Holly Yates, Psychotherapy: MS, LCMHC, Certified FAP Trainer
8524 Six Forks Rd Suite 101
Raleigh, NC 27615
(919) 931-3270
hyates99@gmail.com

POLICY AND PROCEDURES:

Appointments; Sessions are scheduled by appointment only. If an emergency arises outside of scheduled sessions please call 911 or go to your nearest Emergency Room

Files: A confidential case record is established for each client. A treatment plan will be developed with your input and will be reviewed and updated as necessary.

Fees: The fee for service is 150.00 for the initial 60 minute session and will be adjusted if the session is longer than 60 minutes.

Subsequent sessions are between 50-60 minutes and are 125.00-175.00 per session and will be adjusted if the session is longer than 60 minutes.

Payment is due on or before time of service.

Cancellation policy: In the event that you cannot make your scheduled appointment at least a 24 hour cancellation notice is required. Full fee will be charged if you don't cancel at least 24 hours prior to scheduled appointment.

If there is no cancellation and you don't come to your scheduled appointment it will be considered a "no show" and you will be responsible for the full fee.

If there are three "no show" missed appointments Client may be terminated.

I have read and agree to the above policies and Procedures:

Name of Client:_____

Signed:_____

Date:_____

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LIMITS ON PATIENT CONFIDENTIALITY AND PATIENT CONSENT

We required to discuss confidential information if any of the following conditions exist

1. You are a danger to yourself or others
2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime
3. Your therapist was appointed by the court to evaluate you
4. Your contact with a therapist is for the purpose of determining sanity in a criminal proceeding
5. Your contact is for the purpose of determining your competence
6. The contact is one in which your psychotherapist must file a report to a public employer or as to information required to be recorded in a public office, if such a report or record is open to public inspection
7. You are under the age of 16 and are the victim of a crime
8. You are a minor and your psychotherapist reasonably suspects you are a victim of child abuse or neglect
9. You are a person over the age of 65 and your psychotherapist reasonably suspects you are in danger of elder abuse or neglect
10. You die and the communication is important to decide an issue concerning a deed or conveyance , will or writing executed by you affecting an interest in property
11. You file suit against your therapist for breach of duty or your therapist files suit against you
12. You have filed suit against anyone and have claimed mental/emotional damages as part of your suit
13. You waive your rights to privilege or give your rights to limited disclosure by your therapist
14. Your insurance company that might be paying for services has a right to review records

IF YOU HAVE ANY QUESTIONS ABOUT THESE LIMITATIONS PLEASE DISCUSS THEM WITH YOUR THERAPIST

Clients Name_____

Signature_____

Date_____

RELEASE OF INFORMATION:

I authorize Holly Yates MS, LCMHC to contact my primary care physician _____

Or my psychiatrist_____ for continuity of care if deemed helpful or necessary

Signature_____

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

In 1996 Congress enacted a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your **Protected Health Information (PHI)** used for the purpose of treatment, payment and healthcare operations.

This regulation includes:

1. Patient's right to request restrictions on certain uses and disclosures of protected health information.
2. Patient's right to receive confidential communications by alternative means and alternative locations
3. Patient's right to inspect and copy the protected health information in the clinical report
4. Patient's right to amend the protected information
5. Patient's right to an accounting of the disclosure of protected information for which there has not been a previous consent (abuse reporting, duty to warn, harcourt ordered reporting)
6. Patient's right to receive a paper copy of notice of disclosures

Pursuant to **HIPPA,** the Therapist in this practice keeps protected Health Information about clients in a protected record.This clinical record includes information about client's symptoms, diagnosis, goals set for progress, any past treatment records from previous providers, reports of any professional consultations, billing, records, and any reports that have been sent to anyone, including reports to insurance companies.
As a licensed professional, I am required by law to maintain the privacy of your health information and to provide you with a notice of my legal duties and private practices, unless I notify you of my intent to change any of those practices with written notice, According to **HIPAA** law, I am not required to agree or comply with patient's rights numbered 1,3 and 4 of the above. If you have a concern that your privacy rights have been violated, I would encourage you to discuss this with me. If this is not satisfaction, you may send a written letter complaint to the Secretary of the US Department of Health and Human Services. That office can provide you with appropriate contact information.
This practice reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information. Clients will be provided with these revisions

Name of Patient:_____

Signature: _____. Date: _____

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CLIENT REGISTRATION FORM:

Client's full name:_____

Date Of Birth: _____

Home Address: _____

Home Phone:_____ Moblie Phone_____

Email Address:_____

Family Physician:_____

Emergency Contact:_____ Phone:_____

Billing Policy:

I understand that I am responsible for the full amount of my bill on or before time of service. I understand there is a 24 hour cancellation policy. Client will be responsible for the full fee if not cancelled at least 24 hours prior to session.

NAME:_____

SIGNATURE:_____

DATE:_____

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CLIENT RIGHTS

All clients are guaranteed the following rights and personal protections : Article 3 of the North Carolina Statutes defines clients' legal rights in receiving mental health, developmental disabilities or substance abuse services.

CLIENTS RIGHTS AND PROTECTION

* Clients have a right to a treatment plan and will participate in the goals of treatment
* Clients have right to refuse any service, treatment or referral to other professionals
* Clients have the right to confidentiality. Client written consent is required before any information can be released
* Sessions will not be video or audio taped without verbal and/or written consent from client

CONFIDENTIALITY

Information that the client shares in sessions is confidential and can only be released to another party by written consent of the client or guardian.

Exceptions to confidentiality

* Client presents a danger to themselves or others
* Alleged neglect or child abuse
* Court subpoena of clinical records

I **have read and understand the Clients Rights Statements above**

Clients Name:_____

Signature_____

Date_____

Professional Disclosure Statement

Holly Yates, MS, LCMHC, Certified FAP Trainer

THERAPIST INFORMATION: I am a North Carolina Licensed Clinical Mental Health Counselor (#4745). I am trained in ACT, Functional Analytic Psychology (FAP), CBT, and DBT. I am a Certified FAP Trainer, I train professionals in the community and internationally in Functional Analytic Psychotherapy (FAP) and Acceptance and Commitment Therapy (ACT) . I earned a Masters of Science in Mental Health Counseling from Nova SouthEastern University in Ft. Lauderdale FL and a Bachelors of Fine Arts from Ramapo College of New Jersey. I received my FAP Trainer Certification in 2017 from The University of Washington. I have been working as a Mental Health Professional for 20 years. I have worked with at risk youth and families providing outpatient therapy for emotional and mental health disorders. I have worked with military families and soldiers as an MFLAC as well as in private practice. I have been licensed in the state of North Carolina since 2004 and have been working in private practice for the last 18 years. I provide individual, group, and couples counseling to adults. My office is located in Raleigh, NC.

THEORETICAL ORIENTATION: My theoretical orientation is a mindfulness and acceptance based approach to therapy. Included now, in what is referred to as the Third Generation or Third Wave Cognitive and Behavioral Therapies, are FAP, ACT, DBT, MBSR, and MBCT. My training has been most specifically in FAP, DBT, ACT, and mindfulness practices. There is much research to support that many of the ways in which we have been taught to manage or solve problems has led, in fact, to greater suffering. Utilizing mindfulness and acceptance strategies allows for not only a change in perspective but a fundamental way in which we view our life and our personal experiences allowing for cognitive flexibility and values-based living. As your therapist I will help you to utilize these strategies according to your needs with compassion and kindness.

POLICIES AND PROCEDURES:

OFFICE HOURS: Appointments are scheduled by appointment only. Sessions are 50 to 75 minutes in length. If an emergency occurs outside of office hours please call 911 or go to your nearest emergency room and then call me so I can begin coordination of care

FEES AND CO-PAYS: The fee for service is $150.00 for the initial intake session and is up to 60 minutes in length. If the session runs over the 60 minutes fees will be adjusted

accordingly. Subsequent sessions are $125.00-175.00 for a 50-60 minute therapy session and if session run longer that 60 minutes fees will be adjusted accordingly. Payment is due and payable on or before the time of service. I accept Personal Checks, Cash, Zelle, Venmo and PayPal as forms of payment.

CANCELLATION: In the event that you cannot make your scheduled appointment, at minimum a 24-Hour notice is required or you will be charged full fee. If there is a missed appointment you will be charged in full. These fees are not reimbursable and the client is responsible for payment. Clients may be terminated for repeated failure to follow this policy.

RECORDS AND CONFIDENTIALITY: Pursuant to HIPPA laws, I keep protected Health Information about clients in a professional record. This clinical record includes information about client's symptoms, diagnosis, goals set for progress, any past treatment, records from previous providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports of private insurance companies. Information that you share in session with me is confidential and may only be released to another party with written consent of the client or the parent/guardian of a minor. Substance abuse information can only be released with the signature of the minor in addition to the parent/guardian. There are limits and exceptions to confidentiality and they are as follows: A) you provide me with consent to release information. B) I have a reasonable suspicion that you are a threat to yourself or someone else. C) You disclose abuse or neglect of a child, elderly or disabled person. D) You disclose sexual contact with another mental health professional. E) You involve me in a lawsuit and I need to release specific information in order to receive compensation for services rendered. F) I am ordered by a court to disclose information. G) I am otherwise required by law to release information.

REGISTERING COMPLAINTS: I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time you are dissatisfied with my services please let me know. If you wish to file a complaint against a North Carolina Licensed Clinical Mental Health Counselor, you may do so by putting it in writing and sending it to the NCBLCMHC. You may place your complaints in writing citing the ACA ethical codes you believe to have been broken, and submit your letter to the board. The address to send the complaints is: North Carolina Board of Licensed Clinical Mental Health Counselors, PO Box 77819, Greensboro, NC 27417. Phone: 844-622-3572 or 336-217-6007. Fax: 336-217-9450. For further information,

please refer to the website: http://www.nclcmhc.orgcomplaints.html or email: complaints@nclcmhc.org

By your signature below, you are indicating that you read and understand this statement, or that questions regarding this statement were answered to your satisfaction, and that you were furnished with a copy of this statement. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

Client Signature: _____

Date: _____

Counselors Signature: _____

Date: _____