John P Sheppard, MD LADC ICADC

Associates in Psychotherapy & Family Counseling: An Affiliation of Independent Practitioners
34 Patchen Road, South Burlington, Vermont 05403
(802) 658-4208 ext. 6

Education

Fordham University, New York City, NY
Georgetown University School of Medicine, Washington, DC

Licensure

State of Vermont: Licensed Alcohol and Drug Counselor # 000424

The Purpose of Counseling:

Life can be difficult at times, and the way we relate to our lives can either promote growth or cause long-lasting consequences and suffering. My role in counseling is to help you discover ways to mindfully cultivate those parts of you which promote growth, while becoming more aware of and reducing habitual patterns which cause continued suffering.

Counseling is a collaborative process between you and your counselor. Together we will address personal, relational, mental health or substance abuse problems that you find important. As your counselor I will provide support, diagnostic information, feedback, a treatment plan, suggestions for readings/education, referrals as needed, and a space for your **confidential** disclosure. Please remember that counseling can be challenging, rewarding, and sometimes a difficult process. This policy statement is intended to clarify financial and legal aspects of the process so that these aspects can be agreed upon and thus interfere as little as possible with the ongoing therapeutic process.

Confidentiality:

Information disclosed in counseling is confidential. This assurance is the cornerstone of trust between you and me. There may be times when you and I decide that it would be helpful for me to speak to someone else about your treatment, such as a physician. In these instances information may be disclosed if you give me permission in writing. The limits to confidentiality are the following:

1) If you are using insurance, many insurance companies require treatment plans and diagnostic information before payment will be made.
2) If, in my clinical judgment, I determine that you are in imminent danger of hurting yourself or another person and no safety plan can be established, I am required to alert others.
3) I am legally required to report situations which involve abuse or neglect of children, adults who are incompetent, or adults who are physically or mentally disabled.

Methods and Duration of Treatment:

The duration of counseling varies based on your history, current circumstances, the issues we explore, and our mutually established goals for treatment. I use a variety of treatment methods including person-centered, cognitive-behavioral, psychodynamic and psycho-developmental. I have extensive experience in both mental health and substance issues and have treated both adults and adolescents. I have been supervised and trained in Individual, Group, and Family Counseling. I have experience working with a wide range of issues including Depression, PostTraumatic Stress Disorder, Substance Abuse and Dependence, Anxiety, Dual Diagnosis with Substance Abuse. I have been trained in brief therapy and longer-term models. Please feel free to ask me any questions you may have about my experience, training, the methods I use in treatment, or the expected duration of your treatment.

Appointments:

Appointments generally last between 45 and 50 minutes and are usually scheduled on a once a week or every other week basis. It is important that you arrive on time. If you are late, you will be unable to utilize your full appointment, but you will still be financially responsible for the whole session. I will wait 15 minutes for a late client, but will feel free to leave if I have not heard from you by then. My cancellation policy is as followsYou are requested to notify me by voice mail at least 24 hours in advance if you are unable to keep your scheduled appointment.

1) Notification at least 24 hours in advance of your appointment will result in no charge for the appointment and you will not be billed.
2) Notification less than 24 hours in advance of your appointment will result in a charge for the **FULL FEE [$95]** which will be billed **DIRECTLY TO THE CLIENT** (i.e. insurance will not be billed for a late cancellation or missed appointment). **Payment** will be expected by the next scheduled appointment. If your appointment time can be filled, however, there will be no charge for a late cancellation, so I appreciate you notifying me even if it is already a late cancellation, as I often can fill your time if I hear from you.

Fees and Payments

My fee is $95 for a 45-50-minute session of individual, couple, or family counseling. The length of the session may be determined by your managed care insurance coverage. Please feel free to talk to me about this. Co-Payment is expected at the time of service unless we have made other arrangements. In your first session we will agree upon your session fee and payment schedule. Electronic billing will be used if your insurance had made this service available. If you choose to use a charge or debit card to pay for services, there will be a $2 fee per transaction. This is a transaction fee and not a clinical service fee.

Please feel free to discuss payment questions or problems with me if you anticipate any difficulties. Should collection action ever be necessary I reserve the right to use a collection agency and/or pursue traditional court assisted collection methods. If this is necessary you will be responsible for my attorney fees and court costs.

Agreement and Confirmation of Disclosure

I agree to pay fees at the time of service, unless other arrangements have been made, and I will abide by the policies regarding fees and cancellations. This agreement will remain in effect until services have terminated and all payments for rendered services have been made.

I also give permission for John P Sheppard, MD LADC ICADC to release medical and other information necessary to process insurance payments that you as the client might request be rendered as partial or full payment for services rendered. A photocopy of this agreement is valid.

I have been given notification of the professional qualification and experience of John P Sheppard, MD LADC ICADC 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.

I also understand and attest to acknowledging that **Associates and Counseling and Family Counseling is an affiliation of independent practitioners**. *What this means is that each counselor practicing at 34 Patchen Road has a legally independent and separate practice from every other counselor here at 34 Patchen Road or at any other location of practice.*

Client Signature: _____ Date: _____

Parent or Guardian Signature: _____

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Demographic and Insurance Information

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone_____ Work Phone: _____

May I leave messages for you at these numbers? Yes No Preferred Number is: Cell Work Home *Please Circle*

Email Address:_____@_____ May I contact you by Email? _____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____ Gender: M F

Marital Status: S M D W CU Employment Status: Full-time Part-time Not Employed Student

Employer Information

Employer's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Work Phone _____ ext. _____ May I contact you at work during the day? Yes No

Primary Insurance Company Information - (If you choose to use insurance)

If do not choose to use insurance for personal reasons, please place a check mark here _____ and sign below:

Signature of Client: _____ Date ____/_____/_____

If you do choose to use insurance and have an insurance plan please fill out the information below:

Your relationship to the Insured: SELF SPOUSE CHILD OTHER (specify) _____

Insured's Name: _____Date of Birth of Insured _____/_____/_____

Insured's Employer _____

Insurance Company Name _____

Billing Address _____ City

_____ State _____ Zip Code _____

Insured's ID Number _____ Insured's Social Security Number _____

Policy or Group Number _____
Pre-certification Phone Number (usually on back of insurance card) _____

Secondary Insurance Company Information

Your relationship to the Insured: SELF SPOUSE CHILD OTHER (specify) _____

Date of Birth of Insured _____/_____/_____ Insured's Name: _____

Insured's Employer _____

Insurance Company Name _____

Billing Address _____

City _____ State _____ Zip Code _____

Insured's ID Number _____ Insured's Social Security Number _____

Policy or Group Number _____ Pre-cert Phone # _____

IS AUTHORIZATION NECESSARY FOR THERAPY? YES NO

Authorization Date _____ Spoke with _____

Person who made authorization call _____

In case of emergency contact the following person:

Name_____ Phone number_____

Name of Primary Care Physician _____ Phone # _____

Do we have your permission to contact your physician? Yes No

Current medications and amounts

Name of Medication	**Dosage**	**Frequency**	Prescribed for	Side-effects experienced

I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of medical benefits to John P Sheppard, MD LADC ICADC for services rendered.

Signature of Client or Guardian _____

Date _____

For Office Use Only

DSM DX

Axis I a_____ I b _____ II _____ III _____ IV _____ V (GAF)_____

Intake Date _____ Referral Source _____ Referral Phone _____

GAF: Current: ____ Highest GAF in Past Year: _____Clinicians Signature: _____

NOTICE OF PRIVACY PRACTICES

John P Sheppard, MD LADC ICADC

34 Patchen Road, South Burlington, VT 05403 (802) 658-4208

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. For psychologists this requires little change from the practice of confidentiality that has been required of our profession prior to HIPAA. In general, the HIPAA Act gives you, the client or patient, significant new rights to understand and control how your health care information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Please note that, for the practice of psychology, these HIPAA requirements compliment rather than add any significant change to our normal and usual practice as regards record keeping and confidentiality.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be performing counseling in this office, or making a referral to another health care provider for additional evaluation or treatment.

Payment means such activities as obtaining reimbursement services, confirming insurance coverage, billing or collection activities, and utilization review for managed care coverage and approval and/or at the request of a third party payer for your treatment (your insurance company). An example of this would be sending a bill for your counseling visit to your insurance company, or telephonically, by mail, or by fax, sending the necessary clinical information for your insurance company to approve more sessions for coverage for you.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to any and all individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that might be requested by or is of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior written authorization to take such actions.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer or to your psychocounselor.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction if Vermont law or Federal law indicates that to do so would be a violation of Duty to Warn Statutes of person or property, violation of mandated reporting of known abuse of a minor or child, or violation of mandated reporting of known abuse of an elderly or incapacitated person. As a counseling client/patient you own the privilege of confidentiality, and no information, including your presence in therapy or the fact that you are a patient, will be disclosed without your specific written permission in a release of information request. Counseling has traditionally always been more restricted in its mandated legal and ethical protection of your protected health information. HIPAA regulations do not affect any previous safeguards to your privacy as a patient, except in certain cases to strengthen them.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternate locations.

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1) The right to inspect and copy your protected health information.
2) The right to amend your protected health information.
3) The right to receive an accounting of disclosures of protected health information.
4) The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected heath information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, the Department of Health and Human Services, or the Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you in any fashion for filing a complaint.

Please speak with me or contact my office for more information. For more information about HIPAA or to file a complaint Please write to or contact:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 or Toll Free: 1-877-696-6775

Signature: _____

Witness: _____

The Vermont Statutes Online

Title 33: Human Services

Chapter 8: ALCOHOL AND DRUG ABUSE COUNSELORS

33 V.S.A. § 810. Unprofessional conduct

§ 810. Unprofessional conduct

The following conduct and the conduct set forth in 3 V.S.A. § 129a, by a person authorized to provide alcohol and drug abuse services under this chapter or an applicant for licensure, constitutes unprofessional conduct:

(1) Violation of any provision of this chapter or rule adopted under this chapter.

(2) Failing to use a complete title in professional activity.

(3) Conduct which evidences moral unfitness to practice alcohol and drug abuse counseling.

(4) Negligent, incompetent, or wrongful conduct in the practice of alcohol and drug abuse counseling.

(5) Harassing, intimidating, or abusing a client.

(6) Agreeing with any other person or organization, or subscribing to any code of ethics or organizational bylaws, when the intent or primary effect of that agreement, code, or bylaw is to restrict or limit the flow of information concerning alleged or suspected unprofessional conduct to the director. (Added 1999, No. 133 (Adj. Sess.), § 38, eff. Jan. 1, 2001; amended 2005, No. 148 (Adj. Sess.), § 52.)

John P Sheppard, MD LADC ICADC
Licensed Alcohol and Drug Abuse Counselor

ACKNOWLEDGEMENT

My signature(s) below indicates that I have received and had an opportunity to review the following materials from John Sheppard Licensed Alcohol and Drug Abuse Counselor:

1) THE HIPAA REGULATIONS REGARDING CONFIDENTIALITY AND THE HANDLING OF RECORDS AND BILLING

2) THE DESCRIPTION OF UNPROFESSIONAL CONDUCT FOR Alcohol and Drug Abuse Counselors

_____ _____
Signature date

_____ _____
Signature #2 (if needed) date