Megan Bisbee, LCMHC
Licensed Clinical Mental Health Counselor
(VT #068.0134164)

26 North Main Street, 2nd Floor
Waterbury, VT 05676
Ph. 805-850-3839
info@meganbisbee.com

Client(s) Information

Name:_______________________________ DOB_______________ Age______ Preferred Pronouns_______
Name:_______________________________ DOB_______________ Age______ Preferred Pronouns_______
Name:_______________________________ DOB_______________ Age______ Preferred Pronouns_______
Name:_______________________________ DOB_______________ Age______ Preferred Pronouns_______

Mailing Address____

City____ State________ Zip Code_____________________

Physical address (if different)____

City____ State________ Zip Code_____________________

Home Phone____________________________________ Cell____

Communicate by text? (*Please circle one)* Yes No

Numbers where I may leave a voicemail message____

Work and/or School (If applicable: Place name, location, brief description of work or grade in school, phone number)
____
____

Household(s) Family Members (name, relationship, age):____
____
____

Emergency Contact (name, relationship and phone number):____
____

Insurance Information *(Please provide therapist with insurance card to be copied)*

Insurance Company:________________________________ Insurance ID:_______________________________________

Subscriber's Name (exactly as listed on card): ____

Subscriber's Date of Birth:____

Address associated with insurance: ____

Please fill this out and bring it to our first session. We will go over this together.
What are the primary reasons for seeking support?

____

____

Please indicate which of the following apply to your seeking psychotherapy:

___depressed or "down in the dumps"
___trouble sleeping
___work/school stress
___thoughts of harming yourself
___concerns about drug use
___medical illness or physical health concerns
___marital/relationship problems
___feeling that people are watching you
___poor appetite
___difficulty relaxing
___caring for an elderly parent/relative
___trauma
    ___physical
    ___sexual
    ___emotional
___trouble remembering things
___feelings of guilt
___sexual problems
___adoption issues
___risky behavior
___extreme fear of something or some situation
___reliving a difficult experience as if it is happening again
___dissatisfaction with:___________________
___difficulty accepting some part of yourself or your history
___anger

___concerns about alcohol use
___feelings of worthlessness
___feeling bored or uninterested in your life
___pain
___low/lack of motivation
___loss of a loved one
___trouble concentrating
___being made fun of
___weight concerns
___discomfort in social situations
___anxiety
___domestic violence
___loneliness
___hearing or seeing things that others may not see/hear
___concerns about death or dying
___difficulty with finances
___trouble forming friendships
___infertility
___episodes of panic
___feelings of abandonment
___nightmares
___family conflict
___concerns related to sex, sexual orientation or identity
___parenting concerns/struggles
___limited social support or isolation
___concerns about behavioral addiction type:_____________

Have you ever been hospitalized for psychological reasons or substance use? (If yes, please provide details)

____

____

Anything not listed that concerns you?:____

____

____

(Leave blank for clinician notes)

Initial DX: Client: Date: Clinician's signature:

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THERAPIST-PATIENT AGREEMENT

(Please read and retain for future reference)

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and note any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist, the client, and the particular problems you bring forward. There are many different methods I may use to address the difficulties that have brought you to therapy such as exploring and evaluating the various facets of your life, which include your current belief system, behaviors, lifestyle, and goals. I recognize the complexity of an individual subsystem (school, culture, family), which needs to be acknowledged as an important part of the therapy process.

Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will need to work on things we discuss both during our sessions and at home or out in the world. Together, we will identify, and agree upon, goals for therapy. The purpose of any modality or procedure will be fully explained and discussed in order to acquire your verbal agreement. While there is an expectation of benefit from psychotherapy, there is no guarantee this will occur. Maximum benefit will occur with consistent attendance. You may feel conflicted about your (or your child's) therapy as the process, at times, can be uncomfortable. Sometimes we feel worse in therapy before feeling better.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

RELATIONSHIP WITH THE THERAPIST

The therapeutic relationship is a unique relationship and is different that most relationships. It is different in how long it lasts, the topics discussed, the goals set, and how interaction takes place inside and outside of the therapy office. In order to maintain professional boundaries, I will not be your supervisor, teacher, or friend. I will not give legal, medical, or financial advice and I will not have any other business relationship with you. Therapists are required to keep the identity of our clients confidential. If we see each other in public, we may decline to acknowledge each other. You may choose to greet me, and I will respond, but you do not need to introduce me to anyone present. If therapy is court mandated or otherwise required by an outside party, we will discuss your particular situation together, and only the information pertinent to help you reach your goal and within requirement of the mandate, will be shared with the outside individual(s). This is considered a limit of confidentiality and will be discussed further later in this document. Also, due to the nature of living in small towns, there may be individuals we mutually know, and even if you have shared with them that I am your therapist, I will not divulge our relationship. Finally, our relationship will be a crucial focus for our work together as issues and patterns that bring one to therapy often show up in the consulting room in our relationship of therapist and client. Together we will use a here-and-now approach to explore the dynamic of these patterns so that newer and healthier patterns can form.

MEETINGS

An assessment phase will last from 1 to 3 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 55-minute session per week at a time we agree on, although some sessions may be more or less frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide at least 24-hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, we will try to find another time within the same week to reschedule the appointment.

PROFESSIONAL FEES

My fee is $110 per 55-minute individual session, In addition to weekly appointments, I may charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal issues that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Due to the difficulty of legal involvement, I charge $140/hour for preparation and attendance at any legal proceeding. Please note that insurances do not cover fees outside of our regular therapy sessions.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is a name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and may be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national information databank. I may provide you with a copy of any report I submit, at your request.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. Please remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

CONTACTING ME

I am often not immediately available by telephone. I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for psychiatric services or you may call Washington County Mental Health (802-229-0591). If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

You may utilize my email address to share information with me, but please note, that although it is password protected, I cannot guarantee confidentiality of the contents. Our therapy sessions take place in person so I will be unable to engage in any back-and-forth communication of information via *any* electronic means that would typically be discussed during our regularly scheduled time unless we have scheduled a regular session via secure video chat or phone. You may also text me for scheduling purposes. I will not engage in conversation via text beyond these purposes.

IN CASES OF EMERGENCY

If there is a serious emergency, or you are feeling unsafe, it is important that you get the immediate help you need by going to a local emergency room, calling 911, or calling Washington County Mental Health (802-229-0591). If you are in distress, you may call me. I will attempt to return your call as soon as possible, although I may not be able to get to your message immediately. In addition, there may be times during our work together in which I become concerned with your personal safety. I may need to contact someone close to you, such as a parent, family member, spouse, or close friend. I will ask you to sign a release of information for an emergency contact to allow us to make this contact if necessary.

SESSION TIME

The standard session time is about 53 minutes. If you are late, we will end on time. If I am late, you will still receive your full 53 minutes for the session. This time may be provided at the end of that session, or during a future session.

CANCELLATION POLICY

I consider our work together to be very important and assume that you do the same. However, there may be times in which you need to cancel a session. In the event that you are unable to keep an appointment, please notify me immediately. If you miss a session without calling, give less than 24-hour notice for a cancellation, or are unable to attend at least 20-minutes of a regularly scheduled session, you will be charged my full fee ($110) for the missed appointment. If you are using insurance, insurance companies do not reimburse for missed appointments, therefore, you will be responsible for the fee if you miss an appointment or do not give 24 hours notice. Clients covered by Medicaid insurance cannot be billed directly and are not responsible for this cancellation fee. However, patterns of missed sessions or late cancellations may result in termination of treatment. In general, if you miss three

appointments in a short period of time, I will no longer hold your place in my schedule. Any missed appointment will be discussed openly and assessed together to determine the possible impact on your therapy.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CONFIDENTIALITY IN COUPLES/MARITAL/FAMILY TREATMENT

In couples and family treatment, you should be aware that information shared with me outside of sessions may be disclosed to the members of the couple/family who are also participating in treatment. A disclosure of this nature may occur when the information is relevant to the treatment in which both parties are participating, and every effort to advise you of the necessity to disclose this information will be made.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychotherapist is protected by law, and I can only release information about our work to others with your written consent. There are some exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment:

- If I believe that a child, elderly person, or person with a disability is being abused, I may be required to file a report with the appropriate state agency.
- If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is legally bound to keep the information discussed confidential. I may tell you about these consultations only if I feel it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

TERMINATION OF TREATMENT

Typically, termination will occur gradually as symptoms are reduced and goals are met. Ideally, the termination process, as with the initial establishment of goals, will be a collaborative process. There are times, however, where termination may occur prematurely by either the therapist or the client. A therapist also has the right to terminate treatment for reasons including: Non-payment of fees with no mutual agreement on future payment, *three* repeated cancelations or no-shows in a short period of time, ethical conflicts, lack of therapeutic progress, therapist illness, retirement, and personal challenges. There are times, a therapist may terminate and refer his/her client to another therapist if a difficulty arises that cannot be treated within the limits of my scope of my competence. If you decide to terminate therapy with me, I request that we meet for a closing session to address your concerns with the therapy or myself and so I can connect you with another therapist to continue your care. It is also common for clients to want to terminate when difficult material in therapy begins to be addressed. Although it can be a difficult process, it is often helpful for therapist and clients to work through the issue at hand together in a skillful way rather than terminate the relationship at that time. If premature termination happens, I will make sure to connect you with another therapist.

During the termination period, clients may experience feelings of loss, abandonment, happiness, doubt, an increase in self-confidence, and some anxiety about the future. At times, a client's behavior or mood may briefly deteriorate. These feelings are typical and important to discuss. Also, it is typical to return to therapy for a brief time for "tune up" sessions after termination, or to return to therapy when new issues arise in life during which our familiar relationship can fee supportive for continuing therapeutic work.

THERAPIST-CLIENT AGREEMENT

(Please sign and return to therapist)

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

____ ________________
Client/Parent/Guardian Signature(s) Date

____
Printed Name (s)

____ ________________
Client/Parent/Guardian Signature(s) Date

____
Printed Name (s)

____ ________________
Client/Parent/Guardian Signature(s) Date

____
Printed Name (s)

____ ________________
Megan Bisbee, LCMHC Date

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Telehealth Informed Consent

I_______________________________ hereby consent for myself or ______________________ to engage in telehealth with Megan Bisbee, LCMHC. as part of my mental health care. I understand that "telehealth" includes the practice of mental health care delivery, diagnosis, assessment, consultation and treatment using live interactive audio-video software. Megan Bisbee uses Doxy.me, which is HIPAA compliant. Telehealth serves to more broadly meet the needs of the community by not requiring in person face-to-face sessions. Both the client and the therapist will be in the state of Vermont when these services are provided.

I understand that I have the following rights with respect to telehealth:

1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2) The laws that protects the confidentiality of my medical records also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder and dependent adult abuse; expressed threats of violence to an identified victim, risk of harm to oneself; and when required by a court of law. I understand that the dissemination of any personally identifiable images or information from telehealth interaction to another entity or person shall not occur without my written consent.
3) I understand there are risks and consequences related to Telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of therapist, that: there could be disruptions related to technical difficulties or failures; and/or the potential for your private healthcare information being accessed by an unauthorized individual. Steps have been taken to protect your private information and confidentiality including the use of HIPAA compliant software.
4) I understand my records will continue to be stored in a locked cabinet only accessible to my therapist or me upon request as federal and state law requires.
5) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
6) Should there be a crisis, I understand I am to still to utilize Washington County Mental Health Screeners, 911 or my local hospital.
7) Telehealth does not mean that your therapist will be available to you at times outside of planned therapy sessions.

8) In the event that there is an unexpected disruption to a telehealth session, I give Megan Bisbee, LCMHC permission to contact me via these means. I understand that insurance will not cover sessions that do not use live audio-visual software.

_____Phone provide number:___________________________________

_____Text provide number:___________________________________

_____email Provide email:_____________________________________

9) I understand that Megan Bisbee reserves the right to deny telehealth services if, in her clinical opinion, it is not an appropriate means of health care delivery for my particular circumstances, clinical presentation or safety.

_____________________________________ _______________________________

Signature of Client/Parent/Guardian/Conservator Indicate relationship if not client

_____________________________________ _______________________________

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NOTICE OF PRIVACY PRACTICES
(Please read and retain for future reference)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT SHOULD BE REVIEWED WITH CARE.

Megan Bisbee is required by federal and state law to maintain the privacy of your health information, as well as give you this notice about privacy practices, legal obligations, and your rights concerning your health information, "Protected Health Information" (PHI). Megan Bisbee must follow the privacy practices that are described herein and these practices may be amended as needs or requirements change.

For further clarification of anything noted in this document please contact Megan Bisbee.

Uses and Disclosures of Your Protected Health Information
The following will explain the ways in which your health information may be used *without your consent* under Federal and State law. In all cases, Megan Bisbee practices disclosing minimum information necessary to achieve the purpose of said disclosure. This is not intended to be an exhaustive list, but instead an explanation of cases and scenarios where disclosure of PHI may be necessary falling under general categories. These disclosures exclude psychotherapy notes as described in the next section.

A. Treatment: Megan Bisbee may use and disclose information related to your treatment to members of your current treatment team for the purposes of continuity of care and to coordinate and manage your healthcare and related services.

B. Payment: Megan Bisbee may use and disclose information in your protected health record for billing purposes with your insurance plan. Your insurer may require certain information about your treatment prior to authorizing payment for services.

C. Health Care Operations: These include quality improvement activities, consultation with colleagues, licensing, and credentialing activities.

D. Wherever required by law, your protected health information will be disclosed.

E. In the event of an emergency your protected health information may be disclosed in order to allow for your treatment and care.

Uses and Disclosures Requiring your Written Consent
Notes recorded by Megan Bisbee, documenting the contents of your session (Psychotherapy Notes), will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

Marketing activities will never include your protected health information without your written approval. Any disclosure to individuals not directly involved in your treatment or care (ie: your attorney, school, etc.) will require your written authorization for release of PHI.

Note: Your "authorization" to release PHI may be revoked at any time by providing the revocation in writing. This revocation will go into effect when the written notice has been personally received and reviewed.

Your Rights Regarding Your Health Information

A. Right to Inspect and Copy: You have the right to inspect and copy your medical and billing records, but not your psychotherapy notes. All requests of this nature must be made in writing. There will be a fee associated with copying records and mailing records if you chose to receive them via mail.

B. Right to Request Confidential Communications: You have the right to request that Megan Bisbee communicate with you only in a certain location or through a certain method (i.e. at work only, or through email, etc.) All requests must be received in writing and reasonable requests will be honored. A reason for the request is not necessary, but it is important to know the specifics on where and how you wish to be contacted.

C. Right to Request Restrictions: You have the right to request a restriction on the health information that is used or disclosed about you for treatment, payment, or health care operations. Requests for restrictions must be submitted in writing. Megan Bisbee is not required to agree with your requested restriction, however, Megan Bisbee will honor your request unless the restricted health information is needed to provide you with emergency treatment.

D. Right to Accounting of Disclosures: You have the right to request to be provided with an accounting of the disclosures that have been made of your protected health information. This request must be made in writing and will not include disclosures made for the purposes of treatment, payment, and health care operations.

E. Right to Request an Amendment: You have the right to request amendment of your health information. Your request must be made in writing and should detail the reason for the requested amendment. This request may be denied in certain circumstances.

F. Right to a Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

G. Out-of-Pocket-Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

H. Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

. I. Questions or Complaints: Any questions or complaints regarding your privacy rights should be addressed with the Privacy Officer, Megan Bisbee. You may also contact the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against should you chose to complain to Megan Bisbee or an outside agency.

This notice is effective September 1, 2018. It may be amended at any time, and the revision will be effective for all PHI maintained. In the event of an amendment, a new notice will be posted and you may request a copy of the revised notice.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES
(Please sign and return to therapist)

I, ____,
(Client or Parent/Guardian Name(s))

have received a copy of the privacy practices of Megan Bisbee, LCMHC.

____
(Print Name (s))

____
(Client or Parent/Guardian Signature(s)

____
(Date)

Office Use Only

An attempt was made to obtain written acknowledgement of receipt of the notice of privacy practices for Megan Bisbee, LCMHC, but acknowledgement could not be obtained because:

_____Individual refused to sign

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (specify below)
____
____
____
____

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CLIENT DISCLOSURE SHEET
(Please read and retain for future reference)

Disclosure:

State law requires all psychotherapists practicing in Vermont to provide clients with information about their professional qualifications and experience, what constitutes unprofessional conduct according to Vermont Statute and how to file a complaint with the Office of Professional Regulation. The law further requires that the psychotherapist obtain and keep on file a signed form acknowledging that this information has been made available. A description of my professional qualification and experience is attached. Information cards about the complaints procedures and a list of practices that constitute unprofessional conduct are also attached.

Professional Qualifications and Experiences:

Megan Bisbee, MA is a Licensed Mental Health Counselor (VT #068.0134164). Megan received her Masters of Arts in Counseling Psychology from Pacifica Graduate Institute in Carpenteria, CA. She completed a two-year part-time traineeship and one year part-time internship as a school-based clinician in the Ojai Unified School District in Ojai, CA, a one-year part time traineeship in the Ventura Unified School District in Ventura, CA, and a one-year full-time internship at Maple Counseling Center in Ventura, CA. She completed her pre-licensure clinical hours in private practice at Full Circle Health and Wellness, LLC in Montpelier, VT under the supervision of Dr. Tracy Loysen, PhD. Although a substantial amount of Megan's training and experience has been in the state of California, Megan is originally from Vermont and is intimately aware of issues unique to this part of the country. She has worked with groups, individuals, couples, families, children, adolescents and adults. She has experience treating depression, anxiety, domestic violence, substance use, addiction, codependency, trauma, family reunification, grief and loss, developmental trauma and delays, ADHD/ADD, school-based issues, relational issues, personality disorders, LGBTQ issues, existential issues, identity issues, cultural issues, and difficult life transitions.

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Statutory Definition of Unprofessional Conduct
(Please read and retain for future reference)

§ 3016. Unprofessional conduct

Unprofessional conduct means the conduct listed in this section and in section 129a of Title 3:

(1) Failing to make available, upon written request of a person using psychological services to succeeding health care professionals or institutions, copies of that person's records in the possession or under the control of the licensee.

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

(3) Conduct which evidences moral unfitness to practice psychology.

(4) Engaging in any sexual conduct with a client, or with the immediate family member of a client, with whom the licensee has had a professional relationship within the previous two years.

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

(6) Entering into an additional relationship with a client, supervisee, research participant or student that might impair the psychologist's objectivity or otherwise interfere with the psychologist's professional obligations.

(7) Practicing outside or beyond a psychologist's area of training or competence without appropriate supervision.

(8) Notwithstanding the provisions of 3 V.S.A. § 129a(a)(10), in the course of practice, failure to use and exercise that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent psychologist engaged in similar practice under the same or similar conditions, whether or not actual injury to a client or patient has occurred.

(9) Conduct which violates the "Ethical Principles of Psychologists and Code of Conduct" of the American Psychological Association, effective December 1, 1992, or its successor principles and code.

(10) Conduct which violates the "ASPPB Code of Conduct-1990" of the Association of State and Provincial Psychology Boards, or its successor code. (Added 1975, No. 228 (Adj. Sess.), § 2; amended 1981, No. 241 (Adj. Sess.), § 1; 1993, No. 98, § 7; 1993, No. 222 (Adj. Sess.), § 3; 1997, No. 145 (Adj. Sess.), § 50; 1999, No. 52, § 26; 1999, No. 133 (Adj. Sess.), § 24.)

§ 129a. Unprofessional conduct

(a) In addition to any other provision of law, the following conduct by a licensee constitutes unprofessional conduct. When that conduct is by an applicant or person who later becomes an applicant, it may constitute grounds for denial of a license or other disciplinary action. Any one of the following items, or any combination of items, whether or not the conduct at issue was committed within or outside the state, shall constitute unprofessional conduct:

(1) Fraudulent or deceptive procurement or use of a license.

(2) Advertising that is intended or has a tendency to deceive.

(3) Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession.

(4) Failing to comply with an order of the board or violating any term or condition of a license restricted by the board.

(5) Practicing the profession when medically or psychologically unfit to do so.

(6) Delegating professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, education or licensing credentials to perform them.

(7) Willfully making or filing false reports or records in the practice of the profession; willfully impeding or obstructing the proper making or filing of reports or records or willfully failing to file the proper reports or records.

(8) Failing to make available promptly to a person using professional health care services, that person's representative, succeeding health care professionals or institutions, upon written request and direction of the person using professional health care services, copies of that person's records in the possession or under the control of the licensed practitioner.

(9) Failing to retain client records for a period of seven years, unless laws specific to the profession allow for a shorter retention period. When other laws or agency rules require retention for a longer period of time, the longer retention period shall apply.

(10) Conviction of a crime related to the practice of the profession or conviction of a felony, whether or not related to the practice of the profession.

(11) Failing to report to the office a conviction of any felony or any offense related to the practice of the profession in a Vermont district court, a Vermont superior court, a federal court, or a court outside Vermont within 30 days.

(12) Exercising undue influence on or taking improper advantage of a person using professional services, or promoting the sale of services or goods in a manner which exploits a person for the financial gain of the practitioner or a third party.

(13) Performing treatments or providing services which the licensee is not qualified to perform or which are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice.

(14) Failing to report to the office within 30 days a change of name or address.

(15) Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.

How to File a Complaint

Complaints can be filed with the Vermont Secretary of State's Office of Professional Regulation. The complaint form can be found on line at: http://vtprofessionals.org/opr1/psychologists/

If you do not have access to a computer you may call the Office of Professional Regulation and request a form be mailed to you at 802 828-1505 or I would be happy to provide one for you.

Once you complete the complaint form it can be mailed to:
Vermont Secretary of State
Office of Professional Regulation
Attn: Carla Preston, Case Manager
National Life Bldg., North FL2
Montpelier, Vermont 05620-3402
802 828-1505
cpreston@sec.state.vt.us

Megan Bisbee, LCMHC
Licensed Clinical Mental Health Counselor
(VT #068.0134164)

26 North Main Street, 2nd Floor
Waterbury, VT 05676
Ph. 805-850-3839
info@meganbisbee.com

Receipt of Disclosure Information
(Please sign and return to therapist)

I, ____, have been provided documents disclosing the following information:

a) a synopsis of Megan Bisbee's experience and qualifications to provide psychological services
b) a copy of the statutory definition of unprofessional conduct
c) information on the process for filing a complaint with, or making a consumer inquiry to, the Director of the Office of Professional Regulation

In addition, I have been afforded the opportunity to ask questions or get clarification about these documents.

____________________________________	______________________
Client Signature or Parent/Guardian if under 18	Date
____________________________________	______________________
Client Signature or Parent/Guardian if under 18	Date
____________________________________	______________________
Client Signature or Parent/Guardian if under 18	Date
____________________________________	______________________
Megan Bisbee, LCMHC	Date

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING THE COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to begin/resume in-person services in light of the COVID-19 public health crisis. Our decision is based in part on recommendations by the Center for Disease Control (CDC), but other factors may be considered. Some of these include but are not limited to: whether we and our families have been vaccinated, our health or the health of those we are in close contact with, and risk of exposure outside of this setting. There may be other concerns that we can talk about.

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 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. Reimbursement for telehealth services is also determined by the insurance companies and applicable law, so we'll discuss any financial implications if needed.

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 tell me if you've been vaccinated. If you haven't, we'll talk about the reasons and whether it's possible to meet safely in person. ___
- You will only keep your in-person appointment if you are symptom free. ___

- You will only keep your in-person appointment if you have been fever-free for a minimum of 10 days prior to our appointment. ___
- You will choose to meet by telehealth if you have been in contact with someone who has tested positive within the last 14 days. ___
- 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 which to cancel for this reason, I won't charge you our normal cancellation fee. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit. ___
- You will wear a mask if unvaccinated or near someone other than me for an extended time. ___
- If you are bringing your child, you will make sure that your child follows 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 your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know. ___
- If a resident of your home tests positive for the infection, you will immediately let me know and we will then begin/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
I have taken steps to reduce the risk of spreading the coronavirus within 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.

Megan Bisbee, LCMHC
26 North Main Street, 2nd Floor
Waterbury, VT 05676
Ph. 805-850-3839
info@meganbisbee.com

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

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

___________________________	___________________________
Patient/Client	Date
___________________________	___________________________
Patient/Client	Date
___________________________	___________________________
Megan Bisbee, LCMHC	Date

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