2200 21st Avenue South
Suite 229 – Kinnard Bldg.
Nashville, TN 37212

**MICHELE E. BURGNER, MSSW, LCSW**
Licensed Clinical Social Worker - Psychotherapist

Phone (615) 969-3664
Fax (615) 298-3011
michele@micheleburgner.com

**WELCOME!** I believe that engaging in the psychotherapy process is a courageous step in your efforts toward growth and healing. I approach psychotherapy as a unique kind of learning process that is facilitated by a collaborative therapeutic relationship and a confidential, safe environment. I am committed to upholding the professional boundaries and ethics in the therapeutic relationship that allow me to utilize my skills and experience to focus on your goals for growth and healing. It is both a privilege and responsibility to have the opportunity to earn your trust and honor the vulnerability and confidentiality of the personal information you share with me.

My role is to be a listener, facilitator, teacher, and advocate. I learn with clients through their journeys from despair to hope, confusion to clarity, fear to courage and shame to worthiness. I believe thoughts, feelings, behaviors, and belief systems can change, and that vulnerability is the courageous opposite of weakness that can open a pathway to change.

I am currently seeing clients via telehealth only. When the COVID-19 test positivity rate is below 5% for 30 days and the vaccination rate is above 70% for Davidson and surrounding counties, I may consider options for meeting in person in a space that allows ample ventilation and sufficient space for social distancing.

I acknowledge and appreciate that the nature of a professional relationship between psychotherapist and client is much more personal than most other professional relationships. That being said, my practice functions similarly to other independently owned small businesses regarding operating policies and service agreements. As such, your signatures and initials below indicate your acknowledgment of informed consent about, and agreement to, the information and policies provided in this document. Insert an image of your signature/initials if possible. Otherwise, your typed name/initials will be accepted as your signature.

## CONTACT & BILLING INFORMATION

Please fill in ALL blank areas and check boxes that apply to you.

Today's Date:_____ Date & Time of First Appt.:_____

**Client Name:**_____

Gender:_____ Date of Birth: _____ Ethnicity: _____

Social Security# (for insurance purposes only): _____ Marital Status: _____

Street Address:_____

City: _____ State: _____Zip:_____

Email Address: _____ Send email? _____

Home Phone#: _____ Leave msg? _____

Work Phone#:_____ Leave msg? _____

Cell Phone#: _____ Leave msg? _____

Occupation: _____ Employer: _____

Student: Yes ☐ No☐ If Yes, School name and grade/level: _____

**Emergency Contact:** _____ Relationship to you: _____

Email Address: _____ Send email? _____

Home Phone#: _____ Leave msg? _____

Work Phone#:_____ Leave msg? _____

Cell Phone#: _____ Leave msg? _____

**How did you learn about Michele?** _____

_____

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## POLICIES, INFORMED CONSENT, SERVICE and PAYMENT AGREEMENT

Please fill in ALL blank areas and check boxes that apply to you.

### CONTACT INFORMATION

I check email and voice mail as often as possible during business hours. Email communication is my preference, but you are welcome to leave a message on my confidential voice mailbox. I will make every effort to return your email or call on the same day. Please be advised that while every reasonable precaution is being taken to ensure the confidentiality of email and cell phone communication (including text messages), the possibility exists, by means beyond our control, these communications may not always be secure.

### FEES and PAYMENT FOR THERAPY SESSIONS

Enter the amount of your fee agreement here: $ _____

*Client Initials:* _____

- My fee is $150 per 60-min session. $150/60 min is the basis for prorating costs of sessions shorter or longer than 60 min.
- In consideration of financial hardships, I can offer a discounted fee option to a limited number of clients on a case-by-case basis as my schedule capacity allows.
- I accept payment via cash, credit card or check. Alternative payment methods Venmo, PayPal, and Zelle do not meet HIPAA requirements for protection against the possible sharing of client data. If you choose, I will accept payment via these methods, given your express acknowledgement that you accept the risk and take full responsibility for having read and understood this information (☐ Yes or ☐ No ).
- I prefer to receive payment at the end of each session, or that your balance is paid in full each month.
- NOTE: Billing services are provided through a Business Associate Agreement (BAA) with AGARDO, LLC (Misty Campbell, owner)

### INSURANCE

I do not participate as an in-network provider with any insurance plans except traditional Medicare. I am glad to submit out-of-network claims to your insurance company upon request, so your payments to me may be considered for direct reimbursement to you. I do not keep track of any claims after they are submitted. **Choose one of the options below**:

☐ **Medicare** Complete the insurance information below if you have traditional Medicare.

☐ **No** I do not want Michele E. Burgner, MSSW, LCSW to submit out-of-network claims to my insurance company. STOP HERE.

☐ **Yes** I want Michele E. Burgner, MSSW, LCSW to submit out-of-network claims to my insurance company, specifying that any reimbursements be made directly to me. COMPLETE THE INFORMATION BELOW.

Primary Insurance: _____ Member ID# on card: _____

Policy#: _____ Group#: _____

Phone #s (Benefits/Eligibility): _____

Name of primary insured (if different from client): _____ Date of birth: _____

Secondary Insurance: _____ Member ID# on card: _____

Policy#: _____ Group#: _____

Phone #s (Benefits/Eligibility): _____

Name of primary insured (if different from client): _____ Date of birth: _____

### CANCELLATION POLICY

- There is no charge when a minimum of 24 hours' notice is given prior to your scheduled appointment time.
- There is a **$100** charge for appointments missed (no-show) or cancelled with less than 24 hours' notice prior to your scheduled appointment time.

| *Client Printed Name* | *Client Signature* | *Date* |
|---|---|---|

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## POLICIES, INFORMED CONSENT, SERVICE and PAYMENT AGREEMENT

### BENEFITS and RISKS

The benefits or outcomes of psychotherapy vary according to therapist and client personalities and presenting concerns of the client. Clients may make significant changes in their relationships with partners, parents, friends, relatives, co-workers, and others. Clients may change their personal goals, begin to feel different about themselves or may otherwise alter significant aspects of their lives. No specific outcome can be promised or guaranteed.

### CONFIDENTIALITY

The information you share with me is confidential. I am required by state law and by the ethics of the social work profession to protect your legal right to confidentiality unless you provide express written consent otherwise. This applies equally to adults and minor children. I may ask you to sign a consent form giving me authorization to consult with people who are relevant to your care, such as other healthcare professionals, teachers, family members, attorneys, etc. You can change or revoke an authorization at any time with a direct verbal or written notice.

### LIMITS OF CONFIDENTIALITY

There are a few situations in which your confidentiality is not protected. I am required by Tennessee law to report the following:

- If you are in imminent danger of harming yourself or others
- If I suspect that a child or elder is being abused or neglected
- If you are involved in legal proceedings and I am court-ordered to release your records

### EMERGENCY RESOURCES

My outpatient practice is not equipped to provide emergency services or 24/7 emergency resource support. As needed, I will work with each client individually to develop a personal safety/crisis/emergency management plan. In the event of an acute, life-threatening emergency or a situation that presents imminent risk of harm, clients are directed to call **911** or go to the nearest emergency room. Additional resources accessible 24-hours a day, 7-days a week are listed as follows:

- Tennessee Statewide Crisis Line: 855-274-7471 (855-CRISIS-1); tn.gov/crisisline
- Mental Health Cooperative (MHC) 24/7 Crisis Services: 615-726-0125; mhc-tn.org; 250 Cumberland Bend, Nashville, TN 37228.
- Nashville Metro Police Non-Life-Threatening Emergency Helpline: 615-862-8600
- Crisis Intervention Center: 615-244-7444 or 800-681-7444

### TELEHEALTH SERVICES

See detail and informed consent on separate page.

*Client Printed Name* *Client Signature* *Date*

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## TELEHEALTH INFORMED CONSENT

Please fill in ALL blank areas and check boxes that apply to you.

1. Telemental health is the practice of delivering clinical mental health care services using interactive technology assisted media or other electronic means between a practitioner and a client who are in two different locations. The technology includes but is not limited to video, telephone, email, text, and apps.
2. I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
3. I will need access to and familiarity with the appropriate technology to participate in telemental health services.
4. Telemental health is a useful resource to facilitate improved access to mental health care in circumstances where the client and/or therapist are unable to meet face to face.
5. Telemental health services are not utilized for emergencies. If you are experiencing an emergency, you need to follow the exiting Office Policies to call 911 or go to your nearest emergency department.
6. If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
7. During a telemental health session, we could encounter technical difficulties resulting in service interruptions. If we are unable to reconnect within five minutes, my therapist will contact me using other contact information I have provided (phone, text, email, app) to discuss a different means of continuing the session or rescheduling the session. I may also initiate contact with my therapist in this situation via other contact information she has provided (phone, text, email, app).
8. In preparation for a potential emergency, *I agree to provide the name and contact information of my emergency contact person. Additionally, I agree, at the beginning of each session, to inform my consultant of the address where I am located. Only in the case of a life-or-death emergency will my consultant communicate with my emergency contact person and/or appropriate authorities to go to my location or take me to the hospital*.

   Emergency Contact Name: _____ Relationship to you: _____

   Phone: _____ Email: _____
9. HIPAA compliant interactive technologies used in telemental health incorporate network and software security protocols to protect the confidentiality of client information transmitted via an electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. I am aware my therapist has a Business Associate Agreement (BAA) with Zoom that meets HIPAA criteria.
10. If there are technical issues with Zoom that interfere with the quality of a telehealth session, I assert my choice to utilize a different telehealth platform that provides better quality, even if that platform does not meet HIPAA criteria.
11. There are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to responds to emergencies.
12. The laws and professional standards that apply to in-person mental health services also apply to telemental health services. This document does not replace other agreements or document of informed consent.
13. There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
14. The privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

I have read and understand the information provided above regarding telemental health, have discussed it with my therapist/provider, and all my questions have been answered to my satisfaction.

| _____ | _____ | _____ |
|---|---|---|
| *Client Printed Name* | *Client Signature* | *Date* |

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## Consent and Authorization to Release Confidential Protected Health Information

Please fill in ALL blank areas and check boxes that apply to you.

**The purpose of this authorization** is to allow Michele E. Burgner, MSSW, LCSW to share my protected health information (PHI) with other individuals (primary or other healthcare provider, teacher, family member, attorney, etc.) of your choosing, to develop treatment recommendations and/or enhance support systems.

CLIENT NAME: _____ Date: _____

CHOOSE NO OR YES BELOW.

**NO** ☐ **I do not authorize** Michele E. Burgner, MSSW, LCSW to release information or make a request to obtain information from others in relation to my healthcare. *(If you checked NO, print and sign name, then **STOP HERE**.)*

SIGNATURE: _____ Date: _____

**YES** ☐ **I authorize** Michele E. Burgner, MSSW, LCSW to ☐ release information TO and/or ☐ obtain information FROM the individual/organization named below. *(If you checked YES, complete the information below then print and sign name at bottom of page.)*

Date of Birth: _____ Soc Sec#: _____ Home#: _____
Address: _____ Cell#: _____
City: _____ State: _____ Zip: _____ Work#: _____
Email: _____

**Provider/Physician or Other Specified Person/Entity information is to be shared with:**

Name: _____
Organization/Company: _____ Phone#: _____
Address: _____ Fax#: _____
City: _____ State: _____ Zip: _____ Other#: _____
Email: _____ Work# _____

**Information to be shared:**

☐ Dates of Contact ☐ Diagnosis & Treatment Plans/Recommendations ☐ Client Progress ☐ Other (specify below):

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I have been informed of the type of information being released and/or exchanged and the benefits and risks (if any). I understand psychotherapy/consultation services are not contingent upon my decision concerning the signing of this release. I understand this information is protected as confidential under state and federal law and cannot be disclosed without my written consent unless otherwise permitted in accordance with state and federal law and regulations. I understand this consent is valid as long as I am receiving psychotherapy/consultation services. I understand I may revoke this consent at any time by providing a direct verbal or written request.

SIGNATURE: _____ Date: _____

*Make additional copies of this page as needed for additional authorizations.*

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# Credit/Debit Card Payment Authorization Form Billing Information

Please fill in ALL blank areas and check boxes that apply to you.

Client Name: _____

Credit/Debit Card #:_____Exp: _____

CVV# (three digits on back side of card): _____

American Express_____Discover_____MasterCard_____Visa _____

**Name on Card:** _____

Street Address: _____

City/State/Zip: _____

Email Address: _____

Provider Name: Michele E. Burgner, MSSW, LCSW

**AGARDO, LLC Billing Services** - 2483 Goose Creek Bypass - Franklin TN 37064 - Office: 615-599-1244, Fax: 615-599-8885

**I authorize Michele E. Burgner, MSSW, LCSW c/o AGARDO, LLC, Billing Services to charge my Credit/Debit Card in the following manner:**

☐ Charge my Credit/Debit card at the time of each visit for the balance due. (This option includes an automatic charge of $100 for appointments that are missed or cancelled with less than 24 hours' notice in advance of your scheduled appointment time.)

☐ Charge my Credit/Debit card when I provide written or verbal authorization

I understand that charges will appear on my credit/debit card statement as a charge by "AGARDO, LLC", who will process my card on behalf of my provider.

_____
*Signature of Cardholder*

_____
*Printed Name of Cardholder*

_____
*Date*

**Internal Use Only**

Chart: _____
DOS:_____
Pvd Code:_____Amt: _____
Auth: _____
Dep:_____PD: _____
Processor:_____

MEB - Revised 10/21/2021

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## NOTICE OF POLICIES and PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

As a mental health professional, I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

### HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

**For Treatment**. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

**For Payment.** I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** I may use or disclose, as needed, your PHI to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law.** Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Limits of Confidentiality - Without Authorization.** Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is my practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

- **Child Abuse or Neglect.** I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.
- **Judicial and Administrative Proceedings.** I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order, or similar process.
- **Deceased Patients.** I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care

_____ *Client Initials* _____ *Date*

prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

- **Medical Emergencies.** I may use or disclose your PHI in a medical emergency to medical personnel only to prevent serious harm. I will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
- **Family Involvement in Care.** I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- **Health Oversight.** If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law Enforcement.** I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- **Specialized Government Functions.** I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public Health.** If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
- **Public Safety.** I may disclose your PHI, if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Research.** PHI may only be disclosed after a special approval process or with your authorization.

**Fundraising.** I may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

**Verbal Permission.** I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization**. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that I have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at ATTN: Michele E. Burgner, MSSW, LCSW, 2220 21st Avenue South, Suite 229, Nashville, TN 37212:

*Client Initials* *Date*

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- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I are not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with us. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

**COMPLAINTS.** If you believe I have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at ATTN: Michele E. Burgner, MSSW, LCSW, 2220 21st Avenue South, Suite 229, Nashville, TN 37212 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

**The effective date of this Notice is September 2013.**

**REFERENCES** 45 C.F.R. § 164.520 (https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html)

| *Client Printed Name* | *Client Signature* | *Date* |
|---|---|---|

*LAST PAGE – END OF DOCUMENT*