CHERYL L YAKAVONIS, MEd, LPC
CLIENT INFORMATION AND POLICY STATEMENT

As a new client, it is important to provide you with information relevant to treatment, confidentiality, and office policy. Please review the following information. I am happy to respond to any questions you may have regarding treatment, confidentiality, fees, or office policy during your initial session or at any time during your treatment.

Professional Disclosure

I, Cheryl Yakavonis (counselor), earned a Master of Education Degree in Counseling from William Paterson University (Wayne, NJ) in 2006. I am a licensed professional counselor (LPC), licensed both by the Commonwealth of Pennsylvania's State Board of Social Workers, Marriage and Family Therapists and Professional Counselors (License#: PC004848) as well as the Professional Counselor Examiners Committee of the New Jersey State Board of Marriage & Family Examiners (License#: 37PC00408600). I am also a Nationally Certified Counselor (NCC#: 214886). I have been licensed as an LPC since 2008 and am also a member of the American Counseling Association and Pennsylvania Counseling Association. Periodically, for professional development, I consult with other licensed professional counselors. My education and training have prepared me to counsel individuals, couples, groups, parents, families, children and adolescents.

Purpose and Effects of Counseling

The basic purpose of psychological counseling is to help people cope with problems in daily living and to deal with inner conflicts which hinder various aspects of personal satisfaction and functioning. The purpose is usually accomplished by increasing the client's personal awareness, increasing the client's acceptance of himself or herself and others, and having the client make behavioral changes to attain his or her personal goals.

At any time you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from the counseling process, specific results cannot be guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Benefits vs Risks of Face-to-Face and/or Telehealth Video Counseling

As a result of the impact of the COVID 19 virus ("corona virus"), and the stay-at-home orders that have been implemented by the national government as well as the government of Pennsylvania, a number of options have been made more readily available for individuals to access mental health counseling via virtual means. As of the date of this informed consent revision (May 23, 2020), the U.S. Department of Health and Human Services' Office of Civil Rights (OCR) continues to exercise enforcement discretion and waive potential HIPAA penalties for consumer communication applications if used for telehealth during the COVID-19 nationwide public health emergency.

The OCR's discretion applies to widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19.

The following virtual options are currently offered to all clients as counseling platforms until the OCR makes the recommendation to return to the original HIPAA requirements and/or until the OCR provides an update to these requirements:

- Video Conferencing Sessions will be offered via: "SimplePractice Telehealth" and "Zoom" virtual platforms
- Direct, telephonic sessions will be offered via: direct telephone communication and FaceTime

Face-to-face appointments will be offered to all past/present/future clients as of May 27, 2020. An addendum has been added to this informed consent that reviews the potential risks of virus exposure by choosing to attend face-to-face sessions ("ADDENDUM A"). In the case of a resurgence of the corona virus, or another national medical emergency, this office will return to 100% virtual/telehealth sessions. An addendum for all clients to Consent to Telehealth Consultation has also been added to this informed consent ("ADDENDUM B").

If the OCR determines that the national emergency has been maintained, and HIPAA requirements return to their original, pre COVID-19, regulations, all clients who desire to continue telehealth sessions will be required to attend virtual sessions through the "SimplePractice Telehealth" virtual platform.

Appointments

Appointments usually are scheduled for approximately 50-minute sessions as needed. Since on-going counseling is a negotiated process between client and therapist, it should not be assumed that you will be "automatically" continuing in counseling. Both you and I may need to negotiate the need for further sessions. It is your right to discontinue counseling at any time you feel it is in your best interest to do so.

Length of Counseling

Counseling may be short-term (i.e., between five and twenty sessions) or longer-term depending on the type of problem or issues. For example, when one basic problem of recent onset is identified and is the sole focus of counseling, short-term counseling is likely to be sufficient. When there are multiple problems or difficulties which have persisted over a long period of time, counseling is likely to be longer in duration.

As a client (or the parent of a client), you are in complete control and may end our counseling relationship at anytime. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might not be helpful.

My services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time, for any reason, you are dissatisfied with my services, please let me know.

Confidentiality

Pennsylvania law provides that all information about your case is confidential, except in the following circumstances:

1) If someone is likely to hurt himself or herself, the counselor is required to take action to prevent self-destruction.
2) If someone plans to hurt someone else, there is a duty to warn the potential victim.
3) If a counselor believes that abuse of a child or elderly person is taking place, or may have taken place, the counselor is required to report the suspected abuse.
4) In some instance, the courts may subpoena records, most commonly in cases of contested divorce, custody, civil or criminal actions.

You may waive your right to confidentiality. If you desire that some information be discussed with another person, (i.e. your physician, spouse/partner, children, parents, etc.) your signature on a release of information form will allow me to comply with your request.

Records and Your Right to Review Them

I maintain individual client records which are kept in a secure location. These records include the personal information provided to me during our initial session, diagnosis, treatment plan, and progress notes for each session in which we meet. Progress notes are brief, noting only that you have been here, what interventions happened in session, and the topics we discussed.

Both the law and the standards of my profession require that I keep treatment records for at least 10 years after termination. Please note that clinically relevant information from emails, texts, and faxes are part of the clinical records. If you have concerns regarding the treatment records, please discuss them with me.

Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case, I will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, I will release information to any agency/person you specify unless I assess that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

Health Insurance & Confidentiality of Records

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Upon your authorization, only the minimum necessary information will be communicated to the carrier. I have no control over, or knowledge of, what insurance companies do with the information I submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality and privacy.

Diagnosis

If a third party, such as an insurance company, is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the DSM-V.

HIPAA

You are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality.

Insurance

At this time, I am an approved provider for the following insurance networks:

- Blue Choice Health Plan (PPO)
- Empire Plan (Beacon Health Options)
- OptumHealth/United Behavioral Health
- Highmark Blue Cross/Blue Shield
- Geisinger Health Plan
- GHI Commercial (Beacon Health Opt.)

You must pay me your deductible at the beginning of each calendar year if it applies and any co-payment/co-insurance payment at each session. You must arrange for any pre-authorizations necessary. I will bill directly to your insurance company via electronic means. You must provide me with your complete insurance identification information, and the complete address of the insurance company. If a check is mailed to you to cover your balance due, you are responsible for paying me that amount at the time of our next appointment. If the insurance over-pays me, I will credit it to your account or refund it to you if you would prefer that.

Fees

Fees are based on the amount of time involved. The current fees for services are:

Intake Session 60-75 minutes: $150 **53-75 Minutes: $150** **15-30 Minutes: $65**
43-52 Minutes: $120 **31-42 Minutes: $85**

A sliding scale fee is available to clients who may not be covered by insurance, or in other circumstances.

These fees include individual, marital, or family therapy; letters, consultations, court testimony, including any time waiting to testify, telephone calls made to a client or on the client's behalf (long distance charges are additional), and reviewing formal reports or records. You will be charged for all time spent with you or on your behalf.

You are asked to pay any co-insurance payment/co-payment/session fee payment in full at each session unless other arrangements have been made between the you and the counselor. The following payments will be accepted: Cash, check and debit card, credit card and Apple

Pay. Debit/credit cards and Apple Pay will be processed through Square Card Reader Processing. Electronic receipts will be sent to you via email and/or text message immediately following processing. A "Customer Record" is maintained within my Square Card Reader account that will include:
1) Your first name and last initial
2) Your email address
3) Your cell phone/text phone number.

If you are in need of an itemized statement, for insurance purposes, I will email an encrypted document (Word or PDF) to the email address that I have on file.

If an account is overdue and no provision for payment has been made, the account may be turned over to a collection agency, attorney or filed with the Small Claims division of Municipal Court.

Telephone Calls/Text-Messages/Email Messages

Please try to make any telephone calls to me at (570) 213-2817 during normal business hours, 9:00am-5:00pm, Monday through Friday, in order to assure your call being returned as promptly as possible. If your message is urgent, please say so on the message. I will answer your call as quickly as possible, and do my best to respond within 24 hours.

If you choose to text or e-mail to communicate with me, I strongly encourage you to not include confidential or private information regarding your health/mental health condition

If you have an emergency, please call emergency services at 911 or go to the nearest hospital for help. Do not wait for me to call back.

Cancellation and Missed Appointments

If you find it necessary to cancel a scheduled appointment, a 24-hour advance notice, by means of a message left on my voicemail, (570) 213-2817, is required to avoid charges. You will be charged $60 for the time you reserved for the appointment if 24-hour, or prior notice is not given.

Thank you for taking the time to review these policies. By your signature below, you are indicating that you read and understood this statement, and that any questions you had about this statement were answered to your satisfaction.

I have read and understand the above information on Cheryl L Yakavonis, LPC's procedures. A copy of this statement has been provided to me for my records.

_____	_____
Printed Name of Client or Child	Date
_____	_____
Signature of Client or Legal Guardian	
_____	_____
Signature of Client or Legal Guardian	Signature of Counselor

Cheryl L Yakavonis, LPC
115 Learn Rd, 2nd Floor
PO Box 261
Tannersville, PA 18372
(Form Revised: 5.24.2020)

(570) 213-2817
Cheryl Yak7391@gmail.com
PA License #: PC004848
NPI #: 1598932857

CHERYL YAKAVONIS, MEd, LPC, NCC, ACS
ADDENDUM TO CLIENT INFORMATION AND POLICY STATEMENT
ADDENDUM A: INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the COVID-19 pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. ***Initial each to indicate that you understand and agree to these actions:***

_____ You will only keep your in-person appointment if you are symptom free.
_____ You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee.
_____ You will wait in your car or in my designated office waiting area, until no earlier than 5 minutes before our appointment time.
_____ You will wash your hands or use alcohol-based hand sanitizer when you enter the waiting area and my office
_____ You will adhere to the safe distancing precautions we have set up in the waiting room and my office. For example, you won't move chairs or sit where we have signs asking you not to sit.
_____ You will wear a mask in all areas of the office (I will too).
_____ You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me.
_____ You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.

_____ If you are bringing a child or another family member, you will make sure that all visitors follow all of these sanitation and distancing protocols.

_____ You will take steps between appointments to minimize your exposure to COVID.

_____ If you have a job that exposes you to other people who are infected, you will immediately let me know.

_____ If a resident of your home tests positive for the infection, you will immediately let me know and we will then resume treatment via telehealth.

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and I have posted these efforts on my website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Counselor Signature Date

Form adapted from the following web resource:
https://www.apaservices.org/practice/clinic/covid-19-informed-consent

Cheryl L Yakavonis, LPC
115 Learn Rd, 2nd Floor
PO Box 261
Tannersville, PA 18372
(Form Revised: 5.24.2020)

(570) 213-2817
Cheryl Yak7391@gmail.com
PA License #: PC004848
NPI #: 1598932857

CHERYL YAKAVONIS, MEd, LPC, NCC, ACS
ADDENDUM TO CLIENT INFORMATION AND POLICY STATEMENT
ADDENDUM B: CONSENT FOR TELEHEALTH SERVICES

1. I understand that my therapist/mental health clinician wishes me to engage in a telehealth consultation and/or transition to telehealth therapy sessions.
2. My therapist/mental health clinician explained to me how the video/telephonic conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that telehealth consultations/telehealth therapy sessions have potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my therapist/mental health clinician or I can discontinue the telehealth consult/session if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with therapist/mental health clinician, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature: _____

Parent/Guardian Signature: _____

Date: _____

Cheryl L Yakavonis, LPC
115 Learn Rd, 2nd Floor
PO Box 261
Tannersville, PA 18372
(Form Revised: 5.24.2020)

(570) 213-2817
Cheryl Yak7391@gmail.com
PA License #: PC004848
NPI #: 1598932857