Healing Path counseling

Brigid Zarbock, PsyD
Shannon Merkin, LCSW, PMH-C
Jordyn Varga, PsyD

1010 Jorie Blvd
Suite 112
Oak Brook, IL 60523

2100 Manchester Rd.
Bldg C, #1620
Wheaton, IL 60187

10540 S. Western Ave.
Suite 312
Chicago, IL 60643

p.630-296-7449
f.630-296-7532

Communication Policies and Informed Consent

Phone Communication

Our main office number is 630-296-7449. This line is not monitored 24/7. You are able to leave a voicemail for the provider you are calling or for administration if you are calling about billing, hours and location, services inquires, etc. The office voicemail is not monitored over the weekend and calls will usually be returned within 1 business day. If you are having an emergency, do not call the office, call 911 or go to your local emergency department.

Email Communication

As you recall, when you first called the office, we asked you to verbally consent to the use of email, or decline the use of email to communicate with us. This allowed us to be able to send you the intake paperwork electronically and for you to send us information electronically. As we mentioned, email is not the most secure form of communication, however, we know that this can be convenient for clients.

Additionally, we use email communication only with your permission and only for administrative purposes. Emails should be limited to things like: appointment changes, scheduling, brief information exchange, billing questions, and other related issues. Email communication is NOT to be used to provide/receive treatment services or take the place of therapy sessions. Please do not email about clinical matters (this includes looking for issues or concerns to be addressed that can be addressed in the next session).

If there is a concern that is an urgent emergency and cannot wait until the next session, please call:
911
800-950-NAMI.
Text "NAMI" TO 741741.
Or call the DuPage Crisis Line at (630) 627-1700, this is a 24/7 line.

Please note, emails are typically not monitored over the weekend or after business hours. During the business week, please allow 1 business day for us to respond, although we usually try to respond sooner than that.

Texting Communication

Much like email, although texting is convenient, it is not a secure form of communication. However, we know that this can be a helpful tool for quick communication. Texting will only be done with your consent and should only be used for scheduling or brief administrative questions (to cancel or let us know you will be late, or other related scheduling, to update something with billing or insurance, etc.).

Texting communication is NOT to be used to provide/receive treatment services or take the place of therapy sessions. Please do not text about clinical matters (this includes looking for issues or concerns to be addressed that can be addressed in the next session).

If there is a concern that is an urgent emergency and cannot wait until the next session, please call:
911
800-950-NAMI.
Text "NAMI" TO 741741.
Or call the DuPage Crisis Line at (630) 627-1700, this is a 24/7 line.

PLEASE NOTE: the phone numbers that you have are not actual cell phone numbers. This means that text messages and voicemails do not get checked in real time. They will get checked much like email; during business hours during the business week.

Social Media

We do not communicate with, or contact, any of our clients through social media or networking platforms such as Twitter, Facebook, LinkedIn, Google, Instagram, Pinterest, etc. In addition, if we discover that we have accidentally established an online relationship with you, we will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

We may participate on various social networks for personal and marketing purposes, but not in our professional capacity as a mental health provider. If you have an online presence, there is a possibility that you may encounter us by accident. If that occurs, please discuss it with us during our next session.

Consent for Non-Secure Communication

If you use non-secure electronic methods to communicate with us (email/texting) there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited
to:

· People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
· Your employer, if you use your work email to communicate with your therapist.
· Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with your therapist about ways to keep your communications safe and confidential.

I consent to allow Healing Path Counseling, LLC to use unsecured email and mobile phone text messaging to transmit to me the following protected health information and for myself to transmit the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Acknowledgment of emails and phone calls received
-Insurance information
-Personal and Demographic information

By signing, I attest that I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Name of Client/Insured (Print)

_____ _____

Client Sign Here Date

_____ _____

Responsible party please sign here (self, guardian, parent) Date

_____ _____

Provider Date

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Informed Consent for Psychotherapy & Psychological Services

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, 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. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. We cannot promise that your behavior or circumstance will change. We can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

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/her self 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. Suspected neglect of the parties named in items #3 and # 4.
5. If a court of law issues a legitimate subpoena for information stated on the subpoena.
6. 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 we 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 we see each other accidentally outside of the therapy office, we will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize your privacy. However, if you acknowledge us first, we will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

By signing, I attest that I have read and understand this Informed Consent for Psychotherapy & Psychological Services.

Name of Client/Insured (Print):_____

_____ _____

Client Sign Here Date

_____ _____

Responsible party please sign here (self, guardian, parent) Date

_____ _____

Provider Date

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Release of Information

This form, when completed and signed by you, authorizes Healing Path Counseling LLC (HPC, LLC) and Dr. Brigid Zarbock or Dr. Jordyn Varga to release and obtain protected information to/from persons or agencies you designate.

I authorize HPC, LLC to release and/or obtain the following:

_✘_Verbal Exchange **_____Clinical Chart** (excludes Psychotherapy Notes)

_____Billing Records **_✘_Assessment Results** **_____Other:**

About myself_____ or _____(child)

This information should only be released to or received from the names below:

1. **Insurance Company Name (to bill your carrier)_____**
2. **SURGEON:_____** Please Include your surgeon's Fax #:
3. **_____**
4. **_____**

I am requesting HPC to release and obtain this information for the following reasons:

_✘_At my request **_____For treatment planning and implementation**

_✘_For billing/payment purposes **_____ For continuity of treatment**

_✘_Surgical candidacy **_____Employment evaluation**

****This authorization will remain in effect until:_____**

- I understand I have a right to revoke this information, in writing, at any time by sending written notification to Healing Path Counseling, LLC and Dr. Brigid Zarbock, Shannon Merkin, LCSW, PMH-C, Dr. Jordyn Varga
- I understand that I have the right to inspect the disclosed mental health information.
- I understand the information to be disclosed is confidential and is provided only to the party specified in the above consent. The receiving party cannot redisclose the information, without my consent. This is specific to Illinois Law.

_____
Name of Client/Insured (Print)

_____ _____
Client Sign Here Date

_____ _____
Responsible party please sign here (self, guardian, parent) Date

_____ _____
Provider Date