STEP
NEXT
THE
Counseling Services, LLC

Supporting your every step of the way…

CLIENT HANDBOOK

MISSION STATEMENT

We believe everyone has the right to the best quality treatment and that we can change lives through that treatment…not one life but generations to come. Our mission at The Next Step Counseling Services, LLC is to provide a friendly environment where your involvement will be welcomed, appreciated, and valued. Our hope is that the improvement in individual and family functioning will ultimately lead to what all of us are vitally concerned with – making life more effective, more satisfying and more meaningful. Our goal is to make the counseling process a positive experience and support you every step of the way…

Elizabethtown Office
1106 Tunnel Hill Road, Suite 100
Elizabethtown, KY 42701

Lexington Office
2285 Executive Drive, Ste. 420
Lexington, KY 40505

Office (270)765-2335
Fax (270) 765-2557
e-mail: admin@thenextstepky.com
Website: thenextstepky.com

Agency Mission Statement

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Consumer's Rights & Responsibilities

As a consumer, you have the right:

1. To receive services, if eligible, within the resources of this agency or to be provided with appropriate referral to other resources, regardless of race, religion, sex, ethnicity, age or handicap.
2. To receive quality treatment by competent staff, and to be treated with dignity and respect.
3. To confidential provision of treatment, in accordance with legal guidelines and agency policies.
4. To receive services in a clean and safe environment.
5. To receive services within the least restrictive environment possible.
6. To receive an itemized statement upon request if you are a paying consumer with an explanation of charges and fees for services.

It is your responsibility as a consumer or parent/guardian of a minor:

1. To be open and honest with treatment provider(s) and to participate in the development of and to comply with all aspects of your plan of care and treatment recommendations. Active participation of the family in planning for treatment, as needed.
2. To provide accurate financial information and arrange for payment of services.
3. To provide staff of The Next Step Counseling Services, LLC, information regarding any changes in income, insurance, address, phone number, and medication.
4. To keep appointments as scheduled or, to contact staff at least 24 hours prior to the appointment if needing to reschedule or cancel.
5. To show respect and concern for other consumers and staff and to respect their privacy.
6. To ask questions at any time you do not understand anything related to our services.

Limits of Confidentiality

The confidentiality of mental health, substance abuse, and mental retardation/developmental disabilities records maintained by the agency are protected by one or more Federal and/or State laws and regulations. Information cannot generally be disclosed about a consumer unless:

1. The individual is a danger to him/herself or others;
2. The individual consents in writing;
3. The disclosure is allowed or required by a court order;
4. The individual is being evaluated for the purpose of establishing his/her competence;
5. The individual is a victim or perpetrator of child abuse, neglect or dependency;
6. The individual is a victim or perpetrator of adult abuse, neglect or dependency;
7. Funding and accreditation bodies require us to give information to verify that we provide the services we said we did, and that the services provided met quality standards;
8. Release of information is necessary to collect just debts (e.g., name, address, telephone number, amount owed);

9. The disclosure is made to qualified personnel for research, audit, or program evaluation;
10. Occasionally a court may, by power of subpoena, attempt to obtain privileged information against the consumer's wishes. In such cases, attempts are made to protect the client's rights and confidentiality. Success at doing so cannot be guaranteed and we may be court ordered to release information or take deposition;
11. Mental health professionals have a duty to warn intended victims of a consumer's threat of violence.

Federal law and regulations do not protect any information about a crime committed by you either at the time of service or against any person who works for the program or about any threat to commit such a crime.

As a participant in a therapeutic or education service provided by The Next Step Counseling Services, LLC, individuals are required to maintain confidentiality where it pertains to other participants of our services (e.g., participants of group therapy or education classes). In addition, you are required to maintain confidentiality where it pertains to issues discussed by any such other participants.

If you have any questions about confidentiality, please discuss them with your therapist or service provider.

Notice of Privacy Practices

Effective date: April 14, 2003

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

Introduction
At The Next Step Counseling Services, LLC we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information.

Understanding Your Health Record/Information
Each time you visit The Next Step Counseling Services, LLC a record of your visit is made. Typically, this record contains your demographic information, your presenting problems, diagnosis treatment, and a plan for future treatment. This information, often referred to as your health or medical record, serves as a:

1. Basis for planning your care and treatment,
2. Means of communication among health professionals who contribute to your care,
3. Legal document describing the care you received,
4. Means by which you or a third-party payer can verify that services billed were provided,
5. A tool in educating health professionals,
6. A source of data for medical research,
7. A source of information for public health officials charged with improving the health of this state and the nation,
8. A source of data for our planning and marketing,
9. A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights
Although your health record is the physical property of The Next Step Counseling Services, LLC the information belongs to you. You have the right to:

1. Obtain a paper copy of this notice of information practices upon request,
2. Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524,
3. Request a correction or amendment to your health record as provided in 45 CFR 164.528,
4. Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
5. Request that we send you confidential communications of your health information by alternative means or at alternative locations as provided in 45 CFR 164.522,
6. Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
7. Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities
The Next Step Counseling Services, LLC is required to:

1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction, and
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain at any time. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Telehealth Services

Technology Assisted Mental Health Services, hereafter referred to as "Telehealth", involves the use of electronic communications to enable therapists to provide services to individuals who choose access to care via technology assisted services. Telehealth may be used for services such as individuals, couples, or family therapy, follow ups, and training/education in a group setting. There are some barriers to telehealth compared to sitting with a therapist in the same room. Limitations include, but are not limited to, not being an appropriate means of therapy for all populations. The limitations can be addressed and are minor depending on how well the sound and video are working during telehealth sessions and depending on the level of care needed by the patient.

Expected Benefits: There are several benefits to telehealth services including improved access to care and expanded access to providers with expertise that may not be available in your local community.

Possible Risks: There are potential risks associated with the use of telehealth services. The risks include, but may not be limited to information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate treatment, the client may choose a location that is not private or secure, delays in treatment could occur due to the deficiencies or failures of equipment, and security protocols could fail (potentially causing a breach of privacy of personal information). However, security measures will be taken to prevent a breach of privacy.

An additional risk may include the use of email messages which are not secure forms of communication. Some therapists may have encrypted emails so please discuss with them their preference on email. If you contact a therapist via email regarding clinical issues understand that these are not guaranteed a secure form of communication, and there is possibility that we will not get the message in a timely manner, or that communication will be interpreted in an unclear manner.

Additional Points for Client Understanding:

1. I understand that telehealth services are completely voluntary and that I can choose not to do or not to answer questions at any time.
2. I understand that none of the telehealth sessions will be recorded or photographed by the therapist or the patient.
3. I understand that the laws that protect privacy and confidentiality of client information also apply to telehealth and that no information obtained in the use of telehealth which identifies me will be disclosed to other entities without my consent.
4. I understand the telehealth is done over a secure communication system that meets or surpasses HIPPA encryption standards, but there is no absolute guarantee that a security breach is not possible, and I freely accept the very rare risk that this could affect confidentiality.
5. I understand there are potential risks of technology, including interruptions, unauthorized access, and technical difficulties. I understand my therapist or myself can discontinue the telehealth sessions if it is no longer effective.
6. I understand that my demographic information may be shared with other individuals for scheduling and billing purposes.
7. I understand that I may experience benefits from the use of telehealth, but that no results can be guaranteed or assured.
8. I understand that if there is an emergency during a telehealth session, my therapist will call emergency services and my emergency contacts.
9. I understand that if the telehealth connection drops while I am in a session, that I will try the link again. If I still cannot make the connection work, then I will wait ten minutes for my therapist to contact me. If they are unable to reach me, then I understand there was a major technical difficulty and will expect the therapist's office to call within 24 business hours to reschedule the appointment.
10. I understand that I will be asked to create a safety plan with my therapist in case of an emergency.
11. I understand that the session will be scheduled in Eastern Standard Time and the delivery of services will be synchronous.
12. I acknowledge that I will not seek to meet with my therapist if I am outside of the state of Kentucky.

Additional Documentation Required to Begin Telehealth (these must be faxed, scanned, emailed or mailed to therapist prior to treatment beginning):

Valid Driver's License or copy of Birth Certificate.
If a minor is a patient and parents are divorced, or a child is living with someone other than parents, custody papers evidencing guardians' authority to seek treatment.

Consent to Use and Disclosure of Health Information

Examples of Disclosures for Treatment, Payment and Health Operations
We will use your health information for treatment.
For example: Information obtained by a nurse, physician, therapist, case manager, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, and services rendered.

Uses and Disclosures Requiring You to Have an Opportunity to Agree or Object
Others Involved in Your Care: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your protected health information that directly relates to that person's involvement in your care or payment related to your care. In case of emergency, we may notify or assist in notifying a family member, personal representative or other person responsible for your care of your location, general condition, or death.

Uses and Disclosures Not Requiring Consent or Authorization
When Required by Law: We may disclose your PHI when law requires that we report information regarding suspected abuse, neglect, or domestic violence to the governmental agency authorized to receive such information. We may also disclose your PHI in response to a valid subpoena or court order.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to drugs, food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Health Oversight: Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Coroners, Medical Examiners, and Funeral Directors: We may disclose health information to a coroner, medical examiner, or funeral director consistent with applicable law to permit them to carry out their duties.

Coordination of Benefits Policy:

If you or your child have more than one insurance plan, you must update your Coordination of Benefits (COB) with your insurance provider. This helps determine which plan pays first and prevents claim denials.

It is the responsibility of the policyholder (e.g., parent or guardian) to keep COB information current. If COB is not updated and claims are denied, the client may be responsible for the full session fee until insurance is corrected and claims can be reprocessed.
Please note: We are unable to update COB on your behalf, but we're happy to guide you on how to do so.

Consent for Treatment for 16-17 Year Olds

In accordance with state law (*Kentucky Revised Statute § 214.185)*, individuals aged 16-17 may consent to their own mental health treatment without the need for parental consent. However, if the treatment involves payment, we will seek parental consent for financial matters, including billing and insurance coordination.

Court-Involvement

Our practice does not get involved in court-related matters concerning individual, marital, or family counseling. However, we do offer court-ordered services for specific programs, including Anger Management, Parenting, Substance Abuse, and Domestic Violence counseling.

Please note that these services are distinct from individual therapy. We do not provide documentation, testify, or participate in legal proceedings related to individual therapy sessions. If such involvement is requested, we reserve the right to refer the client to an alternative agency.

Agreement to Pay for Services

I request that the therapist providing services to me (or this client) provide professional services to me (or this client). I agree to pay this therapist's fees as follows: Session fee $90, Assessment fee $125, Group Fee $30.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.
I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

Our office requires a 24-business-hour notice in order to cancel an appointment. All appointments cancelled or not kept without a 24-business-hour notice will incur the full session charge or may be referred out to a more appropriate resource.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the agency's Privacy Officer, at 270-765-2335. If you believe your privacy rights have been violated, you can file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

The Next Step Counseling Services, LLC
Client Handbook Agreement

I, _____, had the opportunity to review and/ or received The Next Step
(Client Name)
Counseling Services Client Handbook, which contains information about the following topics. My signature and initials below indicate that I understand the information pertaining to:

_____ Consumer Rights & Responsibilities

_____ Limits of Confidentiality

_____ Notice of Privacy Practices/HIPAA

_____ Telehealth Services

_____ Consent to the Use and Disclosure of Health Information

_____ Court Involvement Policy

_____ 16–17-Year-Old Consent to Treatment

_____ Agreement to Pay for Services

- Session fee $90
- Assessment fee $125
- Group Fee $30

Our office requires a 24-hour notice in order to cancel an appointment. All appointments cancelled or not kept without 24-hour notice will incur the full session charge of $90. If missed appointments become an issue services may be referred out to a more appropriate resource.

_____ _____
Consumer/Guardian Signature/Relationship Date

_____
Printed Name

_____ _____
Witness Signature Date

The Next Step Counseling Services, LLC
Authorization to Release Information

I, _____

Client Name **Social Security Number** **Date of Birth**

hereby authorize: **The Next Step Counseling Services, LLC**
1106 Tunnel Hill Road, Suite 100
Elizabethtown, KY 42701
Phone (270) 765-2335 /Fax (270) 765-2557

To obtain from _____ To release to _____

Name:_____Agency:_____

Address:_____

The following information: (nature of information is as limited as possible) Check each category that applies:

____ Attendance Report; _____Discharge Summary; _____Status of Recommended Services;
____ Summary of Assessment/Evaluation Summary to include information regarding impressions of the Therapist in the areas of Substance Use, Domestic Violence, Mental Health and Learning Problems, to include recommendations and plan for services and to redisclose any collateral information collected during the assessment process;
____ Referral Information/Treatment Information to include Drug and Alcohol Abuse;
____ Referral Information/Medical Information from a Referring Physician
***Referring Physician Signature _____
____ Any and all Client Care/Treatment Information

I understand that the purpose of this disclosure is for:

Referral _____ Monitor Progress _____ Coordination of Services _____Other: _____

PROHIBITION ON REDISCLOSURE: According to 45 CFR 164.508 c2Ciii health information may be redisclosed by the recipient. However, pursuant to **KRS 304.17A-555**, **Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure** mental health/chemical dependency info may not be used and/or shared by the recipient of said information unless specific, written consent for redisclosure is authorized by the person to whom it pertains. Additionally, **Federal Regulations 42CFR, Part 2** prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have read this form and agree to the disclosure set forth above. I understand that this form is not required as a condition of my involvement with this agency. I will be given a copy of this form if I ask; and, I may inspect or obtain a copy of material to be disclosed if I ask. I understand that this authorization expires one year from date of signature or sooner. I understand that I can revoke this authorization at any time by signing the bottom of this form. However, The Next Step Counseling Services, LLC cannot be responsible for any release(s) of information prior to notification or when required by law.

Time Limitation of Release: This release expires: _____

_____ _____
Signature of Client Date

_____ _____
Witness Signature of Parent or Authorized Representative