JOE BERGER LICSW

(802) 391-9080
joseph.berger.licsw@gmail.com
www.joebergerlicsw.com
2 Church Street, Suite 4A, Burlington, VT 05401

Name: _____ **DOB:** _____

Phone: _____ **Address:** _____

Informed Consent and Practice Information

This agreement is intended to provide clients with important information regarding my professional services and business policies. This consent form will provide a clear framework for our work together. Any questions or concerns regarding the contents of this agreement should be discussed with me prior to signing it.

Client Rights

1. You have the right to ask questions about any procedures used during therapy.
2. You have the right to decide not to receive therapeutic assistance from me. If you wish, I will provide you with the names of other qualified professionals whose services you might prefer.
3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those *already* accrued. I ask you contact me before you make such a decision without prior discussion.
4. You have the right to expect that I will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, all of which would compromise our work together.
5. Therapy involves a partnership between therapist and client. As your therapist, I will contribute knowledge, skills and a willingness to do my best.

Confidentiality

All information about you is kept confidential to protect your privacy. This information includes the fact that you have or have not received services. Written authorization from you is needed before any release of information takes place, except in the following situations as dictated by state law and professional codes of ethics:

a) If you are at imminent risk of harming yourself or others, I am required to do whatever is necessary to protect human life, including temporarily breaking confidentiality and warning authorities and/or a party in danger.
b) I am mandated by Vermont Law to report actual or suspected physical or sexual abuse involving children, the disabled and the elderly.
c) If a judge orders my testimony or in the context of a legal proceeding you raise your own psychological state as an issue, I may be required to release your confidential information to the court.
d) Your managed care/insurance company may require either written or telephone treatment reviews by their clinical personnel to authorize benefits or services.
e) I participate in supervision to help ensure quality and skilled work. These sessions are confidential and use of a client's name and identifying information is avoided, unless when permitted.

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Payment

My fee is $155.00 per session and is due at the time of the session. Sessions are between 50-55 minutes. If you are using insurance, an estimate of any copay or deductible you are responsible for is due at the time of the session. You can find out what you are responsible for by calling your insurance company. I accept credit card, check or cash.

I use Square, a third-party payment processing service, to handle billing and payments. By signing this form, I consent to the use of Square for the purposes of securely processing payments for sessions, services, or late fees. Square's privacy policy can be obtained at https://squareup.com/us/en/legal/general/privacy. I understand my rights and responsibilities regarding my payment data.

I also understand that invoices may be sent to me via email through Square. While these communications are intended to be secure, email is not a guaranteed confidential method of communication. By signing below, I consent to receiving invoices by email and accept any associated privacy risks. I understand that I may request alternative payment methods or communication methods if I prefer not to use Square or receive invoices by email.

Insurance

I am currently a contracted provider with Blue Cross Blue Shield, MVP, Medicaid and Medicare. For other insurances, if you have out-of-network coverage I can submit a claim for our sessions. Otherwise I ask that clients pay me in full at the time of their session. I can provide you with a receipt. I offer a sliding scale which I can discuss with you.

Claims and receipts for insurance must include an approved mental health diagnosis to prove that your therapy or treatment is "medically necessary."

Cancellation Fee: I keep a strict cancellation policy. *If you cancel with less than 24 hours notice or do not show up for your appointment, you will be charged a $75.00 fee for the missed appointment*. Insurance does not reimburse for missed appointments.

Hours and Emergency Procedure:

I conduct sessions between 9:00am and 3:00pm on Tuesday through Friday, and on telehealth on Monday mornings. If you are in crisis and in need of support after-hours, you can call me on my cellphone at (802) 391-9080. Typically, I will be able to call you back within two hours but occasionally may be out of reach and will return your call within 24 hours. If you are not able to reach me and are having an emergency, you should contact First Call of Chittenden County at (802) 488-7777, go to your local emergency room, or call 911.

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I, _____, agree and consent to participate in psychotherapy
(Name of Client)

provided by Joseph Berger, LICSW.

I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider's license, certification and training. My signature acknowledges that I have been given the professional qualifications and experience of Joseph Berger, LICSW and a listing of actions that constitutes unprofessional conduct according to Vermont Statutes, the methods for making a consumer inquiry of filing a complaint with the Office of Professional Regulation, and practice information and expectations for treatment.

If the client is under the age of 18, or unable to consent to treatment, I attest that I have legal custody of the individual receiving treatment and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

I understand that my participation in treatment, or the participation of my child, is voluntary and I understand that I may terminate the treatment at any time.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or the elderly.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that my therapist originates and maintains health records describing my history, symptoms, diagnoses, and treatment for the duration of care and will be stored for ten years past the date of termination of services, or ten years past the clients 18th birthday, if the client is under 18 at the time of services. I understand that confidentiality of these records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

_____ _____

Signature of Client or Parent/Guardian **Date**

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NOTICE OF PRIVACY PRACTICES

Effective Date: 5/1/25

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

MY LEGAL DUTY

As a licensed clinical social worker and a covered entity under the Health Insurance Portability and Accountability Act (HIPAA), I am required by law to maintain the privacy of your protected health information (PHI) and to provide you with this Notice of Privacy Practices. I am legally obligated to:

- Maintain the confidentiality of your health information.
- Inform you of my legal duties and privacy practices regarding your PHI.
- Abide by the terms of this Notice currently in effect.

USES AND DISCLOSURES OF HEALTH INFORMATION

I may use or disclose your health information for the following purposes without your written consent:

Treatment

To coordinate or manage your care.

Payment

To bill and collect payment for services rendered. This may include contacting your insurance company for prior authorization or verifying coverage.

Healthcare Operations

To manage my practice, including quality assurance, case consultation, and staff supervision.

Required or Permitted by Law

Your information may also be disclosed without your authorization under the following circumstances:

- If required by federal, state, or local law.
- To report suspected abuse or neglect of a child or vulnerable adult.
- In response to a valid court order or subpoena.
- For health oversight activities such as audits or investigations.
- To prevent or lessen a serious threat to the health or safety of you or another person.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

All other uses and disclosures of your PHI will be made only with your written authorization. This includes:

- Most uses and disclosures of psychotherapy notes
- Disclosures for marketing purposes
- Sale of your health information

You may revoke your authorization in writing at any time, except to the extent that action has already been taken.

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YOUR RIGHTS

You have the following rights concerning your health information:

- **Right to Access**: You may inspect or obtain a copy of your records (with limited exceptions).
- **Right to Amend**: You may request corrections to your health record if you believe there is an error.
- **Right to an Accounting of Disclosures**: You may receive a list of non-routine disclosures made in the last 6 years.
- **Right to Request Restrictions**: You may ask me to limit the use or disclosure of your information. I am not required to agree, but I will make reasonable efforts to accommodate your request.
- **Right to Confidential Communications**: You may request that I contact you in a specific manner (e.g., via phone or email).
- **Right to a Paper Copy**: You have the right to receive a paper copy of this notice, even if you agreed to receive it electronically.

CHANGES TO THIS NOTICE

I reserve the right to change the terms of this Notice at any time. Any updates will apply to all PHI I maintain. A current copy will be available in my office and you may request a printed version at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me or with the U.S. Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

CONTACT INFORMATION

If you have questions about this Notice or wish to file a complaint, please contact:

Joseph Berger, LICSW
2 Church St. Suite 4A
Burlington, VT 05401
(802) 391-9080

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Joseph Berger, LICSW's Notice of Privacy Practices:

_____ _____

Signature of Client or Parent/Guardian **Date**

Title 3: Executive

Chapter 5: SECRETARY OF STATE

Sub-Chapter 3: Professional Regulation

3 V.S.A. § 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, or knowingly providing professional supervision or serving as a preceptor to a person who has not been licensed or registered as required by the laws of that person's profession.

(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, or 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, or failing to notify patients or clients how to obtain their records when a practice closes.

(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.

(b) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes:

(1) performance of unsafe or unacceptable patient or client care; or

(2) failure to conform to the essential standards of acceptable and prevailing practice.

(c) The burden of proof in a disciplinary action shall be on the State to show by a preponderance of the evidence that the person has engaged in unprofessional conduct.

(d) After hearing, and upon a finding of unprofessional conduct, a board or an administrative law officer may take disciplinary action against a licensee or applicant, including imposing an administrative penalty not to exceed $1,000.00 for each unprofessional conduct violation. Any money received under this subsection shall be deposited in the Professional Regulatory Fee Fund established in section 124 of this title for the purpose of providing education and training for board members and advisor appointees. The Director shall detail in the annual report receipts and expenses from money received under this subsection.

(e) In the case where a standard of unprofessional conduct as set forth in this section conflicts with a standard set forth in a specific board's statute or rule, the standard that is most protective of the public shall govern. (Added 1997, No. 40, § 5; amended 2001, No. 151 (Adj. Sess.), § 2, eff. June 27, 2002; 2003, No. 60, § 2; 2005, No. 27, § 5; 2005, No. 148 (Adj. Sess.), § 4; 2009, No. 35, § 2; 2011, No. 66, § 3, eff. June 1, 2011; 2011, No. 116 (Adj. Sess.), § 5.)

- **§ 3210. Unprofessional conduct**

(a) The following conduct and the conduct set forth in 3 V.S.A. § 129a by a licensed social worker constitutes unprofessional conduct. When that conduct is by an applicant or a person who later becomes an applicant, it may constitute grounds for denial of a license:

(1) failing to use a correct title in professional activity;

(2) conduct which evidences unfitness to practice clinical social work;

(3) 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;

(4) harassing, intimidating, or abusing a client or patient;

(5) practicing outside or beyond a clinical social worker's area of training, experience, or competence without appropriate supervision;

(6) engaging in conflicts of interest that interfere with the exercise of the clinical social worker's professional discretion and impartial judgment;

(7) failing to inform a client when a real or potential conflict of interest arises and to take reasonable steps to resolve the issue in a manner that makes the client's interest primary and protects the client's interest to the greatest extent possible;

(8) taking unfair advantage of any professional relationship or exploiting others to further the clinical social worker's personal, religious, political, or business interests;

(9) engaging in dual or multiple relationships with a client or former client in which there is a risk of exploitation or potential harm to the client;

(10) failing to take steps to protect a client and to set clear, appropriate, and culturally sensitive boundaries, in instances where dual or multiple relationships are unavoidable;

(11) failing to clarify with all parties which individuals will be considered clients and the nature of the clinical social worker's professional obligations to the various individuals who are receiving services, when a clinical social worker provides services to two or more people who have a spousal, familial ,or other relationship with each other;

(12) failing to clarify the clinical social worker's role with the parties involved and to take appropriate action to minimize any conflicts of interest, when the clinical social worker anticipates a conflict of interest among the individuals

receiving services or anticipates having to perform in conflicting roles such as testifying in a child custody dispute or divorce proceedings involving clients.

(b) After hearing, and upon a finding of unprofessional conduct, an administrative hearing officer may take disciplinary action against a licensed clinical social worker or applicant. (Added 1985, No. 253 (Adj. Sess.), § 1; amended 1989, No. 250 (Adj. Sess.), § 4(b); 1993, No. 98, § 30; 1993, No. 222 (Adj. Sess.), § 6; 1997, No. 40, § 36; 1997, No. 145 (Adj. Sess.), § 52; 1999, No. 133 (Adj. Sess.), § 29.)

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Joseph Berger, LICSW

Vermont law requires Licensed Independent Clinical Social Workers to disclose to each client his or her professional qualifications and experience, those actions that constitute unprofessional conduct, and the method for filing a complaint or making a consumer inquiry. This must be done by the third appointment.

Qualifications and Experience

FORMAL EDUCATION

University of Vermont, Burlington, VT
Master of Social Work- 2012

University of Vermont, Burlington, VT
Bachelor of Arts, Psychology and Political Science - 2010

SCOPE OF PRACTICE

Therapeutic orientation: Bowen Family Systems Theory

Treatment methods:

I view the issues that prompt people to come to therapy in the context of their relationships and the patterns present in these relationships. I believe that becoming a better observer of how one behaves when feeling anxious is an important part of the process of making life changes. I work with clients who are interested in changing the way they behave in their most significant relationships, particularly with members of their nuclear and extended families. I believe progress happens from efforts the client puts in between our meetings and is unlikely to occur through our conversations alone. I think a broad, sustained effort to behave more maturely and responsibly, for example, to respond out of thoughtfulness rather than emotions, or to be present and accounted for during important life events, can be beneficial for a variety of issues and life challenges.

Examples of issues that bring clients into therapy with me include anxiety, OCD, relationship issues, depression, sexuality and gender concerns, addictive behaviors, parenting challenges, and college or workplace stress.

Professional Experience: I have experience working with adults, couples, families and groups in a variety of community and residential settings. This includes providing therapy for people who experienced domestic and sexual violence, conducting home visits with children and families, and providing direct support to patients at the Vermont State Hospital struggling with severe emotional symptoms. I also worked at a program for incarcerated mothers and their children where I facilitated groups, provided case management, and supervised visits in the prison. Following this I spent several years coordinating a residential program for women returning to the community from prison. I have been in private practice since 2018. I have given presentations for the Vermont Center for Family Studies, the Bowen Center for the Study of the Family, and currently serve as a faculty member of the Vermont Center for Family Studies.

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Credentials/Additional Skills: Dialectical Behavioral Therapy- training certificate, Vermont Center for Family Studies Professional Training Program, Bowen Center for the Study of the Family-Postgraduate Program, Washington D.C.

Information concerning unprofessional conduct for this profession is found below.

CLIENT DISCLOSURE CONFIRMATION

My signature acknowledges that I have been given the professional qualifications and experience of Joseph Berger, LICSW, a listing of actions that constitutes unprofessional conduct according to Vermont statutes, and the method for making a consumer inquiry or filing a complaint with the Office of Professional Regulation.

_____ _____

Client Signature **Date**

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Telehealth Informed Consent

1. I understand that at times video conferencing may be a viable form of treatment my therapist and I may discuss to promote continuity of care when I cannot physically be present in my therapist's office due to several factors, including but not limited to: travel for work, recovering from an illness and not being able to travel, lack of access to transportation to the office, return to college, when weather advisories that make it unsafe to travel etc.
2. I understand that video conferencing is an option in which my therapist and I may use the internet on various devices, computer, tablet, phone, and will be able to see and hear each other and interact in real time to engage in psychotherapy.
3. I understand that the policy is to use platforms like Doxy.me which are encrypted to the federal standard, are HIPAA compatible and have signed a HIPAA Business Associate Agreement-at-testing to HIPAA compliance. This platform is responsible for keeping any videoconferencing confidential and secure. Skype, FaceTime and other platforms are not as secure and there is a risk that private healthcare information may be breeched.
4. I understand that when I am engaged in telehealth psychotherapy, it is my responsibility to choose a secure location to ensure that family, friends, employers, co-workers, strangers or hackers cannot overhear my communications or have access to the technology or devices I am using.
5. I understand that, on my end, it is my responsibility to make sure that I am using a private and encrypted WIFI, (never a public WIFI) and that my devices have protections like firewalls, anti-virus software and are password protected. I understand that my therapist is using the same standards on their devices to protect my privacy and confidentiality.
6. I understand that most insurances now cover some form of telemedicine but is ultimately my responsibility to know whether or not my insurance company covers telemedicine sessions. I am responsible for payment in full if it is not covered by my insurance.
7. I understand there may be risks to telehealth psychotherapy, including but not limited to: poor internet connections, technical difficulties, power failures in the middle of a session, etc.
8. I understand that if there is a loss of transmission, my therapist will call me on the phone to complete the session. Phone sessions may not be covered by insurance and there may be a private fee assessed for any part of a session that has to be completed via phone.
9. I understand that I can discontinue telehealth psychotherapy sessions and revoke this authorization at any time without affecting my right to future care or treatment. I also understand that my therapist has the right to discontinue telehealth sessions at any time if it becomes apparent that face-to-face treatment with the therapist would be more appropriate. I also understand that I may be referred to a therapist in my area if my therapist feels that this would be more beneficial to me.
10. I understand that I may benefit from telehealth psychotherapy sessions, but that results can- not be guaranteed nor assured.
11. By signing this form, I certify:
    - That I have read or have had this form read and/or had this form explained to me.
    - That I fully understand the risks and benefits of telehealth psychotherapy.
    - That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Client Signature **Date**