

**Clinical Social Workers in Private Practice:
A Reference Manual**

National Association of Social Workers

750 First Street, North East

Suite 800

Washington, DC 20002

Prepared by the Task Force for Private Practice Guidelines

Carol Seacord, LMSW, ACSW, BCD (Chair)

Laura Groshong, LICSW

Katie Malinski, LCSW-S

Daniel Renstrom, LMSW

Leslie Tsukroff, LCSW

Lynn Zakeri, LCSW

Sub Task Force for Private Practice Guidelines

Camille Call, DSW, LCSW, QCSW

Nelda Spyres, LCSW

Doris Tomer, LCSW

Pat Herrera-Thomas, LSCSW

NASW Staff

Mirean Coleman, LICSW, CT (Clinical Manager)

Janice Harrison (Executive Assistant)

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Introduction

The Private Practice Specialty Practice Section of the National Association of Social Workers (NASW) was formed in 1996 to meet the needs of the ever-growing private practitioners within the NASW membership. In 2003, the Private Practice Specialty Practice Section Subcommittee on Revisions developed *Clinical Social Workers in Private Practice: A Reference Guide* in response to requests from NASW members. This guide was put together as a useful tool and reference for clinical social workers contemplating entering private practice and for veteran clinical social workers seeking information on specific issues related to running a private practice. In 2018, a new task force was established to provide NASW members with an updated private practice guide to assist practitioners in preserving the best practices for clinical social workers in independent private practice.

Please note that although this guide is divided into specific sections, there is significant overlap and shared importance among all topics offered. We strongly encourage clinical social workers to develop a clear sense of the entirety of clinical social work private practice to deliver quality services with ethical integrity and confidence. For example, there are separate sections for informed consent, confidentiality, dual and multiple relationships, and record keeping (among others). However, clinical social workers should understand that notifying and discussing issues of confidentiality, dual and multiple relationships, and record keeping are an integral part of informed consent. This example is just one of many issues that private practitioners need to understand in an independent private practice setting.

Clinical social workers respect the dignity, protect the welfare, and maximize the self-determination of the clients with whom they work. According to the NASW (2017a) *Code of Ethics*, “Social workers shall provide services and represent themselves as competent only within the boundaries of their education, training, licensure certification, consultation received, supervised experience, or other relevant professional experience” (p. 11). We hope that this manual will serve clinical social workers for years to come, even as the landscape of clinical social work and private practice continues to evolve.

Definition of Private Practice

The *Social Work Dictionary* (Barker, 2014) contains the following definition of *private practice*:

In social work, the provision of professional services by a licensed/qualified social worker who assumes responsibility for the nature and quality of the services provided to the client in exchange for direct payment or third-party reimbursement. Also, the process in which the values, knowledge, and skills of social work, acquired through sufficient education and experience, are used to deliver social services autonomously to clients in exchange for mutually agreed payment.

There are different types of private practice. One of the most common types of private practice is the use of clinical social work skills to address mental health and substance use problems, including diagnosis of these conditions and evidence-based treatment methods. Other types of private practice include coaching, casework, case management, social policy, and community organization.

Education and Credentialing

Pre-LCSW (Licensed Clinical Social Worker)

There are two parts to an MSW becoming an independent clinical social worker. The pre-LCSW requirements for becoming an independent clinical social worker include the following:

- Receiving an MSW degree from a social work program accredited by the Council on Social Work Education (CSWE)
- Passing the Association of Social Work Boards (ASWB) examination for new MSW graduates in states where this is required
- Acquiring the regulatory title in a given state for new MSW graduates (LMSW, LGSW, or other title used to identify a pre-independent clinical social worker)
- Abiding by the scope of practice for new graduates in a given state

Note: The hours required for supervised experience, direct supervision, and direct contact can vary over the years. Check with the social work board in your state for the current hours required in these areas.

LCSW

Those who graduated with a clinical or nonclinical emphasis such as community organization, administration, or social policy, should meet the minimum requirement of two years of supervised clinical experience. Those from a nonclinical background should take clinical courses that would be the equivalent of clinical social work training provided in an MSW degree program. The Task Force for Private Practice Guidelines recommends five years of clinical and supervised experience prior to entering independent practice.

- Many states have legal regulations for private practitioners at a clinical or independent practice, and practitioners must be licensed or certified at this level to engage in independent private practice. Be advised that licensed clinical social work titles vary greatly from state to state and the same title may mean a different level of practice. The requirements for becoming an independent LCSW include the following:

- Earning the experience hours needed to become an LCSW (or LICSW, LISW, or other title used to identify an independent clinical social worker), which vary in each state
- Earning the direct clinical contact hours required to become an LCSW in a given state, which may vary from zero to 1,500 hours
- Earning the clinical supervision hours required to become an LCSW in a given state

- Passing the ASWB clinical social work examination
- Acquiring the regulatory title in a given state for independent clinical social work (that is, LCSW, LICSW, LISW, or other title according to a given state)
- Earning the continuing education hours required to maintain the title of independent clinical social worker in a given state
- Having malpractice insurance that covers the independent clinical social worker's practice
- Having the skills to make mental health diagnoses as specified in the *International Classification of Diseases, 10 Revision, Clinical Modification* (ICD-10-CM) (or later editions) and to conduct psychotherapy using the accepted methods of practice (American Medical Association, 2018)

- Abiding by the scope of practice for independent clinical social workers in a given state

Continuing Education

Continuing education is a necessary part of all social work practice, and is required by most states in their licensing laws. Please consult your individual state for their requirements.

Continuing education may include the following:

- Review of current professional literature
- Attendance of professional clinical workshops, webinars, or seminars
- Participation in advanced practice training seminars
- Participation in peer education or supervision groups
- Teaching continuing clinical education training programs
- Supervision or consultation

Refer to the NASW's (2002) *Standards for Continuing Professional Education* for more information.

Business Planning

Private practitioners receive extensive professional education to develop clinical expertise, but unfortunately this training usually does not include information on managing the *business* of a private practice. There are financial, legal, ethical, administrative, and emotional challenges associated with running a private practice, and anticipating the most commonly experienced challenges is an important part of successful business planning.

One of the first business planning challenges a private practitioner will encounter is the difficulty of projecting income and expenses. Income must provide for both personal needs and business expenses, and both income and expenses can sometimes be unpredictable. Business expenses vary widely, but may include the following:

- Office expenses such as rent, janitorial services, cleaning supplies, office supplies, letterhead, printing
- Office furnishings such as furniture and decor
- Telephone and answering services
- Computer-related expenses such as a designated work computer, internet services, printer, ink, and software programs for word processing, spreadsheets, and electronic health records (EHR)
- Administrative services such as practice management or billing services
- Taxes such as Social Security, income taxes, business taxes, and property taxes
- Insurance costs such as malpractice insurance, general liability (that is, “slip and fall”), disability, cyber liability, and personal health insurance
- Retirement planning
- Advertising, marketing, and public relations including Web site development, appropriate social media maintenance, business cards, brochures, “pay per click” advertising, or entries in directories
- Professional development costs such as clinical consultation, supervision, or continuing education
- Professional consultations with an attorney, accountant, or financial or business planner

- Professional expenses such as licensing fees, professional organization membership dues, journals and other professional publications
- Time off for vacations, illness, family emergencies, holidays, professional travel, conferences, and workshops
- Planned activities with no compensation such as pro bono client slots, speaking engagements, and voluntary boards
- Non-revenue-producing hours such as cancellations, no-show appointments, and nonpayment of fees for services rendered

Consider financial planning services of a Certified Public Accountant (CPA) or financial adviser to assist in tracking, income, expenses, and tax planning. Private practitioners should open a business bank account, have a designated credit card to keep track of expenses, a computer software program or other system to track business expenses. Having a separate bank account and a credit card dedicated solely to the business will make it easier for the private practitioner to track expenses and adds protection in the event that the business is audited.

One of the most helpful steps a beginning private practitioner can take is the creation of their own support team. Relationships with professionals who are available to assist the clinical social worker when ethical, legal, clinical, and practice-related dilemmas or questions arise are invaluable. This support team typically includes a financial consultant or CPA, attorney, and business adviser. Professionals from these disciplines can help develop a business plan, accounting system, retirement plan, and billing system. In addition, many clinical social workers starting private practices find it helpful to consult with knowledgeable, seasoned clinical social workers with established private practices who can provide mentorship and emotional support.

(This is in addition to clinical supervision and consultation.) The mentor and clinical supporters are very important. Many lessons must be learned or relearned when a clinical social worker no longer experiences the emotional and legal security of being part of a larger entity.

There are many differences between owning a private practice and working for an organization. Many new private practitioners realize that in the private practice setting, one loses the luxury of passively receiving new relevant developments—including laws, state licensure requirements, technological advances, emerging clinical and treatment trends, and evolving ethical standards. Instead, the successful private practitioner must proactively seek out relevant information as changes in clinical social work practice regularly occur.

To balance the clinical work, business work, and staying informed, it is recommended that every private practitioner take these concrete steps:

- Schedule time on your calendar every week to work *on* your business. You can't fill every work hour with clients—you need time to do other important tasks for your success, such as reconciling income and expenses, billing, marketing, networking, advertising, and paying the bills.
- Connect regularly with your professional support team. Ask for and rely on the expertise of other professionals!
- Join, support, and pay attention to the national and state chapters of NASW. NASW is an advocate for you and your professional success. NASW lobbies Congress with the Clinical Social Work Association and other related social work organizations. These

groups lobby against ill-advised bills and in favor of bills that improve social work practice.

- Actively seek out publications and information on emerging trends concerning the practice of clinical social work.
- Include time in your business plan for self-care, which is very important to the success of your private practice. For example, a regular getaway, lunch with a friend, or exercise may all help relieve the stress of running a business.

Health Insurance Portability and Accountability Act

As private practices are becoming increasingly digitized, clinical social workers in private practice should be aware of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which has specific requirements for patient information that is electronically transferred or stored. HIPAA has several administrative simplification provisions to protect the confidentiality of a patient's protected health information. The provisions include privacy, security, and breach notification requirements. Clinical social workers should be aware of these rules and participate in a formal compliance plan to ensure that all HIPAA federal and state requirements are met. Non-compliance with HIPAA can result in fines being levied.

Information is available at: <https://www.govinfo.gov/app/details/PLAW-104publ191?>

HIPAA standards are discussed throughout this manual. In addition, NASW provides a wealth of information and resources on HIPAA as it relates to social work practice. These include HIPAA forms, office policies, and sample documents that may be used in a private practice. Clinical social workers in private practice should become familiar with and implement HIPAA

requirements into their private practice as appropriate. To assist with this, NASW has developed a HIPAA Toolkit, which is available at <https://www.socialworkers.org/About/Legal/HIPAA-Help>.

Contracting with Insurers

There are many factors to consider when filing claims with insurers. A private practitioner is responsible for complying with any contract for psychotherapy services that is signed with an insurer. Although joining insurance panels may be a gateway to building a clinical practice, there may be unexpected consequences concerning what the insurer expects from the clinician that are not consistent with ethical psychotherapy practice. Clinical social workers should develop policies about how they work with insurers and clarify their policies in their informed consent form.

Network Providers

Signing a contract with an insurer to become “paneled” as part of the insurer’s network (what is called “in network”) may have serious legal ramifications, and the clinical social worker should carefully review it before signing, preferably with an attorney. Most insurers expect their patients to make a copay to the provider, in addition to what the insurer pays. Copays are a required payment for the patient and cannot be waived; to do so is insurance fraud. Patients may also have a deductible that must be met before insurance coverage is available. Verifying the kind of benefit that the patient has prior to beginning treatment is an important part of the

process for in-network practitioners. Either the practitioner or the patient may contact the insurer to find out what the patient's eligibility is for a given insurance plan.

Out-of-Network Providers

Some private practitioners are covered by insurers but are not paneled with them. These clinicians are out of network. This means that the insurer has agreed to pay for psychotherapy services, often with a higher copay, higher reimbursement rate, or a higher deductible. This may also mean that the patient pays more for psychotherapy than the patient would for an in-network provider.

Types of Insurers

There are two kinds of insurers, public and private. Public insurers are funded by federal and state funds. Two major examples of public systems that cover psychotherapy provided by clinical social workers are Medicare and Medicaid. Many public systems require clinical social workers to apply to become providers and may not reimburse out-of-network provider.

Private insurers may be nonprofit or for-profit organizations that cover clinical social workers as in-network or out-of-network providers. Each private insurer is likely to have many different health plans, so it is difficult to generalize about the way all plans cover psychotherapy.

Examples of private insurers include United Behavioral Healthcare, Blue Cross Blue Shield, and Cigna. Clinical social workers who become paneled with a given private insurer are not employees of the insurers, but are independent contractors, according to the Internal Revenue Service (IRS) designations. It is helpful for private practitioners to have an accountant who is

familiar with the tax laws that affect independent contractors and, if possible, mental health practitioners.

Another type of insurer-like organization is the employee assistance program (EAP). EAPs are provided as a service by employers, often contracting with a mental health organization or individual clinical social workers. EAPs provide crisis intervention, short-term counseling, and evaluations for potential mental health or substance use problems. Becoming an EAP provider means that the practitioner agrees to the limits of EAP services and is willing to abide by them. Some EAP services may allow private practitioners to become the ongoing practitioner if one is needed.

Considerations When Working with Insurers

Most public and private insurers may have explicit and implicit expectations for clinical social workers who choose to become paneled. Examples of explicit expectations include accepting the reimbursement rate of the insurer, agreeing to provide documentation of the treatment goals and progress, using ICD-10-CM diagnostic codes, and agreeing to an audit of cases covered by the insurer. Implicit expectations may include limiting treatment to one session a week, restricting the use of Current Procedural Terminology (CPT) codes, and allowing the insurer to determine what “medical necessity” is for a given diagnosis.

Some of the implicit expectations by insurers may be in conflict with the federal and state mental health parity laws. The private practitioner should understand that this is a possibility and consider whether becoming paneled is worth the limitations that the insurer may put on clinical practice. It is becoming increasingly common for insurers to ask for treatment reviews of patients who are seen more than once a week or a year, to assess medical necessity or to provide evidence that the treatment is progressing. This may lead to a more formal audit if the review shows a lack of progress. When a patient submits an out-of-network billing to their insurance, that provider may be subject to treatment reviews.

Group Private Practice Settings

For many private practitioners, starting a private practice involves significant financial, legal, and emotional risks. Joining a group practice may also pose some risks, particularly if other members of the group are already established, although the group model affords an opportunity to reduce isolation through information sharing, mutual support, consultation, peer review, and referral opportunities. Skills of each private practitioner may thereby be maximized in group settings. Another advantage of group practice is backup coverage when a private practitioner is out of town or otherwise unavailable for a client.

Group practice may make private practice within a group setting more vulnerable and be problematic—when one or more members fail to abide by group agreements or fall short of accepted practice standards, malpractice of each group member may be affected. Sometimes significant differences in treatment philosophy or interpretation of professional ethics arise between practitioners in the group.

Group practices may share nothing more than rent, or there may be elaborate collection arrangements where all billings accrue to a central account from which income can be drawn and expenses paid. A common arrangement requires that private practitioners pay some portion of their daily collections to the shared account for overhead expenses. The account may, in turn, pay for administrative support, billing, telephone, answering service, utilities, and other practice management services. Some groups include part-time private practitioners who pay a fixed rate per hour for office space. Some group practitioners pool their clinical skills into preferred provider organizations (PPOs), which enable them to deliver a variety of services to clients at a reduced cost and to enjoy increased opportunity for financial stability and business growth through greater client volume.

Another variation on the group structure may involve establishment of a partnership entity, purchase of equipment, joint lease arrangements, and perhaps joint or corporate purchase of a building in which offices are housed. Participants in this arrangement may benefit from group insurance plans. Clinical corporations are becoming more commonplace and can facilitate a more streamlined relationship with managed care systems. The NASW (2017a) *Code of Ethics* addresses the professional responsibility and liability that each partner has in such an arrangement, and state laws may also apply. There are legal and tax implications for the private practitioner whether the individual is a partner, shareholder, employee, independent contractor, or a combination thereof, including whether the arrangement is a for-profit or nonprofit business. Private practitioners should consult with legal and financial experts to understand the consequences of various arrangements and then develop the structure that best suits each private

practitioner's needs. A written contract is recommended between the private practitioner and the group.

Items that need to be discussed in an explicit agreement between a private practitioner and other members of the group include but are not limited to the following:

- Intended status or relationship (such as partner, shareholder, contractor, or regular employee)
- Salaries and income distribution
- Financial obligations and expense sharing
- Billing and collection procedures
- Marketing and public relations
- Malpractice and other types of liability insurance
- Taxes
- Benefits
- Rental and lease arrangements for space and equipment such as security systems and utilities
- Space usage (for example, offices, waiting areas, and filing cabinets)
- Record keeping and maintenance
- Consultation or supervision
- Coverage in the absence of a colleague and division of responsibilities
- Conditions and procedures for termination of the contract initiated by either party (group members should include such circumstances as death, permanent disability, geographic move, or dissolution of the business)

- Termination procedures relating to notice, financial obligations, and options for current clients at the time of termination of the contract between the social worker and the group.

Income Distribution and Fee Sharing

Several arrangements for distributing income exist, including division or sharing of fees, establishment of a set payment for specific services, or a combination thereof. Income distribution plans must accommodate the responsibility to protect clients from practices that may not be in their best interests; the obligation to protect private practitioners from exploitation; and the need to uphold the legitimate rights of institutions, groups, and individuals to earn reasonable incomes. It is recommended that each contract be carefully reviewed by an attorney before signing, with close attention paid to reimbursement fees and reporting requirements according to individual state laws.

Private practitioners should consider the following elements when structuring a plan for division of income:

- The patient should experience benefits from all parties with whom income derived from the patient (or patient's fee) is shared. Examples of services include but are not limited to information, referral, treatment, problem solving, supervision or consultation, facilities, administrative support, and program activities.
- If asked, all parties should feel comfortable informing clients of the general framework of the income distribution.

- The income distribution plan should take into account quantifiable costs for tangible services, such as office space, administrative services, and so forth.
- The arrangement should reflect a reasonable relationship between the amount paid and the value of the service received.

Reimbursement Issues

Sliding Scale

The concept of a sliding scale is not a new one. Agencies, hospitals, and organizations have been offering them in one form or another since the inception of social work and other helping professions.

Although not mandated by the NASW (2017a) *Code of Ethics*, private practitioners can offer a reduced rate to clients who are uninsured or experiencing temporary or persistent financial hardship resulting from job loss, catastrophic illness, natural disaster, or other struggles. As clinical social workers, we are encouraged to embrace the mission, core values, and ethical principles that are the foundation of our profession as laid out in the code. Social work's primary focus is on empowering those populations that are most "vulnerable, oppressed and living in poverty" (CSWA, 2016), and it is out of this spirit that the concept of a sliding scale was born.

However, as private practitioners, sometimes this can be challenging. We must reconcile our commitment to our social work values and our need to create a profitable business. We must find a personally and professionally acceptable balance between the tenets of the code and supporting ourselves and our families.

The NASW (2017a) *Code of Ethics* asserts: “When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients’ ability to pay” (1.13 a. Payment for Services) (pg. 16). This principle is further developed in the *NASW Standards for Clinical Social Work in Social Work Practice* (NASW, 2005), which states that private practitioners may offer a sliding scale to those clients who cannot otherwise afford services or whose insurance benefits have run out. Neither document provides guidance on whether the private practitioner should include a sliding scale or how to structure it, what criteria should be included, or what fee range is recommended. For those who wish to adapt one in their practice, careful consideration should be given to conforming with applicable ethical and legal manuals and with contracts with third-party payers.

Private practitioners are cautioned against routinely and randomly adjusting clients’ fees without determining their actual financial status. To avoid allegations of insurance fraud, preferential treatment, or a randomized assignment of fees, private practitioners are advised to develop a standardized method of calculating a patient’s fee based on documented financial need. This sliding scale should be applied uniformly to each patient who requests a reduced rate.

For private practitioners who wish to implement a sliding scale, policies and procedures should be developed that consider the following:

- Income qualifications for receiving a reduced rate
- Time period during which the reduced rates will be in effect
- How the reduced rates will be determined

- When and how often the reduced rates will be reviewed
- Patient's obligations to disclose a change in financial status in a timely manner

Bartering

Some private practitioners include in-kind exchange, sometimes referred to as “bartering,” as an option for payment for services., The NASW (2017a) *Code of Ethics* states:

Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship. (p. 14)

Alternative arrangements, in which services are essentially pro bono but an in-kind exchange allows for the maintenance of client self-esteem, are more acceptable. Personal service arrangements such as massages, haircuts, and so on (which establish dual relationships) are to be avoided.

Pro Bono

All private practitioners are encouraged to provide some services on a pro bono basis. This may be accomplished in a variety of ways, including volunteering treatment hours at a community-based organization, providing free workshops, serving on local community boards, setting aside a number of clinical hours per week as free hours, or offering free time to patients in financial difficulty.

Marketing

Marketing efforts can concentrate on the many opportunities that exist to generate clientele and make the practice and the practitioner's expertise known. The following are some ideas for marketing your practice:

- Provide good clinical services to present patients, who may talk about your services with other potential patients or referral sources. Remember, of course, that social workers are ethically prohibited from soliciting testimonials from current patients, and it can be problematic to do so even from previous patient.
- Good marketing begins with self-awareness and the identification of one's "ideal patient." Identifying your strengths and your niche as a provider will help you better target your marketing efforts. Focusing on the patients that are the best match for you will also help make the most of your limited marketing efforts and dollars.
- Identify potential referral sources for the type of patient you wish to serve, for example psychiatrists, hospital social workers, school guidance counselors, physicians, human resources professionals, and therapists with other specialties. Establish relationships and provide information about services to referral resources.

- Contact hospitals, schools, businesses, and nursing homes.
- Use marketing tools to help develop Websites, brochures, newsletters, cards, and announcements. Consider hiring professional designers for the most polished and professional products.
- Offer public presentations on topics within your areas of expertise and hand out business cards or flyers at your talks.
- Write short articles on topics within your areas of expertise, with your ideal client as the intended audience. Look for venues to publish these articles, for example blogs (yours or others'), school newsletters, wellness programs within large corporations, your local newspaper, or Web sites that your ideal patients might be visiting.
- Your potential client's first point of contact with you is a pivotal marketing tool.
 - **Web site:** Does your Web site reflect your awareness of your clients' needs and preferences? Web sites that are visually unappealing, have tiny print, and include long lists of the provider's credentials are less compelling than those that are visually appealing and reflect the needs and preferences of the visiting potential client.
 - **Phone conversation:** How skillfully are you able to communicate your clinical skills in a 10- to 15-minute phone call with a stranger? From the patient's perspective, that phone call may be the only way to make sure that you are professional, capable, trustworthy, and able to build rapport with them. Warmth, professionalism, and a balance of confidence and openness with guidance and listening are all characteristics that will help clients feel comfortable taking the

next step with you. Make it a rule to return all calls, even if they are clearly not a match for you. It is your ethical obligation.

- Contact insurance carriers, managed care firms (PPOs and health maintenance organizations), EAPs, and major employers to contract as an affiliate or preferred provider.

Evaluate your marketing plan periodically and modify as needed in light of experience and changing market conditions.

Advertising

According to the *NASW Code of Ethics*, “Social workers shall provide services and represent themselves as competent only within the boundaries of their education, training, licensure certification, consultation received, supervised experience, or other relevant professional experience” (p. 11). Clinical social workers shall represent themselves to the public with accuracy.

The public needs to know how to find help from qualified clinical social workers. Private practitioners should ensure that information about their therapeutic services is available to the public by using, for example, online provider directories and identify their credentials.

Advertising is acceptable as long as it is factual and avoids false promises of cures. Promotional material might include the following information: practitioner’s name, professional credentials, address, telephone number, types of services provided, types of problems treated, hours and days of operation, and listing on provider panels. Private practitioners should only claim competency

in specific skills and areas of expertise in which they are clinically trained and competent. They should maintain documentation of their specific training including course work, supervision or consultation, and experience that support an advertised claim of specialty or expertise.

Many states have individual requirements related to advertising and what must or cannot be included. Be sure to consult your state regulations.

Testimonials and Reviews

The NASW *Code of Ethics* states:

Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence (p. 26),

Although the use of testimonials is a popular marketing tool in other professions, it is not recommended that clinical social workers publish or promote the use of patient testimonials related to their private practices, even when those testimonials are given freely from patients and are not solicited from current or vulnerable patients. The publishing of testimonials on a practitioner's own Web site is discouraged, as this can imply to other patients that a testimonial from them might be appreciated or expected. Testimonials can interfere with the patients' or prospective patients' expectations.

Online reviews are a common venue for potential patients to gather information about others' experiences with a particular practitioner. Whether the reviews are positive or negative, it is

never appropriate for a private practitioner to respond to a patient's review in a public manner. If the writer of the review is a current patient, it is recommended that the private practitioner address the review, including both content and confidentiality concerns, within the boundaries of the therapeutic session. In the case of the patient who has terminated treatment, it is recommended that the private practitioner seek both support and consultation.

If a practitioner wishes to have testimonials or reviews published on a third-party Web site, it is more appropriate to ask for testimonials from colleagues who identify themselves as such within the review.

Risk Management

The NASW, ASWB, CSWE, and CSWA (2017) standards, *Standards for Technology in Social Work Practice*, define *risk management* as “the practice of ethical, competent social work services and accurate documentation of practice decisions and interventions to protect clients and prevent litigation and ethics complaints” (p. 56).

The concept of risk management to avoid malpractice claims has been widely accepted in the health care industry since the 1970s. Private practitioners should carry malpractice insurance for both active and closed practices using social work expertise. It is generally recommended that clinical social workers purchase maximum individual and aggregate limits of malpractice insurance because of the high-risk circumstances of their work. Sometimes state laws, administrative bodies, employers, managed care companies, and other insurance carriers may

dictate the amount of malpractice insurance required for their providers. Private practitioners should also take the following important steps to help avoid malpractice claims:

- Assess and document clinical risks such as potential for suicidal or homicidal behavior, violent behavior, and personality disorders.
- Consultation with risk management specialist through your professional liability policy.
- Be alert to practice risks such as breach of confidentiality, negligence, inappropriate or unsuccessful treatment, negligence in the treatment process, ethical issues in the use of technology, and potentially litigious patient.
- Establish a clear understanding of expectations at the beginning of treatment using documents and written information such as, but not limited to,
 - notice, receipt, and acknowledgment of privacy practices
 - record of disclosures
 - consent for involvement of others (often referred to as “collaterals”) in the treatment process, if appropriate
 - informed consent for any audiovisual aids
 - the private practitioner’s use of professional supervision or consultation
 - what to expect in therapy and the length of sessions
 - fee policies
 - consultation and information sharing with other professional practitioners
 - conditions that might require hospitalization, duty to inform, or reporting of suspected abuse or neglect

- Respond quickly and comprehensively to patient complaints, investigate problematic situations immediately, create an action plan to provide a remedy, and monitor the outcome closely. Problems resolved quickly are generally not litigated.
- Regularly review, keep current copies of, and abide by the NASW (2017a) *Code of Ethics* and the NASW, ASWB, CSWE, and CSWA (2017) technology standards.
- Always behave in an ethical and professional manner; maintain a professional patient–social worker relationship to avoid future problems. When in doubt about a proper action, consult with peers, supervisor, consultant, attorney, or NASW resources.
- Maintain clear and concise records (information that is not documented may be difficult or impossible to prove later). Document important items and avoid nonrelevant information.
- Maintain adequate professional liability insurance on a continuous basis, such as that offered through NASW Assurance Services.

<https://naswassurance.org/>

Problems or issues that most commonly motivate malpractice suits against private practitioners include, but are not limited to,

- sexual impropriety between private practitioner and patient
- incorrect treatment or failure to make a proper diagnosis
- providing legal testimony or documentation that may result in legal decisions or recommendations that disrupt child placements, parenting time, and so on
- improper placement of child in adoption or foster care
- breach of confidentiality or privacy

- removal of a child from home after approved placement
- fees and collection procedures
- suicide or attempted suicide of a patient
- acts that lead to the death or harm of the patient or another person

NASW has many publications and ongoing trainings that are useful and relevant to risk management. To access those resources, visit www.socialworkers.org.

Clinical Supervision and Consultation

Supervisors or consultants provide guidance based on experienced and objective viewpoints on treatment issues. Supervision in general enables social workers, pre- and post-licensure, to enhance and improve their treatment skills. There are many issues to consider in both supervision and consultation. Having a supervisor whose treatment methods are understandable to the supervisee is important, as is the confidentiality of the material discussed whether in supervision or consultation. For additional information on how to conduct supervision and consultation, see the NASW (2013a) *Best Practice Standards in Social Work Supervision*.

Although the terms “supervisor” and “consultant” are often used interchangeably, they have their own separate meaning and each role is discussed in the following sections:

Supervision

As a supervisor, the clinical social worker has the authority to make suggestions to a supervisee. These suggestions should be followed by the supervisee; if they are not, the supervisor is still responsible for the way that the supervisee conducts their work with patients. State regulatory

boards and professional credentialing bodies may have more specific definitions of supervision for their purposes, and it is the responsibility of both the supervisor and the supervisee to know what is expected of them. It goes without saying that the supervisor is responsible for making sure that supervisees conduct social work practice in an ethical manner, understand the treatment methods being used, and learn to make mental health diagnoses.

As stated in NASW's (2013a) supervision standards, there are multiple definitions of what supervision is and is not. As specifically defined in this guide, *supervision* recognizes the relationship between supervisor and supervisee as one that leads to effective development of competency, conduct, and ethical practice. It is important to note that both parties—the supervisor and the supervisee—have the duty and share responsibility for their individual roles in the supervisory process.

According to Milne (2018), *supervision* is defined as “the formal provision, by ‘approved supervisors’, of a relationship-based education and training that is work focused and which manages, supports, develops, and evaluates the work of colleagues” (p. 17). Based on this definition combined with that of the NASW (2013a) supervision standards, social workers who are currently, or desire to become, supervisors should make sure that they obtain the necessary education and ongoing training according to state requirements to effectively and successfully provide supervision. Once a social worker has become a supervisor in a given state, they may begin to supervise newly graduated social workers for the required years of supervision, typically two to three years, to achieve clinical licensure for independent practice. New MSW graduates should choose supervisors who understand the social work methods that the new graduate wishes

to use, and with whom they desire to be associated. Likewise, approved supervisors should choose supervisees who share the supervisor's understanding of social work practice. Good communication between supervisor and supervisee is key to a successful supervisory relationship.

Regardless of the form of social work practice, an accountability process should be built into the practice. Supervisors should develop suitable plans in the form of a written contract that explains the responsibilities of the supervisor and supervisee. Supervisors may be held accountable for the manner in which their supervisees practice social work, and thus may be held liable in licensing board complaints or malpractice suits.

The written contract, as agreed to by the supervisor and supervisee, should be reviewed regularly no less than annually. The following are issues that may be considered in a contractual relationship between supervisor and supervisee:

- Is the supervisor familiar with the type of or specialty practice of the supervisee?
- Do the supervisor and supervisee agree on the frequency of supervision?
- Have the supervisor and supervisee agreed on the fee for supervision?
- Does the supervisee agree to follow the direction of the supervisor?
- Does the supervisory relationship meet all statutory and regulatory requirements in a given state?
- Does the supervisor meet the qualifications required by their state Board of Social Work?

Consultation

Consultants differ from supervisors in that the consultant can make recommendations for a specific direction but has no power or authority over the actions of the social work practice or practitioner. Consultants weigh in on clinical social work issues when requested. This may lead to some disagreements, which is acceptable. The nature of the consulting relationship does not have the same level of responsibility for the work of the consultee as a supervisor has for the work of a supervisee.

Consultation takes place when one professional seeks advice from another concerning any aspect of practice, most typically on an as needed and self-determined basis. A social worker should seek consultation in any instance that involves specialized understanding of a patient or a complex case in which consultation is a best practice. This may include managing individual cases, understanding the meaning of a difficulty in the treatment relationship, upgrading the private practitioner's skills (new techniques or new patient group), managing health issues, monitoring the effects of prescription drugs, managing the business of private practice, or dealing with legal and financial issues.

Non-social work consultants such as attorneys, pharmacists or other health care professionals, or accountants are vitally important to the integrity of a social worker's private practice and should be taken advantage of when deemed necessary.

Patient-Clinical Social Worker Practice Agreements

Private practitioners should be aware that patients are consumers of a service, and that service is clinical social work practice. Thus, it is important that the patients have a clear understanding of

what is expected of them and what can reasonably be expected of the private practitioner. In creating the patient–clinical social worker practice agreement, clinical social workers should consult relevant NASW documents, such as the *Code of Ethics* (NASW, 2017a); the NASW (2015) *Standards for Clinical Social Work in Social Work Practice*; NASW, ASWB, CSWE, and CSWA (2017) *Standards for Technology in Social Work Practice*; NASW (2015) *Standards and Indicators for Cultural Competence in Social Work Practice*, and NASW (2013b) *Standards for Social Work Practice with Clients with Substance Use Disorders*.

At www.socialworkers.org, NASW provides many additional resources to help both the aspiring and the seasoned private practitioner. For example, NASW’s Legal Defense Fund has developed many articles, tip sheets, and sample forms. The NASW office of Professional Development and Programs publishes valuable information specific to private practitioners through *Practice Perspectives*; holds monthly teleconferences titled “An Hour with Private Practice: Questions and Answers;” and puts out *Private Practice Section Connection*, a biannual newsletter designed specifically for members of the Private Practice Specialty Practice Section.

As clinical social work practice is regulated by individual states, clinical social workers developing a private practice should refer to their state statutory, regulatory, and administrative laws in creating patient–clinical social worker practice agreements. Additional resources should include consulting federal HIPAA laws and contacting individual NASW state chapters, as some chapters have developed manuals to assist members wishing to develop a private practice.

The NASW (2005) clinical social work standards instructs social workers in private practice to “develop and implement written policies” that explain their professional services, business policies, and office procedures. “These policies shall be made available to and reviewed with each client at the beginning of treatment” (NASW, 2005, p. 17).

To minimize malpractice risk and to ensure that informed consent standards have been met, it is recommended that both the clinical social worker and the patient sign the patient–clinical social worker agreement. One copy should be given to the patient and another copy should be retained as part of the patient’s clinical record.

The patient –clinical social worker practice agreement should include the following information:

- Private practitioner’s qualifications and experience, including education, degrees, certifications, areas of expertise, accomplishments, publications, and professional memberships
- The private practitioner’s basic approach to treatment
 - Philosophy, treatment modalities, clinical orientation, client population
 - Adoption of the NASW (2017a) *Code of Ethics*, individual state social work licensing laws, and HIPAA into the practice
- Matters involving informed consent, such as explaining (refer to section on informed consent for more details):
 - Consent for treatment
 - Benefits and risks to treatment
 - Social worker and patient’s responsibilities

- Time and attendance expectations:
 - Notification of absences—advanced notice, planned (vacations) and unplanned (emergencies)
 - Coverage and contact procedures when the clinical social worker is unavailable, for example during holidays, vacations, evenings, weekends, emergencies, and so on:
 - Patients should be connected with a competent mental health professional who would be available in the clinical social worker’s absence.
 - Patients should be provided with information for handling life-threatening emergencies arising during or after office hours—call 911 or 611, list local crisis contact number, suicide hotline
 - Clinical social worker availability
 - Preferred method of contact: phone, text, e-mail
 - Office hours
 - Length of time before a response to a contact made outside of sessions will occur
- Patients rights
 - Termination (refer to section on termination):
 - Procedures and reasons for termination, right to referral to qualified mental health professional

- Refusal of treatment (exceptions: court ordered, crisis or emergency, to prevent imminent, serious, and foreseeable harm to self or others)
 - Access to the patient's clinical file after termination (check with state laws regarding storage, retention, and destruction of patient record after termination; check current state laws, Medicare or Medicaid laws, and provider contract with insurance companies)
- Grievance procedures (discuss with clinical social worker, complaint to state licensing board; list contact information for both)
- Involvement of family or significant others
- Joint development and periodic review of a treatment plan
- Clinical social worker participation in consultation or supervision (confidentiality)
- How appointments are handled:
 - Scheduling of sessions:
 - By appointment only or other arrangements
 - By telephone, e-mail, text, online system
 - Frequency of sessions:
 - Weekly, biweekly, or as determined in treatment plan
 - Length of sessions:
 - Agreed to in advance by patient and clinical social worker
- Location of sessions offered:

- In office, in home, at a skilled nursing facility, by telephone, videoconferencing— should be agreed to in advance (including crisis intervention, long- or short-term treatment, forensic evaluations, child custody evaluations)
- Cancellation policies, including reasons for cancellations (advanced notice, missed appointments, late arrivals, sick, emergencies) and whether there are fees associated with each situation
- Clarify the parameters of confidentiality and procedures for release of information (refer to section on confidentiality for more information):
 - Use of authorizations to release records:
 - HIPAA notice of privacy practices
 - Revocation of authorization to release records
 - Patient’s right to access or deny access to their clinical record
 - Social worker’s duty to deny unlawful access to the clinical record
 - Legal exceptions: situations in which disclosure of confidential information with or without prior written consent may be legally or ethically required, for example: medical emergency; to prevent serious, foreseeable, and imminent harm to a client or others; when required by law or ordered by the court; suspected or revealed domestic violence; child abuse or neglect; elder or differently abled abuse (consult state law)
 - Confidentiality policies when the patient is a couple, a family, a minor, or when parents are divorced

According to the NASW (2005) clinical social work standards, the patient–clinical social worker practice agreement should also include written office policies and procedures about the financial

aspects of the private practice (for more information, refer to relevant sections in this manual).

This section of the agreement should clearly state:

- When the patient will be billed for clinical social work services
- Who is responsible for making payment (third-party payer, patient or patient representative, or a combination of both or others), including fees associated with specific services:
 - Assessment or evaluation, individual, couple, family, group
 - Differing length of services
 - Phone contacts with patients, attorneys, and other professionals
 - Services typically not covered by insurance (out-of-pocket expenses), for example phone sessions, court visits, observations, written reports
- Methods for making payments (check, cash, flexible spending account, health care spending account, health care reimbursement account, credit card) and when payments should be made
- Actions taken in the event of late payments or failure to pay:
 - Collection procedures
 - Policies about advanced notice (phone call, collection letter, bill)
 - Policies on interest for late payments and outstanding balances
- Who is responsible for filing claims, that is, clinical social worker or patient
- The private practitioner's status with the patient's insurer or EAP
- Criteria for offering sliding scale to patients

Informed Consent

Informed consent is the process whereby patients are given adequate information to aid them in making informed choices in their treatment plan, and it contains several important components discussed in this section. Clinical social workers are ethically obligated to obtain a patient's informed consent for treatment, either before treatment commences or as early in the treatment process as possible. It is important to review and follow all state laws and regulations pertinent to informed consent. Obtaining informed consent is incumbent on the clinical social worker to preserve a patient's right to exercise self-determination. A patient can exercise their right to self-determination by having a clear understanding of what services a clinical social worker offers and understands the purpose, benefits, and potential risks of entering treatment.

Clinical social workers are tasked with taking steps to ensure comprehension of informed consent by patients who may be limited in their ability to actually consent because of, for example, language barriers, literacy issues, cognitive challenges, mental illness, brain injury, or substance use. These steps might include providing an interpreter, working with a translator, conducting a mental status assessment, or obtaining informed consent from a person legally authorized to act on the patient's behalf.

Minor patients and other patients who are unable to give legal consent indicate their assent for treatment by their participation. Assent for treatment cannot be considered a substitute for legal informed consent. The ability for minors to independently give assent varies from state to state.

In states where minors are not allowed to give independent assent, informed consent must be obtained from a person legally authorized to do so such as a parent, guardian, etc.

Informed consent may be obtained in person or electronically. Of particular importance is the social worker's understanding of how obtaining and preserving informed consent applies to electronic information and communication. Updates contained in the 2017 edition of the NASW *Code of Ethics* must be reviewed, understood, and clearly stated in any informed consent agreement.

Informed consent includes, but is not limited to, the following:

- Clear and understandable language about the purpose of the service
- Patient competency to understand and appreciate what is being agreed on
- Privacy and confidentiality rights (for example, HIPAA compliance and use of technology in practice and how it may limit privacy and confidentiality)
- Understanding of the clinical social worker's ethical and legal obligations, such as duty to warn or report
- Knowledge of the clinical social worker's verifiable credentials such as education, licensure, and relevant training
- Risks, benefits, and limitations of specific services
- Relevant costs of services offered, including legal services
- Permission to audio or video record sessions or to be observed by a third party
- Limits of services because of third-party payer requirements

- Designated or responsible party for payment for late or missed sessions (see section on billing practices)
- Alternative forms of service or treatment approaches
- Gaining written permission before disclosing confidential information to a third party
- Right to refuse or withdraw consent
- Knowledge of the clinical social worker's policies and procedures around the use of technology, including electronic searches of the patient.
- Valid consent mechanism (usually written)
- Time frame of the consent
- Application of all standards to all types of communication—in-person, by phone, and electronic (for example, e-mail, text, and so on)
- Emergency procedures and availability beyond the clinical hours
- Policies on accepting insurance

Dual or Multiple Relationships

The NASW (2017a) *Code of Ethics* states: “Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client” (p. 12). There are instances when dual or multiple relationships are unavoidable (especially in rural settings or when the social worker's community is where they practice). Clinical social workers are responsible for protecting the therapeutic relationship, including setting clear, appropriate, and culturally sensitive boundaries. It is also the clinical social worker's responsibility to anticipate potential situations to discuss with and protect the patient.

Clinical social workers must also pursue and preserve appropriate boundaries with patients regarding electronic communication. Communication methods such as e-mail, text, and social media should be handled with the same degree of confidentiality as written or in-person communication. Clinical social workers must understand and anticipate how their presence on social media may influence personal and professional boundaries with current and potential patients. This includes the social worker's pursuit of client information, which should remain strictly for professional reasons and not to settle curiosity.

Dual or multiple relationships can occur simultaneously or after the termination of the therapeutic process has already occurred. Although this rule is meant to apply to all clinical social workers, private practitioners tend to be held to a higher standard. The Taskforce for Private Practice Guidelines highly recommends that private practitioners hold to the standard of "once a patient, always a patient," thereby minimizing risk of perceived exploitation, potential for harm, or improper patient-clinical social worker interaction. This standard assists the private practitioner to set and maintain strong and clear boundaries related to perceived or potential dual or multiple relationships, anticipated and actual.

Confidentiality

Confidentiality has become much more complicated with the use of technology to communicate with patients, communicate with other treatment providers about patients, store information about patients, and process claims for treatment. Presently there are two primary ways to think about preserving patient confidentiality. One way is the traditional definition of confidentiality in

terms of disclosing information about the patient to others. The other way is to consider how the new methods of electronic communication with patient and storage of patient information are part of the treatment process, and how these methods affect confidentiality.

For purposes of this manual, *confidentiality* is defined as the basic ethical principle that clinical social workers will maintain the privacy of information shared by a patient unless the patient provides authorization to the clinical social worker for its release (subject to exceptions, such as disclosures required by court orders or to prevent serious, imminent harm to the patient or another person).

The Privacy and Confidentiality section of the NASW *Code of Ethics* (2017a) defines confidentiality as follows:

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible, before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker–client relationship and as needed throughout the course of the relationship. (Section 1.07, p. 12)

Text According to the NASW, ASWB, CSWE, and CSWA (2017) technology standards, confidentiality of electronic communications includes the following:

The ability to provide services electronically has many benefits as well as risks that social workers should consider. Social workers who use technology to provide services should assess whether clients will benefit from receiving services through electronic means and, when appropriate, offer alternative methods of service delivery. (p. 11)

Social workers who conduct supervision or consultation, and those who facilitate other confidential meetings through the use of technology, should take appropriate precautions to protect the confidentiality of those communications. Precautions to protect confidentiality depend on the type of technology being used, and may include

- using passwords, firewalls, encryption, and antivirus software
- using electronic service providers that rely on standards of security for data that are transmitted and stored
- ensuring a private setting when using their electronic devices (pp. 23–24)

Written Disclosure of Confidential Information

Clearly, confidentiality is a basic tenet and principle of psychotherapy. This principle assures the patient that what is shared in the session remains private unless the patient authorizes the private practitioner to release the record, or a summary of the record, in writing, signed by the patient, to another party for any purpose. The permission to release information should be time limited, usually 90 to 120 days. The permission to release information should be renewed and signed again by the patient if a longer period of time is required. It is a best practice to receive written

permission before disclosing a patient's record, a report based on their record, or any verbal information about the patient even if the information is disclosed to what HIPAA calls a covered entity. It is also a best practice for private practitioners to have patients read their record, a report based on their record, or be apprised of any verbal information about the patient that is disclosed.

Release-of-information forms may vary in style, but usually include the following information:

- Date
- Name of patient
- Identifying information such as birth date, address, and phone number
- Private practitioner's name, address, phone number, and other access information
- Information to be shared (for example, intake assessment, reports, or progress notes)
- Purpose for release of information (such as transfer of case, utilization review, or continuum of care)
- Expiration date of the release of information
- Patient signature or parent or legal guardian signature (if indicated) and provider signature

From a professional ethical standpoint, all documentation and written information related to or obtained from the patient should be viewed as confidential.

Confidentiality and Electronic Communication

As previously noted, confidentiality also applies to any communication with patients using technology. The potential for violation of confidentiality has increased exponentially with the

use of technology for videoconferencing, text messaging, e-mail, and other forms of online communication. It is prudent for clinical social workers to use platforms that are encrypted, to encrypt communications using their own electronic devices, to use servers that accept the confidentiality standards of the clinical social worker by signing a business associate agreement (BBA), and to avoid use of social media for communication with patients to maintain confidentiality. Any blogs or vlogs that a private practitioner creates should avoid the use of any identifiable patient information.

The private practitioner also has a duty to warn patients about the limits of confidentiality as defined by HIPAA. This includes release of patient information if a third party is likely to be harmed; if there are state or federal laws that require disclosure of patient information; and if there is a criminal investigation that requires disclosure of patient information. Private practitioners should be aware of the state and federal laws that apply to limitations on confidentiality and notify patients of these limitations.

According to the NASW, ASWB, CSWE, and CSWA (2017) technology standards,

Social workers who provide electronic services should develop protocols and policies to protect client confidentiality. They should use encryption software and firewalls and periodically assess confidentiality policies and procedures to ensure compliance with statutes, regulations, and social work standards. (p. 17)

In addition, the technology standards address confidentiality in the area of payments:

Social workers who submit insurance claims for payment electronically shall take reasonable steps to ensure that business associates use proper encryption and have

confidentiality policies and procedures consistent with social work standards and relevant laws. (p. 17)

One way to ensure proper encryption is to have the payment services such as credit card processing platforms, mobile payment service, etc. sign a business associate agreement.

Confidentiality of Electronically Stored Records

Clinical social workers who gather, manage, and store information electronically should take reasonable steps to ensure the privacy and confidentiality of information pertaining to patients or research participants. Information should be stored in secure locations, using strong passwords, firewalls, or other appropriate precautions. Strong passwords may include a combination of upper and lowercase letters, symbols, and numbers that are not obvious (for example, not the worker or patient's name). Changing passwords regularly can also enhance security. For group practices or home offices, knowledge of passwords and access to online files should be restricted to those who require access. When files are backed up, reasonable protections should also be taken to maintain confidentiality of the backed-up files.

Additional methods of reducing risks of breaching confidentiality (depending on the context of practice) could include the following:

- Using a closed server in which access to information is limited and is not accessible through the Internet
- Using encryption, strong passwords, and other means for ensuring the integrity of information that is gathered, managed, and stored

- If identifying information is not needed, gathering data on an anonymous basis so the patient or research participant cannot be linked with the information collected
- Encouraging the patient to use a private password-protected computer with a secure Internet connection
- Encouraging the patient to ensure that they are in a private location when providing the information electronically (for example, not surrounded by family, friends, or strangers, or in a location where others can hear or observe as the information is being shared)
- When using a cloud server for storage, being mindful of potential risks such as breach of client privacy

Cloud storage has become increasingly popular. Social workers who use cloud storage should adhere to applicable HIPAA privacy and security standards.

Breach of Confidentiality

According to the NASW, ASWB, CSWE, and CSWA (2017) technology standards, “Social workers should develop and disclose policies and procedures concerning how they would notify clients of any breach of their confidential records” (p. 35).

Laws That Supersede Confidentiality

An increasing number of state laws govern the private practitioner’s duty to warn, starting in 1976 after the *Tarasoff v. Regents of the University of California* (1976) decision that highlighted the practitioner’s duty to warn third parties that are at risk and have been named by a client. The laws vary by state:

- Some states recognize a duty to warn when there is a general threat or a threat against the public at large
- Some states recognize the duty to warn only against specific and readily identifiable victims
- Some states have yet to address the issue or have not recognized any such duty at all or, although ostensibly recognizing such a duty, have yet to encounter a situation in which they are willing to impose it

It is up to private practitioners to know what the laws are in their states regarding duty to warn third parties and the impact of the patient's right to confidentiality.

Privileged Communication

Privileged communication is a legal concept rather than an ethical precept or professional principle. The privilege belongs to the person who provided the information, that is, the patient. Because privilege arises when determining whether evidence is admissible in a judicial proceeding, privilege rules are found within the code covering the state's rules of evidence. Not all state laws grant privileged status to clinical social workers' communications with patients; it is up to the clinical social worker to determine whether communications from patients are privileged according to their state's law.

The federal rules of evidence were clarified by the U.S. Supreme Court decision in *Jaffe v. Redmond* (1995), confirming that client communications with licensed clinical social workers in

the context of psychotherapy are privileged communications under the federal rules of evidence. Therefore, these communications are generally not subject to disclosure as evidence in federal courts.

Privilege serves to prevent the private practitioner from being a witness against a patient's wishes or best therapeutic interests. A written waiver or release signed by the patient or a competent person who has legal authority to release such information in the context of a legal proceeding is generally accepted as an effective waiver. In addition, most states consider that the patient has waived the privilege when their mental health is made an issue in either a civil or criminal court.

Occasionally a client will want to have privileged information revealed in a court proceeding. It is the responsibility of the clinical social worker to discuss the possible harm that may be done to the patient and the treatment if privileged information is disclosed in a legal setting.

Subpoenas

A *subpoena* is a legal document that requires a response from the practitioner, rather than a letter requesting information. Private practitioners should check with their professional liability insurance on how to proceed if they are served a subpoena (NASW, Specialty Practice Sections, 2015). If a private practitioner is served a subpoena to submit records or present testimony, it is best to consult an attorney who understands clinical social work practice in the state where the clinical social worker is licensed. The private practitioner should never take action without the direction of an attorney. Subpoenas often have deadlines that must be met, and a private

practitioner cannot make any assumptions about what can or cannot be done without legal advice. *Private practitioners must remember that a subpoena should never be ignored.*

Third-Party Payers

When services provided by a private practitioner for diagnosis or psychotherapy are covered financially by a third party, it is important to keep in mind that the patient is ultimately responsible for payment. Insurance payers provide benefits to the patient for health care services, but the patient has ultimate responsibility. Private practitioners may choose to bill a patient's insurance directly or receive direct payment from the patient and provide required documentation for the patient to submit to the insurance company for reimbursement. To the degree that the patient is able to understand the relevant provisions of coverage, the patient should be aware of the policies of their third-party payers, how to submit claims, and the limitations of coverage before treatment begins. If a private practitioner chooses to file claims directly, they should have thorough knowledge of how third-party claims are filed in a confidential way for the patient's insurers and all the information that is required to file a third-party claim. Private practitioners should also have policies about filing third-party claims that are explained to the patient at the beginning of treatment, preferably in writing.

Network and Out of Network

There are two major ways that private practitioners have a connection to third-party payers. One is as an in-network provider, which means that the private practitioner agrees to accept the payment standards that are offered by the insurer and the limitations on the treatment covered.

The other is as an out-of-network provider, which allows a private practitioner to bill their usual and customary rates, but generally the patient pays a higher copay.

Copays may be required when a third party provides coverage for social work services for diagnosis and psychotherapy. Private practitioners should have accurate knowledge about the copay that the patient is charged at each session. Copays cannot be waived and the timing of payment cannot be changed; to do so constitutes insurance fraud. Many patients also have a deductible that they must pay before their claims are covered by the third-party payer.

Billing Practices

The private practitioner and the patient should respect and accept the requirements of the insurance contract. The private practitioner should be aware of whether the payer covers audio and videoconferencing sessions, and sessions including family members or friends. Missed appointments and late cancellations are not covered by insurance, but the private practitioner may require payment directly from the patient for these situations. Private practitioners should communicate these policies to the patient in writing at the first session.

There are some limitations imposed on clinical social work practice by many third-party payers. Clinical social workers and their patients should be prepared for limitations on treatment that is more than once a week, treatment that is more than 53 minutes a session, treatment that is more than a year in length, and other limits on diagnosis and psychotherapy practice. There are some treatment methods that are routinely questioned, usually for chronic conditions such as posttraumatic stress disorder, personality disorders, and psychotic disorders. Treatment reviews

are conducted by auditors who work for the insurer but are not necessarily clinical social workers and do not understand clinical social work practice. Clinical social workers should request that treatment reviews be conducted by clinical social workers or a related mental health professional.

CPT Codes

There was a change in the primary CPT codes used by social workers to submit claims for their services in 2013. These codes are based on the relative value unit approved by the Centers for Medicare and Medicaid Services (CMS, 2020). There are several psychotherapy codes used by social workers, but not all insurers cover all codes (NASW, 2017b). Clinical social workers should be aware of possible limitations on the CPT codes covered by third-party payers.

ICD-10-CM Codes

Accurate diagnoses must be used when filing a third-party claim. The ICD-10-CM is the code set required by HIPAA for the diagnosis of mental and behavioral disorders. A diagnosis should be reflective of the patient's diagnostic evaluation, which includes a mental status exam, clinical and medical history, and treatment plan. A treatment plan includes a plan of care and goals to be achieved.

Fee Structure

The fee structure used by private practitioners should be standard for both those patients using insurance coverage for psychotherapy services and those who pay privately. Private practitioners should consider their level of experience and competence when deciding their fees. The fee structure should be compliant with state law. Some private practitioners may choose to reserve

time for patients who pay privately to pay on a sliding scale. As previously noted, private practitioners may not adjust the copays, deductibles, or reimbursement level required by a third-party payer by whom they are credentialed. (For more information, see the subsection on sliding scales in the section on reimbursement issues.)

Denials and Appeals

There are a number of reasons that denials of claims occur. Private practitioners can avoid or minimize denials by using evidence-based strategies that cover the range of reasons for denied claims. Denials may include lack of medical necessity, no preauthorization obtained, insufficient documentation, incorrect coding, incorrect diagnoses, and late filing. It is important to understand the reason for a denial and determine whether the denial was issued erroneously.

Insurers may set limitations on coverage of services. Both private practitioners and patients should advocate for the best possible care. If an appeal is needed, follow the appeal requirements of the insurer which may include the following:

- Determine whether the insurance plan is a privately insured plan or a self-insured plan.
- If the client has a health resources coordinator or an insurance broker working for their employer, see if they will support the appeal process.
- Gather all information about the standards of care that a plan uses to determine whether treatment is covered by the plan.
- The patient or clinical social worker should ask the plan representative how the denial is consistent with restrictions on medical and surgical benefits.

- The patient or clinical social worker should send the following request to the insurer by e-mail and certified mail, return receipt requested:

Please provide me with a copy of my complete appeals file, including all internal e-mails, communications, memoranda, and other documents so that I can determine my next steps in the appeals process. Please provide those documents to me on an expedited basis, consistent with state and federal law. Please also provide me with a complete copy of the plan document, summary plan description, and certificate of coverage or contract under which my health benefits are provided.

Record Keeping

Record keeping for third-party payers should be consistent with the information required in the insurance contract. This information generally includes the following:

- Intake information, including presenting problems, other symptoms, and prognosis
- Billing information
- Diagnostic or psychosocial evaluation
- Notes of collateral contacts
- Records obtained from other providers
- Session start and stop times
- The modalities and frequencies of treatment furnished
- Medication prescribed by the patient's treatment providers and over-the-counter drugs
- Functional status
- Treatment plan and goals
- Progress to date based on treatment plan

- Discharge or closing summary

In addition, it is required that the private practitioner keep a signed copy of the notice of privacy practices as required by HIPAA for six years from the day that the patient terminates, unless superseded by state law. The private practitioner should also keep a copy of informed consent and any other documents required by state laws and rules in the record.

Psychotherapy Notes

Clinical social workers have the option of keeping psychotherapy notes, which are for the use of the clinical social worker and not included in the clinical record. If a social worker only keeps one set of notes, they cannot declare that set to be psychotherapy notes. Rather, this would be the clinical record. If a clinical social worker would like to keep psychotherapy notes, they must be kept in a separate file from the clinical record. Psychotherapy notes are afforded a higher level of privacy than the clinical record, provided that the clinical social worker does not include information that is required to be in the clinical record. Information that a provider might document in a psychotherapy note typically includes documentation or analysis of the contents of conversation during a counseling session. To say it another way, psychotherapy notes are the provider's private notes to help them reflect on, and better understand, the work that they are doing. No information that should be in the clinical record may be put into psychotherapy notes to avoid having to disclose it to insurers or others.

It is important to note, however, that the privacy afforded to psychotherapy notes by HIPAA *may not be* absolute. For example, Texas Medicaid's provider contract requires access to psychotherapy notes. In addition, patients who are facing a "return to work" review board might

be required to give access to their clinical social worker's psychotherapy notes (this is more common in medical or law enforcement arenas). It is important to check state laws regarding exceptions to psychotherapy notes. Clinical social workers may decide not to keep Psychotherapy Notes so that they can never be revealed, nor need defending.

National Provider Identifier

Clinical social workers who submit paper or electronic claims are required to obtain a national provider identifier (NPI), which is a 10-digit numeric code that identifies the provider who renders the service or is submitting a claim for reimbursement. The NPI, which replaces former individual and group third-party payer provider identification numbers, is one permanent identifier that is used with all third-party payers. There are two types of NPI: individual practitioner and group numbers (for a group practice or an organization such as a hospital). Clinical social workers in an independent private practice apply for an individual NPI. An individual practitioner who is practicing as an incorporated entity will need both an individual and a group NPI.

The NPI application process is relatively quick and simple. Online applications can be filed at <https://nppes.cms.hhs.gov>.

Under the Freedom of Information Act (FOIA), CMS does *not* disclose the following NPI information to the public in an effort to prevent or minimize fraud and abuse in the Medicare and health care industry:

- provider's Social Security number
- IRS individual taxpayer identification number
- Date of birth

When applying for an NPI, the following information is available to the public:

- Provider's name
- Business address
- Health care taxonomy code
- Other provider identifier and type code
- Provider enumeration date
- Last update date
- NPI deactivation revision code and date
- NPI reactivation date
- Provider gender code
- Provider license number and state code

Clinical social workers should review the information submitted on their NPI application for accuracy and make revisions or deletions within 30 days of any changes to the National Plan and Provider Enumeration system at <https://nppes.cms.hhs.gov>. The

National Provider Identifier Standard is available at

http://www.cms.hhs.gov/NationalProvIdentStand/01_overview.asp

Forms

As discussed in other sections of this document, social workers are required to create and maintain a clinical record that complies with the NASW (2017a) *Code of Ethics* and state regulatory and federal laws. The creation of practice forms will greatly assist the private practitioner in streamlining administrative and operational tasks, implementing sound documentation procedures, and reducing malpractice risk, resulting in an overall improvement in the delivery of services. Because clinical social work practice is regulated by individual states, when social workers begin to develop their private practice forms, they should familiarize themselves with and consult their state statutory, regulatory, and administrative laws. Additional resources that should be reviewed include the following:

- Relevant Legal Issues of the Month developed by NASW's Legal Defense Fund

- The Model Regulatory Standards for Technology and Social Work Practice
- NASW's 8 Social Media and Technology Tips for Social Workers
- The NASW (2005) clinical social work standards
- Federal HIPAA laws
- The NASW, ASWB, CSWE, and CSWA (2017) technology standards
- NASW (2013a) supervision standards

In addition, private practitioners should contact their individual NASW state chapters, as some chapters have developed state-specific forms for their members.

- The following list of suggested forms is intended to help clinical social workers as they begin to create their private practice forms: Communications policy, including but not limited to the following:
 - Acceptable forms of communication (for example, e-mail, text, mail, social media, phone, face-to-face, videoconference)
 - Social worker accessibility (for example, between scheduled appointments, during emergencies, clinician/client vacations, after normal work hours)
 - Procedures and information for contacting the social worker during and after normal working hours
- Informed consent, including but not limited to,
 - treatment contract
 - financial responsibilities

- patient's rights and responsibilities, including terms around client attendance (cancellations, providing advanced notice, missed appointments, late arrivals, illness, emergencies)
- privacy, confidentiality, duty to warn and protect
- use of digital technology (to deliver services, to store or retrieve data, for communication with and about the client)
- all state law requirements
- A comprehensive record of all clinical and financial interactions including, but not limited to, the following:
 - Dates and kinds of services provided
 - Fee arrangements; payment information; insurance coverage and/or private pay; assignment of benefits; billing procedures; how delinquent accounts are managed including collections; fees charged, paid, and by whom
 - Current progress note including risk assessment/mental status, diagnoses, treatment plan, progress towards treatment goals
 - Intake form
- HIPAA required forms:
 - Signature page from notice of privacy practices
 - Authorization for use and disclosure of information:
 - Accounting of disclosures log
 - BAA (for example, with accountant; administrative assistant or biller; company providing secure telehealth, e-mail, text, Electronic Health Record [her], billing

platform); the private practitioner may choose to store the copy of the BAA either in the client's medical record or in the clinician's HIPAA compliance file

For a more in-depth look at what should be included in each form, readers should review the sections of this manual that cover risk management and malpractice, informed consent, confidentiality, HIPAA, record keeping, psychotherapy notes, and client–social worker practice agreements.

Technology

Digital technology can provide convenience, efficiency, and security for private practitioners and their patients. Patients, third-party payers, and government entities are increasingly expecting their clinical social worker to use digital technology in their practice and administrative work. As technology continues to grow in function and popularity, the need for private practitioners to focus proactively on their responsible use of technology grows, too.

From electronic medical records and cloud storage to e-mail, smartphones, apps, and more, private practitioners must educate themselves about the security and privacy risks involved in the use of digital technology. Indeed, not managing technology appropriately can violate NASW ethical standards and state and federal laws, which could result in significant legal penalties or sanctions. Caution should be exercised in using any digital technology, and private practitioners are advised to be especially cautious around new technologies, as the availability of new technology grows far faster than our collective identification of those technologies' associated risks. The responsible private practitioner will recognize that using technology requires ongoing

maintenance work to stay informed about the risks and responsibilities of its use. For specific recommendations, we refer the reader to the most current NASW Social Work Practice Update, “NASW, ASWB, CSWE and CSWA Standards for Technology and Social Work Practice, The Model Regulatory Standards for Technology and Social Work Practice.”

Termination and Completion of Services

Termination is an important part of service and preferably occurs when the clinical social worker and patient agree that specific goals have been achieved. However, it is imperative to remember that a patient does have the right to terminate services at will. Ideally, the termination process provides for exploration of its meaning to the patient, the nature of the services given, and a joint evaluation of the outcome, possibly including a written evaluation. When indicated, the private practitioner should provide information about resources to meet other needs of the patient. When referring a patient, the private practitioner should abide by legal and ethical principles concerning self-determination and confidentiality. Names of at least three providers, institutions, or organizations (such as support groups) should be provided so that the patient is able to make an informed decision. The patient must be informed about the reasons for referral, available options, and the credentials of the recommended practitioners or organizations. It is also recommended that the patient provide written consent to the private practitioner for any future disclosure to a referral.

Premature Termination

Under certain circumstances, services may be ethically terminated prior to the treatment goals having been reached or without the client's consent. Such situations may include, but are not limited to, the following:

- Patient injures the private practitioner, threatens physical harm, harasses, or files an official complaint against the private practitioner. The patient must be fully informed about the reasons that treatment is discontinued, and those reasons should be documented in the record.
- Patient seriously violates an agreement regarding the payment of fees. The private practitioner should make all reasonable efforts to develop a payment plan that is within the patient's means and ability to pay. The private practitioner should assess the clinical and situational issues that may be contributing to nonpayment and attempt appropriate interventions. If necessary, the private practitioner should make referrals to other resources for services. If the private practitioner intends to use a collection service, inform the Patient of the action plan at the initial interview and reveal what information may be given to the collector. In some jurisdictions, referral to a collection agency might violate state regulatory or ethical standards and might also trigger counteraction from the patient. To provide some protection from liability, the clinical social worker must carefully document attempts to reach agreement concerning payments and the referral to alternative sources of help.
- Patient clearly requires expertise different from what the private practitioner can offer. The private practitioner is obligated to discuss the issue with the patient and to provide, facilitate, and follow up on a referral to another appropriate private

practitioner or agency. In the process of referral, the private practitioner should abide by legal and ethical principles of confidentiality and patient self-determination.

- Private practitioner becomes ill or incapacitated, moves, or sells the practice. When a practice is sold, it is the referral sources and office resources that are sold, not the patients, client accounts, or records. The private practitioner should terminate with the patients, discuss the options for treatment with the purchaser or other clinicians, and facilitate a referral accordingly. These decisions are to be made in full recognition that the patient's needs and rights are paramount.
- Patient is chronically noncompliant with the treatment plan, fails regularly to keep appointments, and in general does not cooperate in the therapy process, and the private practitioner's reasonable efforts to encourage patient participation are unsuccessful. The patient should be informed of the reasons for the termination, at least three alternative resources should be given to the patient, and the conditions under which the patient may resume treatment with the private practitioner should be provided. All of these matters must be carefully documented in the record.
- Private practitioner experiences an extensive countertransference issue that may adversely affect patient treatment. It would be appropriate to terminate services (and potentially harmful not to terminate) if the private practitioner is unable to come to terms with the countertransference feelings that arise during the therapeutic process. The private practitioner should discuss these issues with the patient, document accordingly, and provide a written explanation of the matter for the patient. All appropriate steps should be taken to refer the patient to a more suitable practitioner or agency.

- Patient's health plan will not authorize any additional treatment, even though the private practitioner's judgment is that continuing treatment is necessary. In this case, the private practitioner should exhaust all avenues of appeal in advocacy for their patient.

It is unethical to terminate service to pursue a financial, social, or sexual relationship with a client. Private practitioners should be aware of the effects of their influence on and power over patients and the ethical and legal risk of engaging in dual relationships. Private practitioners should be aware of their own feelings and desires that may interfere with or be destructive to the professional relationship and should seek immediate consultation to effectively deal with these feelings and desires.

In addition, it is inappropriate to continue treatment or to pressure the patient to continue therapy when clinical goals have been achieved or when the patient wants to terminate therapy.

Emergency and Disaster Planning

Clinical social workers in private practice should develop an emergency plan to prepare their practice for traumatic events such as natural disasters (floods, tornadoes, hurricanes), infection epidemics and pandemics, fires, plane crashes, and mass casualty events such as terrorist incidents. Emergencies can have a short-, medium-, and long-term impact on a private practice, and clinical social workers should prepare a plan. This is important because emergency events and disasters can exacerbate preexisting mental illness and destroy the financial health of a clinical social worker. To be prepared in the event an emergency arises, the following steps are strongly recommended:

- Maintain a backup file for records in a secure, fire- and waterproof location
- Develop an emergency safety plan for your office
- Secure adequate liability insurance
- Strive to maintain a minimum of three to six months of financial resources to cover business expenses
- Develop alternative ways in which patients may continue to receive services during an emergency, including a temporary virtual or physical office, e-mail address, alternate phone number, and referral source
- Become familiar with the emergency plans established by third-party payers with whom you are credentialed
- Maintain competency skills in crisis intervention and emergency preparedness

Advance Planning

When a clinical social worker retires or closes their private practice, they are required to take certain steps to uphold their commitment to current and past patients and to associated professionals and organizations (for example, supervisors or supervisees; consultants or consultees; colleagues; and national, state, and local membership organizations).

Clinical social workers in private practice may close their practices for a variety of reasons, including planned retirement, forced retirement because of a sudden illness or disability, relocation, and death. Preparing for these situations in advance will allow for a smoother process to a daunting and difficult task.

Preparation and planning are key. Whether closing the practice is intentional or unexpected, clinical social workers are ethically obligated to have a prearranged, detailed plan in place. This is where a professional will comes in.

Professional Will

Planning for retirement at the outset of a clinical social worker's career may be mistakenly viewed as financially irrelevant or premature, but preparing a professional will early on is both sensible and necessary. One cannot anticipate the unpredictability of situations that may render clinical social workers of any age incapacitated or deceased.

Although templates are available, clinical social workers are advised to retain the services of an attorney familiar with the NASW (2017a) *Code of Ethics* and adept in mental health law in the state where the clinical social worker holds licensure to assist them in drafting a professional will that complies with prevailing ethical standards and state-specific laws. An article published in NASW's fall issue (2016) of *Practice Perspectives*, titled "Preparing a Professional Will for Your Practice: Important Factors to Consider," is a helpful resource for clinical social workers to consult while writing their professional will (NASW, 2016b).

A professional will is a legal document in which the clinical social worker outlines the following information:

- What actions should be taken upon their death or incapacitation
- Who will carry out those actions

- How those actions are to be executed
- Where the necessary items to carry out those actions are located

Specifically, a professional will is a set of instructions that provides answers to crucial questions such as these:

- Who will be the executor of the practice upon the clinical social worker's death or incapacity?
 - Who will serve as backup in the event that the primary person is unavailable?
 - What is their detailed contact information?
 - Anyone can be designated as the executor, but it is strongly recommended that the person chosen is an LCSW, knowledgeable about the practice of licensed clinical social work, the NASW (2017a) *Code of Ethics*, and relevant state social work laws and regulations.
- What tasks are the executor responsible for? These may include, but are not limited to, the following:
 - Notifying all current and past patients, colleagues, supervisors and supervisees, consultants and consultees, malpractice and general liability insurance carriers, and third-party payers
 - Coordinating the close of the business with the clinical social worker's accountant, attorney, billing service or administrative staff; arranging for the maintenance, storage, and transfer of patient records
 - Closing of all of the clinical social worker's financial and social media accounts, e-mail, and Web sites
 - Forwarding the clinical social worker's professional mail

- Changing the clinical social worker's outgoing voice mail and e-mail and automatic response text messages
 - Placing a notice in the local newspaper
- Who are the other important people instrumental in carrying out the tasks specified in the professional will? What are their names and contact information? These may include the clinical social worker's personal and professional attorneys, accountant, administrative staff, business associates, life partner, family members, landlord, building manager, officemates and suitemates, colleagues, and supervisors or consultants.
- Where the important items are located and how to access them:
 - Keys to the clinical social worker's office, desk, filing cabinet, and storage space
 - Business checkbook
 - Business credit card
 - Professional malpractice and general liability insurance account information
 - Appointment calendar, schedule, and planner
 - Computer, phone, external hard drives, and flash drives
 - Patient files (physical and electronic), financial files and billing records, backup files
 - Passwords to the clinical social worker's computer, EHRs and patient files, digital appointment calendar, social media accounts, Web site, voice mail, e-mail, and other security systems and communication accounts
 - A list of qualified colleagues and community resources whom patients can be referred to if continued treatment is clinically indicated or requested

- If and how will the executor be compensated for their time and effort in managing the clinical social worker's practice?

After finalizing their professional will, clinical social workers should provide a copy to the executor and review the terms, answer any questions, and clarify any details. A copy should also be retained by the clinical social worker's attorney. As the social worker's practice changes over time, digital technologies are constantly evolving and new situations arise, so the professional will should be reviewed on a regular basis and amended as necessary.

In the clinical social worker's initial informed consent document, practitioners should obtain patient consent permitting the clinical social worker to share the patient's contact information and clinical record with the executor (provide name and contact information of designee) in the event of an emergency. This step is necessary to adhere to informed consent and privacy and confidentiality standards and will ensure that all patients receive speedy and thoughtful care in case of the clinical social worker's incapacitation or death.

Professional wills are invaluable not only when a clinical social worker dies or becomes incapacitated suddenly, but also when a clinical social worker begins preparations for retirement or relocation.

Planning to Retire or Close a Private Practice

In an effort to adequately prepare current patients for either termination or transfer, the private practitioner should inform current patients as least 60 days in advance (some patients may require a longer termination process) of their intention to close the practice. Clinical social

workers who are paneled should check their contract for how much notice needs to be given to the insurers and their members. This advance notification allows for an in-depth exploration of such critical clinical issues as the patients' thoughts and feelings around the loss of the therapist and permits time for closure and for determining whether termination or transfer is warranted. If ongoing treatment is clinically indicated, this process allows for adequate time to help patients find the right fit, connect to the new therapist before the practice closes, and provide for a smooth transition of the care plan.

These recommendations are to be applied to closing a clinical social work practice, not all professional social work activities. Best practice indicates that this notification should occur verbally (preferably in session) and provided in a formal letter. As with all critical correspondence, a copy of this letter should be placed in the patient's clinical record. Former clients should also be informed of the practice closing. Methods to notify former clients may include, but are not limited to, placing a notice in the local newspaper, e-mails, personal phone calls, and written correspondence. However, special care and attention should be paid to the former patient' privacy and confidentiality so as to not unintentionally disclose past treatment to others.

Both current and former patients should be notified of the following:

- The date of closure
- The process for transferring their records
- Where their clinical record will be stored
- Name and contact information for the executor

- Procedure for accessing their clinical record after the date of closure
- Referrals to qualified practitioners whom patients may wish to contact to continue with treatment

Other entities to contact include, but are not limited to, the following:

- Insurance companies and EAPs with whom the clinical social worker is contracted; clinical social workers are cautioned to be aware of their contracts with insurance and EAP companies, as they may stipulate such requirements as the time frame in which the clinical social worker must provide advanced notice to active patients and the process for notifying patients of their closing plans
- National Plan and Number Enumeration System, to place the clinical social worker's NPI on inactive status
- Professional membership organizations the social worker belongs to; the social worker may choose to place themselves on either retirement or inactive status
- State boards that licensed the social worker
- Colleagues, referral sources (for example, schools, attorneys), and adjunct treatment providers (for example, psychiatrists, doctors, nutritionists)
- The clinical social worker's malpractice and general liability insurance companies; it is strongly suggested that the clinical social worker purchase extended reporting period or "tail" coverage in the event that claims are filed against the clinical social worker after the practice closes
- Banks and credit card companies; bank accounts and credit cards associated with the private practice should be closed after all of the business finances have been settled

- The clinical social worker's respective state to determine the necessary steps required for business entities closing operations in that state
- Landlord and utility companies associated with the clinical social worker's office

Retention of Records

Because of regulatory, state, and federal laws and third-party reimbursement contracts surrounding records retention, clinical social workers are required to obtain secure storage for their patients' clinical record after retirement or closing of a practice.

This may require the clinical social worker to continue to pay for either physical (paper) or electronic storage of their patients' files for several years after retirement. Similarly, prior to retirement or closing, the clinical social worker may destroy clinical records eligible for record destruction described by federal and state laws.. In addition, some clinical social workers may have liability insurance that may have other requirements. Before the storage or destruction of their patients' clinical records, clinical social workers are advised to make sure that all of their billing and collections are up-to-date and develop a procedure for following up on any unpaid claims.

If the clinical social worker will maintain custody of their paper records after retirement and they are relocating to another state, they will need to identify a storage facility that meets HIPAA security standards in their new home state. For cloud-based records, the clinical social worker will need to notify the Web-based EHR platform of any change of address or contact information.

If the clinical social worker designates an executor to take over the responsibility for their patients' paper clinical records, a secure transfer of these records will need to be arranged. For cloud-based records, the executor will need to have access to the EHR platform.

Managing Digital Presence When Closing a Clinical Practice

Since many clinical social workers use various electronic technologies in their private practices, they must not forget their digital presence. For several months after the date of the practice's closure, the clinical social worker should do the following:

- Place a notice on their Web site and in online profiles stating the date of the office closure and how former patients may access their records
- Set an automatic message on their e-mail and texts to let those who contact them know that the office is closed and how former patients may access their records
- Close professional social media accounts and any other online communication platforms
- Remove themselves from any online professional referral lists, electronic mailing lists, forums, and chats
- Maintain an active phone number for a period of time, but change their outgoing message notifying callers that the office is closed and how former patients may access their records
- Notify the postal service of where incoming mail should be forwarded

When Closing a Practice Is Unplanned

When a clinical social worker abruptly closes their practice because of life changes, unexpected incapacity, illness, or death, they should have procedures in their professional will to detail how the practice should be closed. This may include notifying their attorney, executor, and others designated to carry out the clinical social worker's wishes, as delineated in their professional will.

Self-Care

Being a clinical social worker in private practice requires special attention to self-care. It can be challenging to pay attention to our own emotional and physical well-being when we put so much focus on these areas with patients. Managing the feelings stirred up in us by the difficulties our patients face takes work on our part; many clinical social workers engage in their own treatment at various points throughout their careers to maintain good boundaries and the ability to work through their own uncomfortable feelings. We also have another occupational hazard—we become so used to tuning in to the emotional experiences of others that we carry that skill into our private lives, instead of building mutual relationships in which we are equal participants. Finally, the occupational hazards of compassion fatigue, burnout, secondary trauma, and countertransference need to be considered by clinical social workers, and awareness of potential challenges can be dealt with through enhanced continuing education.

Self-care for clinical social workers is therefore not optional. While this manual implicitly promotes self-care throughout the business practices it recommends, there is a danger of becoming isolated as a clinical social worker in private practice. We forget to attend to ourselves. Clinical social workers are people, too, and need to have good sleep habits, avoid emotional

eating or malnutrition, make time for exercise, build satisfying personal relationships, and have activities that feed our souls, along with the hopefully satisfying work we do. Actively scheduling time to do the things that bring you joy, such a walk, a coffee date, a movie, a hobby. Finally, knowing that we cannot always prevent patient crises, and accepting those disappointments without being self-critical, is also part of self-care.

Our positive identities as clinical social workers cannot be solely based on the important work we do. To be sure, knowing that we are well versed in the ways to practice ethically is part of self-care. Knowing when to seek consultation is another important part of self-care. A consultant can help with clinical skills, self-awareness, and provide the confidence to trust yourself when with patients. Having someone to tell you that you are on the right clinical path, offer additional perspectives and brainstorming when a patient is clinically challenging, and having someone to call in an unexpected crisis is very relieving. But finding a balance between our work and our own loving relationships, including the one we have with ourselves, is the meaning of self-care used in this context.

In short, we need friends who will support us. We need family who love us. We need our friends and our collegial support system, too. We need to monitor and promote the activities that are crucial to emotionally caring for ourselves as independent adults.

Feeling responsible for others when we work alone can feel like a heavy load, but practicing self-care is an integral part of making the load lighter. Clinical social workers deserve to take care of themselves as well as they take care of so many others.

Conclusion

As this manual demonstrates, clinical social work private practice includes a range of challenges and responsibilities. Much of a private practitioner's success can be measured by their sound business practices that blend together the knowledge, skills, and values of the clinical social work profession. Understanding the complexity and interrelatedness of the topics outlined in this guide is also crucial to building and maintaining an expert and ethical private clinical practice. Private practitioners who follow this manual will have a foundation for an effective and rewarding practice.

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