-injurious behavior?
Partner 1: ☐ Yes ☐ No
If yes, please indicate if this is current or in the past.
Partner 2: ☐ Yes ☐ No
If yes, please indicate if this is current or in the past.

FAMILY/SOCIAL HISTORY

Please describe the nature of your relationship (e.g. dating, married, co-parents) and how many months or years you have been together.

If you have any child(ren), please provide their name(s), and age(s).

Child's name: Age:
Child's name: Age:
Child's name: Age:
Child's name: Age:
Child's name: Age:

Describe your current living situation. Do you live alone, with others, with family, etc...

Is there a history of mental illness in your family?
Partner 1: ☐ Yes ☐ No
If yes, please describe.

Partner 2: ☐ Yes ☐ No
If yes, please describe.

Is there a history of substance abuse in your family?
Partner 1: ☐ Yes ☐ No
If yes, please describe.
Partner 2: ☐ Yes ☐ No
If yes, please describe.

Do you have a history of verbal, physical, or sexual abuse?
Partner 1:
☐ No
☐ Verbal Abuse ☐ Past ☐ Current Which partner: _____
☐ Physical Abuse ☐ Past ☐ Current Which partner: _____
☐ Sexual Abuse Which partner: _____

Please indicate the age/range you experienced this: _____

Partner 2:
☐ No
☐ Verbal Abuse ☐ Past ☐ Current Which partner: _____
☐ Physical Abuse ☐ Past ☐ Current Which partner: _____
☐ Sexual Abuse Which partner: _____

Please indicate the age/range you experienced this: _____

History of significant losses:

Partner 1:

Partner 2:

SUBSTANCE USE/ABUSE HISTORY

Do you drink alcohol?

Partner 1: ☐ Yes ☐ No Type/Amount/Frequency:

Partner 2: ☐ Yes ☐ No Type/Amount/Frequency:

Do you use recreational drugs?

Partner 1: ☐ Yes ☐ No Type/Amount/Frequency:

Partner 2: ☐ Yes ☐ No Type/Amount/Frequency:

Do you smoke cigarettes?

Partner 1: ☐ Yes ☐ No Amount/Frequency:

Partner 2: ☐ Yes ☐ No Amount/Frequency:

Have you received treatment for any of the above substances?
Partner 1: ☐ Yes ☐ No
If yes, when, for what substance and for how long?
Partner 2: ☐ Yes ☐ No
If yes, when, for what substance and for how long?

Do you currently have concerns about alcohol or substance use?
Partner 1: ☐ Yes ☐ No
If yes, please describe:
Partner 2: ☐ Yes ☐ No
If yes, please describe:

LEGAL HISTORY

Do you have a history of legal involvement?
Partner 1: ☐ Yes ☐ No
Number of arrests: Nature of arrests:

Partner 2: ☐ Yes ☐ No
Number of arrests: Nature of arrests:

EMPLOYMENT HISTORY

Partner 1: Are you currently employed? ☐ Yes ☐ No

Occupation:	Years employed:
Educational level:	Degrees/Training:

Have you ever been involved in the military? ☐ Yes ☐ No Branch:

Partner 2: Are you currently employed? ☐ Yes ☐ No

Occupation:	Years employed:
Educational level:	Degrees/Training:

Have you ever been involved in the military? ☐ Yes ☐ No Branch: