

**Professional Disclosure Statement and Consent for Therapy with
Jason Hallman MA, LPC, SRT
License #7345**

General Information

The therapeutic relationship is unique because it is a personal, confidential, and contractual agreement. Due to these factors, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together via therapy. Feel free to ask questions to discuss any of this with me. By signing the bottom of this document, you are agreeing that you have read the entire document and agree with the terms of therapeutic treatment.

Personal Qualifications

Jason Hallman is a licensed professional counselor (LPC) with the South Carolina Board of Examiners for the Licensure of Professional Counselors and a certified sexual recovery therapist (SRT) with the American Association for Sex Addiction Therapy. He received his Bachelor of Science in Psychology from Liberty University and a Master of Arts in Professional Counseling from Liberty University. He is clinically trained to treat emotional issues, relational issues, and mental disorders. He also has 8 years of experience in human services with the South Carolina Department of Social Services.

Therapeutic Process

You have taken an important step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in the therapeutic process. Such engagement can sometimes result in considerable discomfort. For example, exploring unpleasant events and becoming aware of feelings attached to those events can produce strong feelings of anger, depression, anxiety, etc. Therapy is not a miracle cure and I cannot guarantee that your behavior or circumstances will change. However, I will use all necessary therapeutic tools at my disposal to support you and understand your emotional and behavioral patterns. This approach is designed to help you clarify what you want to accomplish via therapy.

EMDR (Eye Movement Desensitization Reprocessing)

Eye Movement Desensitization and Reprocessing (EMDR) methodology is a form of adaptive information processing (AIP) which may help the brain unblock maladaptive material. It also appears that EMDR may avoid some of the long and difficult work often involved in the treatment of anxiety, panic attack, post-traumatic stress symptoms (such as intrusive thoughts, nightmares, and flashbacks), dissociative disorders, depression, phobias, identity crisis and other traumatic experiences. I have also been specifically advised of the following:

- (1) Distressing unresolved memories may be surface through the use of the EMDR procedure.
- (2) Some clients experience reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including but not limited to, high level of emotional or physical sensations. Subsequent to the treatment session, the processing of incidents and/or material may continue and dreams, memories, flashbacks, feelings, etc., may surface.
- (3) Those with limiting or special medical conditions (pregnancy, heart condition, ocular difficulties, etc.) should consult their medical professionals before participating in this therapeutic method. For some people, this method may result in sharper memory, for others fuzzier memory following the treatment. If you are involved in a legal case and need to testify, please discuss this with your therapist.

Before commencing EMDR treatment, I have considered all of the above and I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate. By my signature at the bottom of this document, I hereby consent to participating in EMDR treatment and acknowledge my consent is free from pressure, and I agree to hold harmless my EMDR clinician and Bridge of Hope Counseling Center for any unpleasant or unexpected effect which may arise from my experience.

Services

Jason Hallman provides a number of services in the area of professional counseling including:

- Sexual Addictions Counseling (Adolescents and Adults)
- Behavioral Addiction
- Grief/Loss
- Depression and Anxiety Issues
- Pre-Marital and Marital Counseling
- Spiritual Issues
- Group therapy
- EMDR

Fees

It is customary to pay for professional services at the time they are rendered. The fee for individual and couple therapy is \$90.00 per 50-minute session. Group therapy is \$25-40 dollars per 90-minute session. Appointments may be cancelled up to 24 hours prior to the scheduled time. If you do not cancel the appointment within this timeframe, you will be charged \$90.00 for the missed appointment because the time-slot was held in good faith regarding your request for therapy.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and #4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using

your name. If I need to consult with your attorney, physician, or your counselor(s), I will ask you to sign a written consent for each professional with whom communication is necessary.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you. However, I feel it is not appropriate to engage in any lengthy discussions in public or outside of the therapy office.

Electronic Communication

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. Services by electronic means, including but not limited to telephone communication, the internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you chose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.
3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to, the therapist's inability to make visual and olfactory observations of clinically or therapeutically relevant issues such as: your physical condition (including deformities), apparent height and weight, body type, attractiveness relative to social and cultural norms/standards, gait and motor coordination, posture, work speed, any noteworthy mannerisms or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial expression. Potential consequences thus

include the therapist not being aware of what he or she would consider important information that you may not recognize as significant to present verbally to the therapist.

Minors

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Accessibility

- I am not accessible 24 hours per day. In the event of an emergency, go to your nearest hospital or call 911.
- If you cannot reach me during normal business hours, leave a voicemail and I will attempt to return all calls within 1 business day.
- Phone calls that last more than 10 minutes will be prorated for the amount of a regular therapy session.

Termination

Ending relationships can be difficult. The appropriate length of the therapeutic termination depends on the length and intensity of treatment. If necessary, I may discuss termination with you if I determine that therapy is not being effectively used or if you are in default on payment. If therapy is terminated, I will provide you with a list of qualified therapists.

If you fail to schedule an appointment for three consecutive months without consultation, the professional relationship must be considered discontinued due to legal and ethical concerns.

NOTICE OF PRIVACY PRACTICES

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.

I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories. For Treatment Payment or Health Care Operations: Federal privacy rules (regulations) allow health care providers that have a direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition. Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or complete information in order to provide quality care, the word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

- a. For my use in treating you.
- b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
- c. For my use in defending myself in legal proceedings instituted by you.
- d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
- e. Required by law and the use or disclosure is limited to the requirements of such law.
- f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
- g. Required by a coroner who is performing duties authorized by law.
- h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
8. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
9. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations

purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on December 2, 2019

Acknowledgement of Receipt of Privacy Notice Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

Signed

Jason Hallman, MA, LPC, SRT

I acknowledge that I have received and read the *Professional Disclosure Statement and Consent for Treatment* (document version 12-19) and the *Notice of Privacy Policies* (document version 12-19). I further acknowledge that I seek and consent to treatment with Mr. Hallman. My signature below confirms that I understand and accept the information contained in the documents in italics above.

Client #1 Signature

Date

Client #2 Signature

Date

Client #3 Signature

Date

Client #4 Signature

Date

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