Information – HIPAA – Informed Consent & Agreement Form

INFORMATION

This packet is presented to you in order to provide information that will be helpful to the process of your therapy, please read it carefully. We will be happy to discuss any questions or concerns you may have. A duplicate copy will be offered to you. If you choose to decline a copy of the HIPAA form, please indicate so at the end of this form by placing your initials in the space provided underneath your signature. A copy of the HIPAA form may be found online at www.glenhavencounseling.com under new client information.

CONFIDENTIALITY

Ethical standards of therapy, as well as state and national laws, require that issues discussed during the course of therapy with a clinician/provider be kept confidential, which means that information you reveal will not be discussed with others without your knowledge and consent. Your records will not be sent or shown to others without a signed release from you. Others will not know that you have been to this office unless you inform them, or provide for us specific written permission to do so.

Since electronic communication does not thoroughly and consistently meet the security and confidentiality requirements put forth by federal HIPAA laws and guidelines, Glen Haven support staff and clinicians/providers are unable to schedule, reschedule, cancel sessions or correspond with clients or potential clients via email, text or fax. In accordance with this policy, Glen Haven support staff and clinicians/providers will not communicate with clients or affiliated entities via any form of electronic communication including fax, text or any form of social media or group communication. In cases where your clinician/provider is able to make exceptions to this overall Glen Haven policy, and only in situations where it is still in accordance to HIPAA laws and guidelines, you will be informed directly by support staff or your therapist, and will be asked to sign a Release of Information.

You need to be aware of some *exceptions to confidentiality*. These exceptions are relatively rare, but may apply in your situation. The release of confidential material without your consent may be required of your clinician/provider in these exceptions. In situations of potential harm to oneself or another (suicide, homicide, child or elder abuse/neglect), your clinician/provider may have a duty by law to warn the person or family members or to file a report regarding such information. In other instances, most notable, contested divorce actions or other lawsuits, the court may subpoena your records. It is our request that you notify your clinician/provider of your involvement in a legal process as soon as possible.

If you have chosen to use your insurance to assist in reimbursement for your services here, your insurance carrier will be given your therapy dates and diagnosis (and sometimes a report of your treatment progress and/or psychological testing evaluation, in order to justify such coverage) before reimbursement is made to you or us; your insurance company will then send information to a national data base, thus your diagnosis may become a part of your medical records. This information may also include and require ongoing contact with your insurance provider for the purposes of authorization for ongoing therapy and/or testing services. Signing this document indicates that are giving Glen Haven permission to provide this information.

In all of the above, other than basic insurance billing, we will discuss with you any clinical information to be released – *please be aware that your clinician/provider will take part of your scheduled session time to complete with you the requested information to be exchanged*. Any additional expenses incurred while dealing with your insurance company (or attorney/court, medical personnel) will be charged accordingly to you – it is typically your responsibility for these charges, if any do occur. Additionally, if you have neglected to pay for a counseling session, a late cancellation or a failed appointment and your unpaid balance is sent to a collection agency, demographic information will be required by them (e.g., name, address, telephone, place of employment), no clinical information (e.g., diagnosis, type of treatment) will be released to them. Your clinician/provider may wish to contact you by telephone in order to follow-up on your health and well being after your sessions have lapsed or terminated. If you prefer NOT to be contacted by your clinician/provider for any reason, please inform the clinician/provider directly.

PRIVACY AND CONSENT FOR RELEASE OF INFORMATION

This office is extremely careful to safeguard client privacy and to alert our patients to confidentiality rules and boundaries. We always limit any disclosure or release of protected health information to written authorizations by our patients or as otherwise allowed by law through very limited exceptions. With your knowledge and written consent, we may provide your health information to coordinate treatment and services you receive with other health care clinicians/providers, including third parties; we may disclose any or all of your health information to other clinicians/providers who have legitimate need for such information in order to care for you, we may disclose your health information to family members, guardians or personal representatives who are involved with your medical care (if you are available, such disclosures will be made only if we have obtained your permission, if you do not object to the disclosure after having had the opportunity, or if it is reasonable for us, based on the circumstances, to assume you have no objection to such disclosure; if you are unavailable, incapacitated or in an emergency situation, we may disclose limited information to these persons if we feel disclosure is in your best interest), we may also use and disclose your demographic health information to contact you for appointment reminders, we may contact you to notify you of possible treatment alternatives or health-related benefits or services your clinician/provider feels would be beneficial. If you should ever choose to rescind a signed release of information, please inform our office and your clinician/provider as to the day and time, and document to be rescinded, and it will be officially logged in your clinical file.

DISCLOSURES

We are required by law to disclose your health information to public health officials if it is necessary to report suspected child or elder abuse or neglect or to prevent a serious threat to your health and safety or to the health and safety of another person or the public. We may disclose your health information in response to a court or administrative order, a valid subpoena, discovery request, civil or criminal proceedings, or other lawful process (i.e., regarding a victim or death or a victim or a crime; in emergency circumstances to report a crime and pertinent information about it and its perpetrator, etc.) Again, please inform your clinician/provider via written letter or phone call, (not via electronic communication of any kind), as soon as possible that you are involved in a legal matter so that they may discuss it with you.

RIGHT TO INSPECT/COPY/AMEND

You have the right to inspect your health information and obtain copies of medical, billing or other records that may be used to make decisions about your care. The right to inspect and copy does not apply to psychotherapy/counseling notes that are maintained separately from the health record. You may submit your written request for such to this office, and a fee will be charged to cover costs of copying, mailing, etc. You have

the right to make a written request to amend your health information that you believe is incorrect or incomplete, and include the reason for your request. We are not required to make all requested amendments, but will give each request careful consideration. If denied, you will be provided a written explanation of the reasons and your rights. If you gave us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose information about you, but are obviously unable to take back any disclosures already made with your permission.

RIGHT TO AN ACCOUNTING OF DISCLOSURES/REQUEST RESTRICTIONS

We keep records of any and all disclosures made regarding your health information; you have the right to request an accounting of such disclosures (though you will always be informed by this office before any such disclosure is made, other than for routine billing/payment issues). You must state a time period for your request, which may not be longer than six years and may not include dates before April 14, 2003. You have the right to request a restriction or limitation on how much of your health information we use or disclose for treatment, payment or healthcare operations. You also have the right to request in writing a restriction on the disclosure of your health information to someone who is involved in your care or payment for your care, such as a family member or friend. We are not required by law to agree with your restriction request, however, but will notify you if we are unable to agree and will typically comply with it unless the needed information is due to an emergency situation.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION

We routinely ask patients in their initial contact of this office if it is OK to call you and/or leave any necessary message at each of the telephone numbers you provide. We will always respect this request, however, if you move, change telephone numbers or address, it is your responsibility to provide new information to this office to ensure that an alternative method of contact is made by us if necessary situations arise.

CHANGE TO THIS NOTICE/FILING OF COMPLAINTS

We are required to abide by the terms of this Notice/Consent Form and reserve the right to change it if needed. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. You are entitled to receive a written copy of this notice at any time. You may file a written complaint with us or with the Dept. of Health and Human Services if you believe that we have not complied with our privacy practices, you will not be penalized for filing a complaint. If you have any questions about the privacy laws and this written notice, please contact your personal clinician/provider or our office manager.

TERMINATION OF SERVICES

Therapeutic and assessment services will be officially considered terminated when one or more of the following conditions exist: When the clinician/provider indicates that therapy will no longer be continued based on their professional and clinical judgment and when the client is notified of this decision; when the client states that they are no longer willing or interested in continuing services; when it is mutually agreed upon by both the clinician/provider and the client that services will no longer be continued; and/or when a client has not attended a clinical session for the duration of one year from their last clinical session. In each of these cases the client's clinical file will be officially closed and fee balances will be rendered accordingly. In some cases you may be notified by our offices via mail or phone that your file has been closed and that a balance is due, or any

positive balance left on your account will be remitted to you. Clinical files may be re-opened upon the request of the client and such request is agreed upon by the clinician/provider.

PAYMENT

In consenting to treatment with your clinician/provider you are also consenting to pay for services rendered, late cancellations (less than 24 hours notice), missed appointments and uncollected insurance balances of reserved clinical hours. Please note that each therapist at Glen Haven Counseling Resources operates as a separately owned business entity, with shared support staff for the purposes of scheduling, billing and accounting. Therefore this informed consent agreement, and any fees or charges due for services rendered are due directly to the clinician/provider you work with and their professional practice entity. Any questions or concerns regarding your fees may be directed to support staff, however, are the ultimate responsibility of your clinician/provider.

In the case of preauthorized managed care services, you are responsible for payment of your copay amount at the time of services. Please be aware that your insurance company always gives a disclaimer statement that they may not pay for some reason, even with preauthorized visits; you as the patient are ultimately responsible for any and all charges not paid. In all cases, visits exceeding the 45-55 minute session will be prorated accordingly.

Additional fees may be assessed for work requested by the client or collateral sources on your behalf. Telephone consultations with you or on your behalf will also be prorated and charged to you. Any diagnostic testing carries an additional charge per test. You may also be charged for any report or paperwork you or your employer request to be filed on your behalf related to disability, family leave act, any doctor related reporting or any questions and consultations with attorneys. Any legal consultation in conjunction with court-related time is charged at *twice* the current session fee.

In the event of an outstanding balance on your account we will send a monthly statement to the address you record on your intake documents. If your account balance remains unpaid for more than 90 days from your last appointment date, your account will be considered delinquent. In the case of outstanding insurance payments still pending, the time of delinquency will begin 90 days after the last communication with your insurance company. Accounts that remain unpaid after 90 days may be remanded to a collection agency, or pursued through small claims court. In the event that a client is unable to continue working with their therapist due to financial distress or a change in insurance coverage or status, your therapist will refer you to another therapist or agency that will be able to continue to offer you appropriate therapeutic service in fitting with your needs and circumstances. *Glen Haven also reserves the right to postpone scheduling appointments with clients who carry a balance in excess of $300 until the balance is paid upon. An additional fee of $25 will be charged for any checks returned by any banking institution as unpaid.*

CANCELLATION POLICY

Cancellations of appointments must be received at least 24 hours in advance (preferably sooner). Please be aware you will not be given a reminder call regarding your scheduled appointment time. If you miss a session due to non-emergency circumstances, you are responsible for one half of the session fee ($95). In the event your therapist needs to reschedule or cancel an appointment with you, the same courtesy will be extended to you. Exceptions to this policy may be made at the discretion of your clinician/provider.

Our confidential voice mail system is provided for your after-hours and weekend convenience – we access such messages regularly in order to offer open times to those on our waiting list. National HIPAA laws place restrictions on communicating confidential information via email, therefore we are unable to schedule sessions or receive correspondence regarding the cancellation or change of session times in this manner. *Any emails that are sent to our offices, which are intended to communicate scheduling issues, will not be responded to according to these restrictions.*

INFORMATION REGARDING WORKING WITH MINORS

When we do therapy or testing with minors, parents/guardians consent to treatment for the minor and have access to the minor's medical records. The therapy process often includes communication between the therapist and the minor's parent(s)/guardian(s). This varies greatly depending on your specific treatment needs, concerns, and life situation. When we work with minors, it is most pragmatic to appoint one parent/guardian to handle billing and scheduling—a "logistical contact"—because most minors do not do their own scheduling.

We will discuss who your family's logistical contact person will be in your first appointment. Although we will arrange this on a case-by-case basis, most often they will be the parent/guardian under whom the minor is insured. We ask that the logistical contact person sign the HIPAA agreement and provide their contact information (address and phone number) on the Confidential Client Information form. Streamlining the logistics of scheduling and billing allows us to focus on providing you the help you are seeking. Of course, all parents/guardians involved with a minor are welcome to share pertinent treatment-related information with us, and we are happy to spend a brief portion of the session(s) reviewing this information with you. We are required by law to obtain consent for treatment from **both custodial parents** in the case of a legal separation or divorce. **We are not able to see your child without obtaining this form signed by both custodial parents.**

Client HIPAA - Informed Consent and Agreement – Please Sign and Initial

I acknowledge that I have read this Information – HIPAA – Informed Consent and Agreement Form fully, and that I understand, and agree to abide by the above guidelines, and do authorize therapy. I also understand that any questions regarding privacy are to be directed to my personal therapist/psychologist or to the office manager for this practice

_____ _____

(Signature) **(Date)**

_____ _____

(Signature of clinician/provider) **(Date)**

_____ **(Initial) I have been presented with a copy of the HIPAA agreement and I have read the notice of HIPAA regulations. I have chosen to decline a copy of the HIPAA agreement.**

PLEASE INITIAL CLIENT RESPONSIBLITIES ON NEXT PAGE

Client Responsibilities – Please Read and Initial the following

_____ **Promptness –** I understand that my scheduled hour is reserved for me, and arriving promptly will allow me to make the most of my available time.

_____ **Scheduling –** I understand that to schedule future appointments, I must call the Glen Haven Counseling Resources office. Or I can schedule with my clinician/provider at the time of my appointment. Glen Haven Counseling Resources is unable to correspond via e-mail to schedule or change appointments.

_____ **Patient Portal –** I give my permission to receive an email, with a link, to join Glen Haven Counseling Resources patient portal, where I can view my upcoming appointments and receive email appointment reminders 2 days prior to my scheduled appointment. Email:_____

_____ **Attendance –** I understand that it is my responsibility to keep my scheduled appointments. Glen Haven Counseling Resources patient portal will email you one appointment reminder 2 days prior to your scheduled appointment.

_____ **No-Show Policy –** I understand that cancellations of appointments must be received at least 24 hours in advance. If I miss a session due to non-emergency circumstances, I am responsible for one half of the session fee ($95). Unattended sessions cannot be billed to insurance. Should I need to cancel an appointment before the 24-hour window, Glen Haven Counseling Resources confidential voice mail system is provided for my afterhours and weekend convenience. If Glen Haven Counseling Resources office manager does not answer, I will use the voice mail system to communicate necessary information. I understand that due to HIPAA laws, Glen Haven Counseling Resources cannot schedule or cancel scheduled appointments by email.

_____ **Payment –** I understand that I am responsible for my bill at the end of each session. This includes my copay, coinsurance, unpaid deductibles, missed session fees, and unpaid claims. Glen Haven Counseling Resources accepts personal checks, cash, Visa, Discover, MasterCard or American Express. I understand that Glen Haven Counseling Resources reserves the right to postpone scheduling appointments with clients who carry a balance in excess of $300, until the balance is paid in full.

_____ **Emergencies –** I understand that if I need immediate attention, I must contact my local emergency services by dialing 911.

_____ **Exception to confidentiality** – I understand that if I have chosen to use my insurance to assist in reimbursement for my services here, my insurance company will be given my therapy dates and diagnosis (and sometimes a report of your treatment progress in order to justify such coverage) before reimbursement is made; my insurance company will then send information to a national data base, and my diagnosis may become a part of my permanent medical records.

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