DEE WRIGHT, LCSW
Practice Policies

Fee Policy

I am committed to offering the highest quality, professional counseling services. My fee varies per service. Fees and services are listed on my website. I take payment at the beginning of the session if no credit/debit card is on file. In the event I am unable to obtain approved payment, your appointment will be rescheduled to another time and you will be charged for a missed appointment.

I request cancellations be made twenty-four (24) hours in advance. Otherwise, you will be charged for the full session that was scheduled. As a practice, I am not available to take phone calls or answer emails other than for scheduling questions. I will not participate in dialogue between sessions.

I am not available to testify in a court setting unless required by a court order. Court appearances are billed at $200 per hour including travel time. Related calls and documentation are $90 per hour to prepare and the fees are to be paid one week prior to court proceedings.

Confidentiality

Professional Ethics, as well as Tennessee State Law, require that information shared within a counseling session be held in strict confidence.

There are two exceptions to this rule, however. In the case of an emergency where the counselor believes the client is at risk of hurting him/herself or another person, the counselor is required to breach the confidentiality. Secondly, Tennessee law requires that child abuse in any form (sexual, physical, emotional, neglect) be reported to the Department of Human Services or other authority such as a Juvenile Judge.

In communication, persons sometimes prefer to communicate via text messaging or email. I do accept this form of communication, however, it is important for the client to understand that email is not a secure mode of communication. The correspondence is at risk of being intercepted, can be monitored by email providers and human error could result in someone else receiving the email other than the intended therapist. It is also important to note that text messaging carries the same level of risk. Text messages can be intercepted, stored on a device and later read by others, read by phone providers, or sent to non-intended individuals. If the client chooses to correspond with me via text messaging or email, the messages and emails will be printed off and kept in the client's file.

When working with minors, I will not share the content of sessions with parents/guardians, unless the content must be shared for safety reasons or sharing content for the welfare and health of the minor. I will discuss progress and treatment plans in general terms only as not to compromise confidentiality of client. Parents are encouraged to be an active part of the counseling process and be prepared to be in session with your child at times if requested.

When working with couples I have a no secrets policy, which means that ny information shared with me in or out of session is accessible and will be shared with other members involved in treatment.

Professional Services

I am currently available for counseling services on Thursday only. I can be reached via phone at (731) 410-7755 or via email at deesrite@gmail.com. Phone consultations are not offered. Appointments and changes to standing appointments may be made by accessing the website at www.deewrightlcsw.com. When scheduling an appointment, credit/debit card information is required to reserve the time slot. There will be no charge made until the client appears for the appointment. However, if the appointment is canceled within the twenty-four (24) hour window or the client does not keep the appointment without notice (no-show), there will be a charge incurred in the amount of the fee for the service client had scheduled.

If you have an emergency, please go to the nearest emergency room or call Pathways Crisis Unit at (731) 541-8258.

I am not considered an Expert Witness as defined by the legal system. In the event I am subpoenaed to court, the client will be charged a fee of $200 per hour, including travel, correspondence, writing case summaries, or any preparation involved.

Benefits and Risks of Receiving Counsel

Persons contemplating receiving counseling services should be aware that they may make changes in their lives. Counseling often results in modified emotions, attitudes and behaviors. Other results may include changes in marriages or significant relationships. While I may suggest changes, the client will decide what changes they are willing to make. No change is guaranteed as the client makes that decision. Clients are responsible for their growth.

Credentials

I am a Licensed Clinical Social Worker licensed by the State of Tennessee (#5633).

Do you have any questions about fees, confidentiality, or other matters? YES__NO__
Do you agree with the conditions and provisions of these Practice Policies? YES__NO__
I give permission for the therapist to correspond with me via text message and/or email. YES__NO__; email only ___ text only___
I agree to the fee as indicated by my choice of service on the website. YES__NO__

Signature of Responsible Party _____ **Date** _____

HIPPA Privacy Practices

I am required by law to follow the practices described in this letter. This letter is a summary of my Privacy Practices, but does not replace the full version, which has been made available to you. This notice applies to personal medical/mental health information that I have about you and which are kept in my records. With some exceptions, I must obtain your authorization to disclose (or release) your health care information. There are some situations in which I do not have to obtain your authorization. Neither this pamphlet nor the full Notice of Privacy Practices covers every possible use or disclosure.

Who Has Access To Your Personal Information?
Medical/Mental health information about you can be use to:

- Plan your treatment and services. This includes releasing information to qualified professional involved in your care or treatment. It may also include provider agencies whom we pay to provide services for you. We will only release as little as possible for them to do their jobs.
- Submit bills to your insurance, Medicaid, Medicare, or third party payers.
- Obtain approval in advance from your insurance company.
- Exchange information with Social Security, Employment Security, or Social Services.
- Measure my quality of services.

Without your permission, I may use our personal information:

- To exchange information with other State agencies as required by law.
- To treat you in an emergency.
- To treat you when there is something that prevents us from communicating with you.
- To inform you about possible treatment options.
- To send you appointment reminders.
- For agencies involved in a disaster situation.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- As required by State, Federal or local law. This includes investigations audits, inspections, and licensure.
- When ordered to do so by a court.
- To communicate with law enforcement if you are a victim of a crime, involved ina crime at my office, or you have threatened to commit a crime.
- To communicate with coroner, medical examiners and funeral homes when necessary for them to their jobs.
- To communicate with federal officials involved in security activities authorized vby law.
- To communicate with a correctional facility if you are an inmate.

What are your rights?

- To see and get a copy of your record (with some exceptions).
- To appeal if I decide not to let you see all or some parts of your record.
- To ask for the record to be changed I you believe you see a mistake or something that is not complete.
- You must make this request in writing. I may deny your request if:
    1. I did not create the entry
    2. The information is not part of the file I keep; or
    3. The information is not part of the file that I would let you see; or
    4. I believe the record is accurate and complete.
- To know to whom I have sent information about you for up to the last six years.
- The first request in a 12 month period is free. I may charge you for an additional service.
- To limit how I use or disclose information about you. For example – not to release information to your spouse or a particular provider agency. This must be made in writing and I am not required to agree to the request.
- To ask that I communicate with you about medical matters in a certain way or at a certain location. This must be made in writing.
- To authorize other releases of your personal information not described above. You may change your mind and remove the authorization at any time (in writing).

Signature of Responsible Party(ies): _____ **Date:** _____

I, _____ have received a copy of this office's Notice of Privacy Practices and Policies, and HIPPA.

SIGNATURE: _____

PRINTED NAME: _____

DATE: _____

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. but acknowledge could not be obtained because:

1. **Individual refused to sign**

2. **Communication barriers prohibited obtaining the acknowledgment**

3. **An emergency situation prohibited obtaining the acknowledgement**

4. **Other (please specify)_____**

Client Intake Form

Demographics

Name:_____ Date: _____

Address: _____ City:_____State:_____Zip:_____

County:_____

It is customary practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail at, please provide an alternate mailing address here:

_____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: **Phone** or **Email** (circle one)

Age: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (circle one) **Single** **Married** (years married ___) **Divorced** **Widowed**

Children:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Referred by: _____

Previous Counseling

Previous Counseling? Yes No Who and When? _____

Release of information signed to talk with previous counselors? Yes No

Medical/Mental Health Information

What. if any. medical health problems do you have? _____

Physician _____ Psychiatrist name:_____

Are you on disability? Please describe _____

Please list conditions and medications: _____

Have you ever been hospitalized for a mental or emotional condition? _____

If so, please list where and when: _____

Are you currently suicidal? Yes No Have you been suicidal in the past 6 months? Yes No

Do you currently use any alcohol or drugs? _____ If yes, what is your substance of choice?

Are you in Substance abuse treatment? (such as outpatient) or utilizing support groups (such as AA)? Yes No If yes, please describe: _____

Reasons for seeking counseling:

In a few words, what do you think therapy is all about?_____

How many therapy sessions do you anticipate committing too?_____

What types of self-care practices have been helpful to you in the past when dealing with difficult situations? Examples: journaling, exercising, workbooks, prayer, support groups -

How would you describe your relationship with God?
Do you desire prayer/scripture to be used in therapeutic process? Yes No

Emergency contact information:

Name _____

Relationship: _____ **Phone:** _____

By signing below you agree everything on this form is true to the best of your ability.

Client Signature: _____ **Date:** _____