

LUNA WAY

P.O. Box 470 Saint Albans, VT 05478 • info@lunaway.org • (802)310-3256

Hello,

My name is Jaime Galley and I'll be offering mental health support at BRIGHTality as a psychotherapist. BRIGHTality will be offering a range of services, including individual and community-based psychotherapy, through LunaWay. These services can help your child process their feelings, build social and emotional skills, and function better at school.

A little about me... I gained my Bachelors Degree at Northern Vermont University in Psychology and currently study Clinical Counseling with a focus on youth and adolescent services at the graduate level. Prior to this I have worked within the educational system for the past 15 years specializing in both Speech and Language Pathology and Special Education services. Currently my psychotherapy practice is overseen by psychologist Dr. Jennie Holden, Ph.D.

To access services... There are a few things we have to do in order for your child to access my services.

1. Complete the enclosed paperwork, and feel free to contact me with any questions at jaime.galley@lunaway.org. This includes (1.) Client Intake Packet, Disclosure and Statement of Privacy Practices, (2.) Service Agreement, (3.) Community-Based Psychotherapy Consent, (4.) Telehealth Consent.
2. Establish your child's insurance coverage. I am able to accept Medicaid. Please note that if you have Medicare/SSDI, my services will not be covered.
3. Set up an initial appointment with me!

I look forward to working with you!

Jaime Galley

Psychotherapist

Lunaway Special Education Services at Brightality



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CLIENT INFORMATION SHEET

Client Name: _____ DOB _____ Age _____

Mailing Address _____

City _____ State _____ Zip Code _____

OK to receive mail at this address: Yes No

Physical Address (if different) _____

City _____ State _____ Zip Code _____

Home Phone _____ OK to leave a message: Yes No

Work _____ OK to leave a message: Yes No

Cell _____ OK to leave a message: Yes No

Client/Parent (if client is underage):

Occupation _____

Marital Status _____ Children? _____

Household Family Members (name, relationship, age):

Emergency Contact (name, relationship and phone number): _____

Have you ever been hospitalized for psychological reasons or substance use? (If yes, please provide details:

Current Medications: _____

Presenting Problem(s): _____

Insurance: _____

Subscriber's Name: _____ Insurance ID: _____

Subscriber's Date of Birth: _____ Medicare/SSDI _____

CLIENT DISCLOSURE SHEET

Disclosure:

State law requires all licensed psychologists practicing in Vermont to provide clients with information about their professional qualifications and experience, what constitutes unprofessional conduct according to Vermont Statute and how to file a complaint with the Office of Professional Regulation. The law further requires that the psychotherapist obtain and keep on file a signed form acknowledging that this information has been made available. A description of my professional qualification and experience is attached. Information cards about the complaints procedures and a list of practices that constitute unprofessional conduct are also attached.

Professional Qualifications and Experiences:

Ms. Jaime Galley is a psychotherapist on the Roster of Non-licensed Non-certified Psychotherapists in the State of Vermont. She received her Bachelor's Degree in Psychology from Northern Vermont University. Currently she is enrolled in Graduate School at Vermont State University where she is studying clinical counseling with a focus on youth and adolescent services. She subsequently has worked in the field of education for the last fifteen years specifically within special education and in speech and language services. For full details, please see the following disclosure, as required by the state of Vermont's Office of Professional Regulation.

As a Non-licensed Non-Certified Psychotherapist, Ms. Galley must be overseen by a licensed clinician. As such, she is overseen by Dr. Jennie Holden, Ph.D. In the case that you wish to make a complaint regarding Ms. Galley, you may contact Dr. Holden by phone at (802)272-2545 during business hours or by email at DrJennieHolden@gmail.com.



All sections of this public disclosure must be completed, even if one puts not applicable. All pages need to be included as well.

Every document below is part of public disclosure and must be given to each client no later than the third office visit and must be submitted to this Office as part of your public disclosure.

Board of Allied Mental Health Practitioners

Disclosure Document for Non-licensed and Non-certified Psychotherapists

First Name Jaime	Middle Initial L	Last Name Galley
Previous Name(s) (Maiden)		Jaime L Taylor, Jaime L Progen

Formal Education	Name of Institution:	Northern Vermont University
	Dates Attended:	<u>09 / 01 / 2019 - 08 / 18 / 2021</u>
	Degree(s) awarded, if any:	Bachelor's in Psychology
Formal Education	Name of Institution:	Vermont State College
	Dates Attended:	<u>08 / 23 / 2023 - Current Student</u>
	Degree(s) awarded, if any:	Graduate Student in Clinical Counseling

Training	Title of Training Program:	Diversity ,Equity and Inclusion Training
	Names & Addresses of trainer and/or institution:	Udemy, Andrew Lutrell PH.D
	Dates Attended:	<u>08 / 28 / 2023 - 08 / 29 / 2023</u>
	Subject and/or content	Psychology and Intro of DEI training
	Credential(s) awarded, if any:	Certificate
Training	Title of Training Program:	Life Space Crisis Intervention Training
	Names & Addresses of trainer and/or institution:	The Institute of Life Space Crisis Intervention, Signe Whitson
	Dates Attended:	<u>08 / 25 / 2022 - 08 / 25 / 2023</u>
	Subject and/or content	Conflict cycle, conflict management, conflict resolution
	Credential(s) awarded, if any:	Certificate
Training	Title of Training Program:	CPR and First Aid Training
	Names & Addresses of trainer and/or institution:	American Red Cross, St. Albans Rec. Department
	Dates Attended:	<u>08 / 27 / 2023 - 08 / 27 / 2023</u>
	Subject and/or content	CPR and First Aid Training
	Credential(s) awarded, if any:	Certificate

Experience	Description of Practice:	Speech and Language Pathology Assistant and Special Education paraprofessional @ Derby Elementary School
	Location: City/State/Zip	Derby, Vermont, 05
	Duration:	<u>09 / 06 / 2008 - 06 / 14 / 2015</u>
	Status:	Full-Time <input checked="" type="checkbox"/> Part-Time
	Receive supervision or peer consultation?	YES <input checked="" type="checkbox"/> NO
	How often?	once per week
Experience	Description of Practice:	High needs special education support @ St. Albans City School
	Location: City/State/Zip	St. Albans City, Vermont, 05478
	Duration:	<u>03 / 01 / 2016 - 08 / 25 / 2021</u>
	Status:	Full-Time <input checked="" type="checkbox"/> Part-Time
	Receive supervision or peer consultation?	YES <input checked="" type="checkbox"/> NO
	How often?	Daily
Experience	Description of Practice:	English Language Arts Teacher/ Habits and Attitudes Class @ Brightality Special Education School
	Location: City/State/Zip	St. Albans Vermont, 05478
	Duration:	<u>09 / 05 / 2021 - Current / /</u>
	Status:	Full-Time <input checked="" type="checkbox"/> Part-Time
	Receive supervision or peer consultation?	YES <input checked="" type="checkbox"/> NO
	How often?	weekly

Scope of Practice	Therapeutic Orientation:	Humanistic-Choice Theory
	Area of Specialization:	Teen/Adolescent
	Treatment Methods:	CBT, psychotherapy, reality therapy

My practice is also governed by the Rules of the Board of Allied Mental Health Practitioners. It is unprofessional conduct to violate those rules. A copy of the rules may be obtained from the Board or online.

Client's Disclosure Confirmation

My signature acknowledges that I have been given the professional qualifications and experience of (Name, Name), a listing of actions that constitute unprofessional conduct according to Vermont statutes, and the method for making a consumer inquiry or filing a complaint with the Office of Professional Regulation. This information was given to me no later than my third office visit.	
Client's Signature	Date
Practitioner's Signature	Date

Office of Professional Regulation Notice

The Office of Professional Regulation provides Vermont licenses, certifications, and registrations for over 56,000 practitioners and businesses. Forty-six professions and occupations are supported and managed by this office. A list of professions regulated is found below.

Each profession or occupation is governed by laws defining professional conduct. Consumers who have inquiries or wish to obtain a form to register a complaint may do so by calling (802) 828-1505, or by writing to the Director of the Office, Secretary of State's Office, 89 Main Street, 3rd Floor, Montpelier, VT 05620-3402.

Upon receipt of a complaint, an administrative review determines if the issues raised are covered by the applicable professional conduct statute. If so, a committee is assigned to investigate, collect information, and recommend action or closure to the appropriate governing body.

All complaint investigations are confidential. Should the investigation conclude with a decision for disciplinary action against a professional's license and ability to practice, the name of the license holder will then be made public.

Complaint investigations focus on licensure and fitness of the licensee to practice. Disciplinary action, when warranted, ranges from warning to revocation of license, based on the circumstances. You should not expect a return of fees paid or additional unpaid services as part of the results of this process. If you seek restitution of this nature, consider consulting with the Consumer Protection Division of the Office of the Attorney General, retaining an attorney, or filing a case in Small Claims Court.

Accountancy	Naturopaths
Acupuncture	Nursing
Architects	Nursing Home Administrators
Athletic Trainers	Occupational
Therapists Auctioneers	Opticians
Audiologists	Optometry
Barbers & Cosmetologists	Osteopathic Physicians and
Surgeons Boxing Control	Pharmacy
Chiropractic	Physical Therapists
Dental Examiners	Private Investigative & Security
Services Dietitians	Property Inspectors
Drug and Alcohol Counselor	Psychoanalyst
Electrolysis	Psychology
Professional Engineering	Psychotherapist, Non-
licensed Funeral Service	Radiologic Technology
Hearing Aid Dispensers	Real Estate Appraisers
Land Surveyors	Real Estate
Landscape Architects	Respiratory Care
Marriage & Family Therapists	Social Workers, Clinical
Clinical Mental Health Counselors	Tattooists
Midwives, Licensed	Veterinary
Motor Vehicle Racing	

Chapter 78: Roster of Psychotherapists Who Are Nonlicensed

§ 4090. Disclosure of Information

The board shall adopt rules requiring persons entered on the roster to disclose to each client the psychotherapist's professional qualifications and experience, those actions that constitute unprofessional conduct, and the method for filing a complaint or making a consumer inquiry, and provisions relating to the manner in which the information shall be displayed and signed by both the rostered psychotherapist and the client. The rules may include provisions for applying or modifying these requirements in cases involving institutionalized clients, minors and adults under the supervision of a guardian.

Title 3: Executive

Chapter 5: SECRETARY OF STATE

Sub-Chapter 3: Professional Regulation

**3 V.S.A. § 129a. Unprofessional
Conduct**

(a) In addition to any other provision of law, the following conduct by a licensee constitutes unprofessional conduct. When that conduct is by an applicant or person who later becomes an applicant, it may constitute grounds for denial of a license or other disciplinary action. Any one of the following items or any combination of items, whether the conduct at issue was committed within or outside the State, shall constitute unprofessional conduct:

(1) Fraudulent or deceptive procurement or use of a license.

(2) Advertising that is intended or has a tendency to deceive.

(3) Failing to comply with provisions of federal or State statutes or rules governing the practice of the profession.

(4) Failing to comply with an order of the board or violating any term or condition of a license restricted by the board.

(5) Practicing the profession when medically or psychologically unfit to do so.

(6) Delegating professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, education, or licensing credentials to perform them, or knowingly providing professional supervision or serving as a preceptor to a person who has not been licensed or registered as required by the laws of that person's profession.

(7) Willfully making or filing false reports or records in the practice of the profession, willfully impeding or obstructing the proper making or filing of reports or records, or willfully failing to file the proper reports or records.

(8) Failing to make available promptly to a person using professional health care services, that person's representative, or succeeding health care professionals or institutions, upon written request and direction of the person using professional health care services, copies of that person's records in the possession or under the control of the licensed practitioner, or failing to notify patients or clients how to obtain their records when a practice closes.

(9) Failing to retain client records for a period of seven years, unless laws specific to the profession allow for a shorter retention period. When other laws or agency rules require retention for a longer period of time, the longer retention period shall apply.

(10) Conviction of a crime related to the practice of the profession or conviction of a felony, whether or not related to the practice of the profession.

(11) Failing to report to the Office a conviction of any felony or misdemeanor offense in a Vermont District Court, a Vermont Superior Court, a federal court, or a court outside Vermont within 30 days.

(12) Exercising undue influence on or taking improper advantage of a person using professional services, or promoting the sale of services or goods in a manner that exploits a person for the financial gain of the practitioner or a third party.

(13) Performing treatments or providing services that the licensee is not qualified to perform or that are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice.

(14) Failing to report to the Office within 30 days a change of name, e-mail, or mailing address.

(15) Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

(16)(A) Impeding an investigation under this chapter or unreasonably failing to reply, cooperate, or produce lawfully requested records in relation to such investigation.

(B) The patient privilege set forth in 12 V.S.A. § 1612 shall not bar the licensee's obligations under this subsection (a) and a confidentiality agreement entered into in concluding a settlement of a civil claim shall not exempt the licensee from fulfilling his or her obligations under this subdivision (16).

(17) Advertising, promoting, or recommending a therapy or treatment in a manner tending to deceive the public or to suggest a degree of reliability or efficacy unsupported by competent evidence and professional judgment.

(18) Promotion by a treatment provider of the sale of drugs, devices, appliances, or goods provided for a patient or client in such a manner as to exploit the patient or client for the financial gain of the treatment provider, or selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes.

(19) Willful misrepresentation in treatments or therapies.

(20) Offering, undertaking, or agreeing to cure or treat a disease or disorder by a secret method, procedure, treatment, or medicine.

(21) Permitting one's name or license to be used by a person, group, or corporation when not actually in charge of or responsible for the professional services provided.

(22) Prescribing, selling, administering, distributing, ordering, or dispensing any drug legally classified as a controlled substance for the licensee's own use or to an immediate family member as defined by rule.

(23) For any professional with prescribing authority, signing a blank or undated prescription form or negligently failing to secure electronic means of prescribing.

(24) For any mental health care provider, use of conversion therapy as defined in 18 V.S.A. § 8351 on a client younger than 18 years of age.

(25) For providers of clinical care to patients, failing to have in place a plan for responsible disposition of patient health records in the event the licensee should become incapacitated or unexpectedly discontinue practice.

(26) Sexually harassing or exploiting a patient, client, or consumer, or doing so to a coworker in a manner that threatens the health, safety, or welfare of patients, clients, or consumers; failing to maintain professional boundaries; or violating a patient, client, or consumer's reasonable expectation of privacy.

(b) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes:

(1) performance of unsafe or unacceptable patient or client care; or

(2) failure to conform to the essential standards of acceptable and prevailing practice.

(c) The burden of proof in a disciplinary action shall be on the State to show by a preponderance of the evidence that the person has engaged in unprofessional conduct.

(d)(1) After hearing, and upon a finding of unprofessional conduct, a board or an administrative law officer may take disciplinary action against a licensee or applicant, including imposing an administrative penalty not to exceed \$5,000.00 for each unprofessional conduct violation.

(2)(A) Any money received under this subsection shall be deposited in the Professional Regulatory Fee Fund established in section 124 of this chapter for the purpose of providing education and training for board members and advisor appointees.

(B) The Director shall detail in the annual report receipts and expenses from money received under this subsection.

(e) In the case where a standard of unprofessional conduct as set forth in this section conflicts with a standard set forth in a specific board's statute or rule, the standard that is most protective of the public shall govern. (Added 1997, No. 40, § 5; amended 2001, No. 151 (Adj. Sess.), § 2, eff. June 27, 2002; 2003, No. 60, § 2; 2005, No. 27, § 5; 2005, No. 148 (Adj. Sess.), § 4; 2009, No. 35, § 2; 2011, No. 66, § 3, eff. June 1, 2011; 2011, No. 116 (Adj. Sess.), § 5; 2017, No. 48, § 4; 2017, No. 144 (Adj. Sess.), § 6, eff. July 1, 2019; 2019, No. 30, § 4.)

§ 4093. Unprofessional conduct

(a) Unprofessional conduct means the following conduct and conduct set forth in section 129a of Title 3:

- (1) Providing fraudulent or deceptive information in an application for entry on the roster.
 - (2) Conviction of a crime that evinces an unfitness to practice psychotherapy.
 - (3) Unauthorized use of a protected title in professional activity.
 - (4) Conduct which evidences moral unfitness to practice psychotherapy.
 - (5) Engaging in any sexual conduct with a client, or with the immediate family member of a client, with whom the psychotherapist has had a professional relationship within the previous two years.
 - (6) Harassing, intimidating or abusing a client.
 - (7) Entering into an additional relationship with a client, supervisee, research participant or student that might impair the psychotherapist's objectivity or otherwise interfere with his or her professional obligations.
 - (8) Practicing outside or beyond a psychotherapist's area of training, experience or competence without appropriate supervision.
- (b) After hearing, and upon a finding of unprofessional conduct, the board may take disciplinary action against a rostered psychotherapist or an applicant. (Added 1993, No. 222 (Adj. Sess.), § 17; amended 1997, No. 40, § 71; 1997, No. 145 (Adj. Sess.), § 61; 1999, No. 52, § 37.)



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How to File a Complaint

Complaints can be filed with the Vermont Secretary of State's Office of Professional Regulation. The complaint form can be found on line at: <http://vtprofessionals.org/opr1/psychologists/>

If you do not have access to a computer you may call the Office of Professional Regulation and request a form be mailed to you at 802 828-1505 or I would be happy to provide one for you.

Once you complete the complaint form it can be mailed to:

Vermont Secretary of State
Office of Professional Regulation
Attn: Carla Preston, Case Manager
National Life Bldg., North FL2
Montpelier, Vermont 05620-3402
802 828-1505
cpreston@sec.state.vt.us

Receipt of Disclosure Information

I, _____, have been provided documents disclosing the following information:

- a) a synopsis of Ms. Galley's experience and qualifications to provide psychotherapeutic services
- b) a copy of the statutory definition of unprofessional conduct
- c) information on the process for filing a complaint with, or making a consumer inquiry to, the Director of the Office of Professional Regulation

In addition, I have been afforded the opportunity to ask questions or get clarification about these documents.

Client Signature

Date

Dean Woodhouse-Weil, M.A.

Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT SHOULD BE REVIEWED WITH CARE.

Ms. Jaime Galley is required by federal and state law to maintain the privacy of your health information, as well as give you this notice about privacy practices, legal obligations, and your rights concerning your health information, “Protected Health Information” (PHI). Mr. Woodhouse-Weil must follow the privacy practices that are described herein and these practices may be amended as needs or requirements change.

For further clarification of anything noted in this document please contact Ms. Galley.

Uses and Disclosures of Your Protected Health Information

The following will explain the ways in which your health information may be used *without your consent* under Federal and State law. In all cases, Ms. Galley practices disclosing minimum information necessary to achieve the purpose of said disclosure. This is not intended to be an exhaustive list, but instead an explanation of cases and scenarios where disclosure of PHI may be necessary falling under general categories. These disclosures exclude psychotherapy notes as described in the next section.

A. Treatment: Ms. Galley may use and disclose information related to your treatment to members of your current treatment team for the purposes of continuity of care and to coordinate and manage your healthcare and related services.

B. Payment: Ms. Galley may use and disclose information in your protected health record for billing purposes with your insurance plan. Your insurer may require certain information about your treatment prior to authorizing payment for services.

C. Health Care Operations: These include quality improvement activities, supervision, consultation with colleagues, licensing, and credentialing activities. Ms. Galley conducts his practice under the supervision of Dr. Jennie Holden, with whom the details of on-going cases may be

D. Where ever required by law, your protected health information will be disclosed.

E. In the event of an emergency your protected health information may be disclosed in order to allow for your treatment and care.

Uses and Disclosures Requiring your Written Consent

Notes recorded by Ms. Galley, documenting the contents of your session (Psychotherapy Notes), will be used only by your psychotherapist and will not otherwise be used or disclosed without your written authorization.

Marketing activities will never include your protected health information without your written approval. Any disclosure to individuals not directly involved in your treatment or care (ie: your attorney, school, etc.) will require your written authorization for release of PHI.

Note: Your “authorization” to release PHI may be revoked at any time by providing the revocation in writing. This revocation will go into effect when the written notice has been personally received and reviewed.

Your Rights Regarding Your Health Information

A. Right to Inspect and Copy: You have the right to inspect and copy your medical and billing records, but not your psychotherapy notes. All requests of this nature must be made in writing. There will be a fee associated with copying records and mailing records if you chose to receive them via mail.

B. Right to Request Confidential Communications: You have the right to request that Ms. Galley communicate with you only in a certain location or through a certain method (i.e. at work only, or through email, etc.) All requests must be received in writing and reasonable requests will be honored. A reason for the request is not necessary, but it is important to know the specifics on where and how you wish to be contacted.

C. Right to Request Restrictions: You have the right to request a restriction on the health information that is used or disclosed about you for treatment, payment, or health care operations. Requests for restrictions must be submitted in writing. Ms. Galley is not required to agree with your requested restriction, however, Ms. Galley will honor your request unless the restricted health information is needed to provide you with emergency treatment.

D. Right to Accounting of Disclosures: You have the right to request to be provided with an accounting of the disclosures that have been made of your protected health information. This request must be made in writing and will not include disclosures made for the purposes of treatment, payment, and health care operations.

E. Right to Request an Amendment: You have the right to request amendment of your health information. Your request must be made in writing and should detail the reason for the requested amendment. This request may be denied in certain circumstances.

F. Right to a Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

G. Out-of-Pocket-Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

H. Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

I. Questions or Complaints: Any questions or complaints regarding your privacy rights should be addressed with the Privacy Officer, Ms. Jamie Seeholtzer at jamie.seeholtzer@lunaway.org. You may also contact the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against should you chose to complain to Ms. Galley or an outside agency.

This notice is effective April 14, 2003. It may be amended at any time, and the revision will be effective for all PHI maintained. In the event of an amendment, a new notice will be posted and you may request a copy of the revised notice.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____ have received a copy of the Notices
Client or Parent/Guardian Name
of Privacy Practices.

Print Name

Client or Parent/Guardian Signature

Date

Office Use Only

An attempt was made to obtain written acknowledgement of receipt of the Notice of Privacy Practices,
but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ An emergency situation prevented obtainment of acknowledgement

_____ Other (please specify below)

OUTPATIENT SERVICES AGREEMENT

(Medicaid Insurance - Individual)

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an assessment during the first one to three sessions, lasting 45 minutes each. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-55 minute session per week at a time we both agree on, although some sessions may be longer or more frequent. If you need to cancel an appointment, please provide at least 24 hours advance notice of cancellation when possible. If you cancel an appointment, I will try to find another time within the same week to reschedule the appointment if possible.

SESSION TIME

The standard session time is 50-55 minutes. If you are late, we will end on time. If I am late, you will still receive your full 50-55 minutes of session. This time may be provided at the end of that session or during a future session.

CANCELLATION POLICY

I consider our meetings very important and assume that you do the same. However, there may be times in which you need to cancel a session. In the event that you are unable to keep an appointment, please notify me immediately. Depending on the reasons for cancellation, if three therapy appointments are canceled, therapy may be terminated. Any missed appointment will be discussed openly and assessed to determine the possible impact on therapy.

CONTACTING ME

I am often not immediately available by telephone. While my business hours are between 9:00am and 5:00pm, I will not answer the phone when I am with a patient. When I am unavailable, you may leave me a voicemail that I monitor during my normal business hours. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, the nearest emergency room and ask for psychiatric services, or call Northwestern Counseling and Support Services (NCSS) at (802)524-6554. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

EMAILS, CELL PHONES, COMPUTERS AND FAXES

It is very important to be aware that computers and unencrypted email, texts, and e-fax communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails, texts and e-faxes that go through them. Please notify me if you decide to avoid or limit, in any way, the use of email, texts, cell phones call, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted email, texts or e-fax or via phone messages, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters. Please do not use texts, email, voice mail, or faxes for emergencies.

IN CASES OF EMERGENCY

If there is a serious emergency or if you are feeling unsafe, it is important that you get the immediate help you need by going to a local emergency room, by calling 911, or by calling Northwestern Counseling and Support Services (NCSS) at (802)524-6554. If you are in distress, you may call me and if I am unable to answer, I will return your call as soon as I am able during my normal business hours of 9:00am to 5:00pm. In addition, there may be times during our work together in which I am concerned about your personal safety and may need to contact someone close to you, such as a parent, friend, family member, or spouse. I will ask you to sign a release of information for an emergency contact to allow us to make this contact if necessary.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. If your Medicaid coverage becomes inactive or if you start with another insurance company please notify me immediately, as you will be responsible for covering all sessions that Medicaid does not cover. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health

Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a diagnosis. Sometimes I have to provide additional information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

PROFESSIONAL FEES

My standard fee is \$150 for the assessment session and \$125 per session thereafter. I may charge this standard fee for other professional services you may need that insurance will not reimburse for, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Due to the difficulty of legal involvement, I charge \$160 per hour for preparation for, attendance at, and travel time to and from any legal proceeding.

BILLING

You will be responsible for covering all sessions that insurance does not cover. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient’s treatment is his/her name, the nature of services provided, and the amount due.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence during session so that we can discuss the contents.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my recommendation to parents that they do not request the records so as to preserve the therapeutic relationship. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. If requested, I will also provide them with

a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

In many circumstances, it is helpful for parents to be more intimately involved with the treatment. For example, it may be beneficial for parents to help their children practice the skills he/she learned during session. In such circumstances, it is important that the parents are willing to participate in the aspects of treatment that would prove beneficial for the minor. If this applies, this will be discussed during treatment with both the minor and his/her parents.

CONFIDENTIALITY IN COUPLES/MARITAL/FAMILY THERAPY

In couples and family therapy, you should be aware that information shared during sessions may be disclosed to the members of the couple/family who are also participating in treatment. A disclosure of this nature may occur when the information is relevant to the treatment in which both parties are participating, and every effort to advise you of the necessity to disclose this information will be provided.

CONFIDENTIALITY IN GROUP THERAPY

In group therapy, disclosures of information may be made amongst group participants, and beyond the control of group facilitators. Information shared within the group setting is confidential, and not to be shared outside of the group. However, I cannot guarantee that all group members will respect your confidentiality in group settings.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a therapist is protected by law and I can only release information about our work to others with your written permission. However, there are a few exceptions to this.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. These situations include:

- If I believe that a child, elderly person, or disabled person is being abused or neglected, I may be required to file a report with the appropriate state agency.
- If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

As a Rostered Non-licensed and Non-certified Psychotherapist, my work is overseen by a supervisor, with whom I may discuss details of your case in the course of supervision.

I may occasionally find it helpful to consult with other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Revised 7/1/23

Informed Consent Signature Page

Client Signature

Date

Printed Name

Parent/Guardian Signature

Date

Printed Name

Parent/Guardian Signature

Date

Printed Name

Consent to Telemedicine Services

Telemedicine involves the use of video and audio communication technology to conduct your therapy session at a distance. If you are unable to travel to my office for your appointment it is possible for us connect online through a secure video conferencing connection.

When providing telemedicine services, I always use a secure connection and special video conferencing technology that complies with federal health privacy laws. Before we meet I will send you an email link to connect to our session. I will also create a secure online client portal for you to use to message me if needed.

You can access your telemedicine session with a computer, tablet, or cell phone. Our video and audio feed will work best if your device is connected to a reliable high-speed internet connection.

The benefits of telemedicine include, but are not limited to, improved access to care, better continuity of care, and reduction of lost work time and travel costs. Possible risks include technical difficulties such as interruptions and unauthorized access. There is the possibility that our video or audio connection may not work or that it may stop working during our appointment. It is also possible that the video or audio quality may not be clear enough for us to communicate effectively. If this happens, either one of us may choose to stop the session at any time. In very rare instances, the security of our online connection could fail and cause a breach of your confidential information.

It is also important to note that accessing therapy online has special risks. Meeting by video rather than in person could cause me to miss gestures, cues, or other important non-verbal information during your session. If you are in crisis, I may not be able to intervene as effectively as I could in person. There is the chance that if you need immediate crisis support I might not be familiar with resources available to you in your location. Any of these factors could impact your quality of care.

In the State of Vermont, it is against state law for either the therapist or the client to make a recording of a telemedicine session. All other laws and regulations which apply to in-person therapy sessions will also apply to any sessions conducted online. If you use insurance benefits to pay for our sessions, I will verify with your insurance provider that telemedicine services are covered under your plan. If your plan changes these benefits might change as well.

Please take some time to consider whether telemedicine services are right for you before signing this form. If you prefer, I would be happy to provide you with referrals to providers who may be easier for you to access to you rather than offering you telemedicine services.



P.O. Box 470 Saint Albans, VT 05478 • info@lunaway.org • (802)310-3256

By signing this form, you agree to the following:

1. You have read this form and fully understand its contents including the risks and benefits of telemedicine services.
2. You have had a conversation with me during which you had the opportunity to ask questions in regard to telemedicine services. Your questions have been answered and the risks, benefits and alternatives have been discussed with you in a language in which you understand.
3. You understand that you have the right to withhold or withdraw your consent to the use of telemedicine in the course of your care at any time, without affecting your right to future care or treatment. You may revoke your consent orally or in writing at any time by contacting me directly.
4. You understand that the laws that protect the confidentiality of your treatment also apply to telemedicine services.
5. You understand that it is illegal in the State of Vermont for you to make a recording of any kind of your telemedicine session(s).
6. You understand that you have a right to a copy of this form and have been offered a copy of this form.

Patient Consent to The Use of Telemedicine:

I have read and understand the information provided above, have discussed it with Ms. Jaime Galley, and my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my mental health care and authorize Ms. Galley to use telemedicine in the course of my mental health diagnosis, assessment, and treatment.

Client Name (Please Print)

Date of Birth

Client Signature

Date

Provider Name (Please Print)

Provider Signature

Date

Community-Based Psychotherapy Agreement:

Following the establishment of a therapeutic relationship, your psychotherapist may make a recommendation of community-based therapy for your child. Evidence supports that community-based treatment is an effective approach to reduce mental health symptomatology. This approach can allow youth and psychotherapist to work in ways that may be difficult within the consulting room. However, this form of support has limitations, and requires consent, beyond that of office-based out-patient therapy.

Confidentiality:

The psychotherapist is unable to guard your child's confidentiality to the same degree while working in the community. Your child may encounter individuals who they know, and who may be aware, or become aware, of the psychotherapist's professional responsibilities.

Safety/Security:

Leaving the controlled environment of the consulting room, the psychotherapist will not be able to guarantee the safety of your child's environment.

Session Time/Length:

Sessions will be scheduled at 50-55 minutes, as in out-patient therapy. Due to the nature of community-based work, timeliness is important. Arriving late to a community-based session may result in session time being shorter than planned.

Emergency Contact During Session:

Your psychotherapist will be contactable by phone/email during community-based sessions in the event of an emergency. However, due to the nature of community-based work, it may not be possible for the psychotherapist to respond during a session.

Your signature below indicates that you have read and understand the above, and consent to community-based mental health support.

Client Signature

Date

Parent/Guardian Signature

Date

Client Signature

Date

LUNA WAY

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ DOB _____
(client's name)

Legal representative, if applicable _____

authorize Jaime Galley
(Name of provider)

and Lunaway, Inc. Education and Therapeutic Staff
(Name of provider)

to communicate and disclose to one another the following information:

___ My Mental Health Record in its Entirety **OR** only the following information:

- | | |
|-----------------------------------|-------------------------------------|
| ___ treatment plan | ___ diagnosis/assessment |
| ___ treatment recommendations | ___ progress toward treatment goals |
| ___ expected length of treatment | ___ medication |
| ___ attendance record | |
| ___ other (please specify): _____ | |

This authorization will expire upon case discharge or upon the date, event, or condition noted here:

_____ **OR** unless revoked in writing at a sooner date.

This information will be used and disclosed for the following purpose(s): _____

I understand that I may revoke this authorization at any time by notifying the provider in writing.

Client Signature

Date



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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ DOB _____
(client's name)

Legal representative, if applicable _____

authorize Jaime Galley _____
(Name of provider)

and Brightality Specialized Education and Support Services Education and Therapeutic Staff
(Name of provider)

to communicate and disclose to one another the following information:

___ My Mental Health Record in its Entirety **OR** only the following information:

- | | |
|-----------------------------------|-------------------------------------|
| ___ treatment plan | ___ diagnosis/assessment |
| ___ treatment recommendations | ___ progress toward treatment goals |
| ___ expected length of treatment | ___ medication |
| ___ attendance record | |
| ___ other (please specify): _____ | |

This authorization will expire upon case discharge or upon the date, event, or condition noted here:

_____ **OR** unless revoked in writing at a sooner date.

This information will be used and disclosed for the following purpose(s): _____

I understand that I may revoke this authorization at any time by notifying the provider in writing.

Client Signature

Date