Positive Changes Counseling Center, Debbie Disney, LCSW-C, LLC

HIPAA PRIVACY POLICY

Client Name: _____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

- Positive Changes Counseling Center is committed to protecting your information.
- You have the right to inspect and receive a copy of your records.
- All responses to requests for protected health information will be limited to the minimum amount of information needed to accomplish the purpose of the request or disclosure.
- Positive Changes Counseling Center may use or disclose individual's protected health information, as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, for the purpose of conducting, planning and directing your treatment, making or obtaining payment for care, or otherwise allowed by the Act.
- Positive Changes Counseling Center may use or disclose your protected health information for purposes permitted or required by federal, state, or local law, if court ordered, or determined that you are a danger to yourself or others. It is mandatory that child abuse be reported.
- You may give Positive Changes Counseling Center permission to release your information.

Your information is not shared with anyone for marketing purposed; for this reason, it is not required to obtain an "opt-in election" or an "opt-out election".

The Health Insurance Portability and Accountability Act privacy officer will receive questions or complaints with regard to the use and disclosure of protected health information.

Please read the entire "Notice of Privacy Practices" information. It can be found on the website under the Privacy and Policy tab.

My signature below indicates that I have read and received a copy of this privacy policy.

Signature: _____

Date: _____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries. I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature (Client's Parent/Guardian if under 18)

Date: _____

Permission to Charge Credit Card, Late Cancellation, and Missed Appointment Policy

Late Cancellations and Missed Appointments

If you are not able to keep a scheduled appointment, please give us a least twenty-four hours notice. There will be a **$75 fee** for a missed appointment or a cancelation with fewer than 24 hours notice.

Financial Obligation

I authorize Positive Changes Counseling Center (Deborah Disney LCSW-C, LLC) to automatically charge, as needed, the credit card listed on this form to be used for any and all of the following balances after service is rendered or an appointment is missed:

- Co-pay required for each session (will be charged at the time of session)
- If a deductible is due for each session instead of a co-pay
- $75 fee for missed appointment or late cancellation
- $35 fee for a check returned for insufficient funds
- Balances due not covered by any of the above mentioned charges.

Client name

Name on card		
Card number		
Expiration date	/20 __ __	Security code
Circle card type	HSA Card	Regular Credit Card
Billing address of this card		
State		ZIP Code
If you would like a receipt sent to your cell phone or email address after each charge, provide your number and or email.		
Phone number		email address

My signature authorizes the use of the credit card listed above for charges and fees as detailed in the "Financial Obligation" section of this agreement.

Client Signature ✎

Date ✎

Client-Therapist Contract for Services

Confidentiality:

I am voluntarily engaging in a therapeutic relationship and I understand that whatever I discuss with my therapist during the course of treatment will remain strictly confidential. Information can be shared with others only when I give my written permission.

The only exceptions are as follows: If I disclose information that may directly threaten the well-being or safety of myself or others, my therapist is **legally and ethically obligated** to contact any appropriate persons or agencies, and client confidentiality may be compromised at that time. Should I disclose any information about past or present child abuse or neglect involving myself or someone else, I understand that my therapist is **legally and ethically obligated** to report that information to the appropriate authorities. My therapist will make every effort to include me in the reporting process to make it as reparative as possible. This applies to both minors and adults.

Financial Agreement:

The fee for counseling is $150 for a 53-minute session. Because Positive Changes Counseling Center is an in-network provider for most insurance companies, I understand that usually I am only responsible for my co-pay or deductible at each session. My therapist will take responsibility for submitting claims to my insurance company after every session. I understand that I will be charged $75 for missing an appointment or canceling an appointment if less than 24 hours notice is given. A new appointment may not be scheduled until this fee is paid. I understand that if I have insurance through Medicaid, I am excluded from this $75 charge. There will be no charge for canceled appointments when at least 24 hours notice is given or in the case of a true emergency (at the discretion of my therapist and Debbie Disney). If I initiate telephone contact involving treatment issues and the call lasts less than 10 minutes, I understand there will be no charge. Telephone contact exceeding 10 minutes will be treated as a “session” and billed as such. I understand I may waive my option of using my health insurance if my therapist is not in-network with my insurance and I do not have out of network benefits.

Court/Legal Fees:

It is our preference to not take time away from patients to appear in court or dispositions. However, if there is a situation that requires our involvement, you will be

Cont. to pg. 2

charged $2,000.00 for four hours or less and $4,000.00 for any time greater than four hours. A subpoena received by our office means that you have agreed to these fees, which are due prior to the court date. You will also be responsible for any contact with attorneys billed at our hourly rate and be responsible for any attorney's fees incurred by the therapist or practice during this process.

Other Information:

I understand that if I come to a session under the influence of drugs or alcohol that my therapist may elect to reschedule the appointment and I will be billed for the session.

I agree to contact my therapist by phone or text if I need to change an appointment time or discuss other treatment issues.

I understand that a client/therapist relationship is not the same as a friendship or any other type of relationship and that all interactions must occur in the therapy office.

I understand that psychotherapy has many benefits as well as some risk. The risk may include experiencing uncomfortable feelings; discussing past history and experiences may cause anger, frustration, sadness and guilt to bubble up. I understand that psychotherapy has proven to be beneficial to individuals who participate, and can lead to significant reduction of feelings of distress along with increased satisfaction in relationships with greater personal awareness and insight. I understand that psychotherapy requires an active effort on my part during sessions as well as outside of the therapy sessions. I know I will be given many strategies and coping skills that can provide resolution to many mental health struggles.

If for any reason my therapist must terminate services she/he will, when possible, give at least four (4) weeks' notice and furnish me with at least two (2) appropriate resources should I decide to seek treatment elsewhere.

I understand that I may choose to end therapy at any time, for any reason.

I understand that the session will end at the scheduled end time even if I arrive late.

I have read this contract in full and both understand and agree to its contents.

_____ _____

(Client signature) (Date)

_____ _____

(Therapist signature) (Date)