



# Emergency Responders Health Center

9976 WEST EMERALD STREET | BOISE, ID | 208.229.3742 (ERHC) | info@er-hc.org

## MENTAL HEALTH SERVICES POLICIES

### CONFIDENTIALITY

To build an effective relationship with your therapist, you should feel comfortable and safe during your counseling sessions. Anything that you divulge to your therapist during treatment **will be kept confidential** from parties outside the Clinic (including your partner, family members, case workers, your employer, and others), unless you provide written permission for our clinical team to share information. However, there are a few **exceptions** that you should be aware of, based on legal requirements placed on mental health professionals and billing agreements with outside agencies in specific circumstances:

- 1) **SUICIDE** - If you disclose plans to hurt or kill yourself, your therapist must contact outside help to ensure your safety.
- 2) **HOMICIDE** - If you disclose plans to hurt or kill someone else, your therapist must contact both law enforcement and the intended victim(s).
- 3) **ABUSE/NEGLECT OF A CHILD, OTHER DEPENDENT, OR VULNERABLE ADULT** – Mental health professionals are mandated reporters and must report suspected or confirmed cases of abuse to the appropriate Health and Welfare offices.
- 4) **SUBPOENA** - If a court of law orders your therapist to disclose confidential information about you, your therapist will advise you of the request, and ask the court to reconsider. If the court declines to dismiss its order, your therapist will disclose only the minimum amount of information deemed necessary to satisfy the court order.
- 5) **COLLABORATORS** - To provide effective services, your therapist may discuss your case with other members of the Emergency Responders Health Center clinical and support team. *Your therapist will share only the amount of information necessary for other staff members to fulfill their job function.*
- 6) **BILLING (INSURANCE OR EAP)** - Minimal information will be provided to ERHC billing specialists and your insurance or EAP provider to bill for services provided to you. No information is shared with your department. It is your responsibility to let your department know you attended your session.
- 7) **BILLING (DEPARTMENT-PAID)** - Minimal information will be provided to ERHC billing specialists. Your department will be billed for a total number of check-in visits. No identifiable personal information is shared with your department including that you, specifically, attended your session. It is your responsibility to let your department know you attended your session.
- 8) **FITNESS FOR DUTY ASSESSMENT (AT DEPARTMENT'S REQUEST)** - Minimal information will be provided to ERHC billing specialists. Your department will be billed for your visit and minimal information about your fitness for duty will be shared with your department. Please discuss specifics with your therapist.
- 9) **WORKER'S COMPENSATION** - Minimal information will be provided to ERHC billing specialists. Your adjustor (State Insurance Fund, Corvel, or Intermountain Claims) require a copy of your treatment notes for review. Without these notes, they are authorized to deny payment for your treatment. We do share work clearance status but NOT treatment notes with your department. Please discuss specifics with your therapist.
- 10) **GUARDIANSHIP/CONSERVATORSHIP/HOSPITALIZATION** due to mental incapacitation - If you can no longer make decisions for yourself, your therapist may disclose information to professionals, family members, and other legally authorized individuals engaged in your care to help them make decisions on your behalf.

### NON-EMERGENCY ACCESS

Our mental health services are conducted on an outpatient basis and are designed to accommodate clients on a non-emergency basis. We cannot guarantee immediate availability (i.e. by phone or email) outside of your scheduled counseling sessions, and may not be available during evenings, weekends, or holidays. If either you, or your therapist, feel that this level of support is not adequate to ensure your safety, we will discuss additional resources available to you in the event of a mental health emergency, and/or transition you to a higher level of care or a provider with 24-hour coverage. If you need to contact your therapist between sessions, please call Emergency Responders Health Center at (208) 639-0005 during regularly scheduled Clinic hours. If an emergency situation arises, please call 988, 911 or visit a local Emergency Room immediately.

**TELEPHONE & ELECTRONIC COMMUNICATION**

We may occasionally communicate with established clients via email. Email communications are not a substitute for in-Clinic mental health services and should not take the place of therapy sessions. Email **should not be used** to communicate suicidal or homicidal thoughts or plans; urgent or emergent issues; rapidly worsening symptoms; or life-threatening situations. Please call 988, 911, visit a local Emergency Room, and/or call a crisis hotline in these circumstances. Therapy may be provided through HIPAA-compliant telehealth sessions.

**SOCIAL MEDIA**

To protect patient confidentiality and ensure an effective therapeutic relationship, we cannot accept friend or contact requests from current or former clients on any social networking sites (Facebook, LinkedIn, etc.). We believe that adding clients as contacts on any of these sites may compromise client confidentiality and blur the professional and clinical boundaries of the client-therapist relationship.

**WEAPONS**

We kindly ask clients to refrain from bringing weapons, including firearms, to session. Exceptions are made for clients who are on duty at the time of their session or who are trained to carry a weapon as part of their job. Please speak to your therapist to discuss any individual concerns about this policy.

**PREMATURE DISCONTINUATION OF SERVICES & TERMINATION**

If we have reason to believe that a client is under the influence of drugs or alcohol at the time of their session, their therapist may end the session early and require them to find a safe method of transportation to their residence. Clients will be responsible for covering the full cost of any transportation.

Ending relationships, including relationships that are professional in nature, can be difficult. Therefore, it is important to have a termination process to achieve closure. The timing of termination depends on the recommended length and intensity of mental health services. Your therapist may elect to terminate treatment after initiating a discussion with you, if they determine that psychotherapy is not being used effectively, or if you are in default on payment. Your therapist will not terminate the therapeutic relationship without first discussing this decision with you and explaining the rationale. If therapy is terminated for any reason, or you request another therapist, we will provide you with a list of qualified psychotherapists to assist you. You may also choose another provider on your own or from another referral source.

Additionally, we have the right to discontinue treatment:

- If cancelled and missed appointments (“no shows”) become an issue and cannot be resolved within the therapeutic relationship;
- If the therapist, in their judgment, is unable to meet client needs, either because the client’s circumstances exceed the therapist’s scope of practice or because the severity of symptoms cannot safely be managed at the current level of care;
- If a client acts violently (verbally or physically) toward, or threatens/harasses, their therapist or others within the mental health practice, we will discontinue treatment immediately.

If a client fails to schedule and/or keep an appointment for four consecutive weeks, unless other arrangements have been made in advance, we must consider the professional relationship discontinued for ethical and legal reasons, and the client’s case will be automatically discharged from mental health treatment.

*Please be certain to discuss any questions regarding these policies with your therapist at your next session.*

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO ALL ITEMS CONTAINED IN THIS DOCUMENT.

Client’s Name (please print clearly): \_\_\_\_\_

Client’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_