

Agreement and Consent to Receive Psychotherapy Services

Description of Privacy Practices

This document contains important information about my professional services and business policies. The section on privacy practices describes how information about you may be used and disclosed and how you can get access to it. Please read it carefully. When you sign this document, it will represent an agreement between us regarding the psychological services and the privacy practices.

PSYCHOTHERAPY SERVICES

I provide individual, couples, and families with psychotherapy. Psychotherapy treats a variety of emotional and interpersonal problems. The intent is to reduce or eliminate troublesome psychological symptoms, and to improve social and occupational functioning. Unlike medical consultations, psychotherapy works by having all parties work actively to gain awareness of and alter certain maladaptive emotional states and behaviors. The psychotherapeutic process varies depending on the personalities of the therapist and patient, as well as the particular problems being addressed. In other words, psychotherapy calls for an active effort on your part. Psychotherapy can have both benefits and risks. Since it typically involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, or frustration. Psychotherapy has also been shown to have significant benefits, such as improved relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees.

Psychotherapy involves a large commitment of time, money, and energy, so you should be careful about the psychotherapist you choose. You have the right to ask about other treatments and their risks and benefits. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you obtain a second opinion or another psychotherapist.

If at any point during psychotherapy either of us assesses that I am not effective in helping you reach your therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I will refer you to other therapists or clinics that may be of help to you. If at any time you want another professional's opinion, I will assist you in finding someone qualified, and, if you provide a written authorization, I will provide the essential information needed. You have the right to terminate psychotherapy at any time.

APPOINTMENTS

My normal practice is to conduct an evaluation of your needs which will last from three to five sessions. During this time, we can both decide whether or not I am the best person to provide the services you need in order to meet your treatment objectives. If psychotherapy is begun, sessions are usually scheduled for one 50 minute session per week, although in some cases, sessions may be longer or more frequent.

CONTACTING ME

My telephone is answered by voice mail, which I monitor regularly. I will make every effort to return your call on the same day. If you are difficult to reach, please leave some times when you will be

available. If you cannot reach me, and feel that you cannot wait for me to return your call, you should call your physician or the emergency room at the nearest hospital and ask for the psychiatrist who is on call. If I am unavailable for an extended time, I will provide you with the name of a colleague to contact in case you need to consult a psychotherapist urgently.

CONFIDENTIALITY

In general, the privacy of all communications between patients and psychologists is protected by law. I can usually only release information about you to others with your written permission. Should this be necessary or desired, I will have you sign an Authorization form. But there are a few exceptions, such as: I may occasionally find it helpful to consult other professionals about a case at which time I make every effort to avoid revealing patients' identities. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

Some situations legally require that I take action to protect others from harm, even if I have to reveal information about your treatment. For example, if I believe that a child, elderly, or disabled person is being abused, I must file a report with the appropriate state agency. If I believe that you are threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for you. If you threaten to harm yourself, I may be obliged to seek hospitalization for you or to contact others who can help provide protection. If such a situation were to occur, I would make every effort to fully discuss these possible interventions with you before taking any action.

Whenever you enter your psychological status as an issue in a legal proceeding, you waive the right to past, present, or future confidentiality of any psychological services provided to you. This results from legal precedent, and is not a choice for either of us. I might therefore be ordered to provide your information to a judge.

If a government agency or health insurer is requesting the information for health oversight activities pursuant to their legal authority, I am required to provide it for them.

If you file a complaint or lawsuit against me, I may disclose relevant information in order to defend myself.

If you file a worker's compensation claim, I must, upon appropriate request, disclose information relevant to your condition, to the worker's compensation insurer.

If you are a minor, please be aware that the law may provide your parents the right to examine your records. I typically either request that they relinquish access to your records, or I provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else.

PROFESSIONAL RECORDS

The law and standards of my profession require that I keep professional records. These are maintained, under lock and key, for a minimum of seven years. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will send them to a mental health professional of your choice. I may recommend you review them in my presence so we can talk about them.

BILLING AND PAYMENTS

Payment is due for each session at the time it is held unless we agree otherwise. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payment. I will provide you with a statement that you can submit to your insurance company if you wish. However, you will be personally responsible for all charges.

You should be aware that all insurance agreements require me to provide a clinical diagnosis. Sometimes, additional clinical information such as a treatment summary, or in rare cases, a copy of the entire record is requested. Before I can disclose this additional information, both you and I must receive a written notification from the insurer stating what they are requesting, why they are requesting it, how long it will be kept and what will be done with the information when they are finished with it. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. I will provide you with a copy of any report I submit if you request it. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. For instance, in some cases, they may share the information with the national medical information data bank.

CANCELLATION

Since scheduling an appointment involves the reservation of time specifically for you, I do charge for appointments cancelled with less than 24 hours notice. If you wish, and my schedule permits, I will offer another time within the same week to reschedule your appointment.

PRIVACY PRACTICES

The following paragraphs outline how the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) affects how records are kept and managed. The services you are receiving here concern your psychological status, a most private and intimate component of your life. Therefore, protecting your privacy is of utmost concern. The ensuing paragraphs explain how, when, and why I may use and/or disclose your records which are known under HIPAA legislation as “Protected Health Information” (PHI). Your PHI consists of individually identifiable information about your past, present, or future health/condition and the provision of and payment for health care to you. I may also receive your PHI from other sources, i.e. other health care providers, attorneys, etc. You and your PHI receive certain protections under the law. Except in specified circumstances as outlined above, I will not release your PHI to anyone. When disclosure is necessary under the law, I will only use and/or disclose the minimum amount of your PHI necessary to accomplish the purpose of the use and/or disclosure. Your PHI is limited to progress notes and basic billing information placed in a file in my office, of which I am the only person to have access. Except in unusual situations, such as child abuse, homicidal or suicidal intention, your PHI will only be released with your specific Authorization.

In accordance with the HIPAA Act and its Privacy Rule (Rule), your PHI may be used and disclosed for a variety of reasons. Again, however, every effort is made to prevent its dissemination. For most uses and/or disclosures of your PHI, you will be asked to grant your permission via a signed Authorization which is a separate form. However, the Rule allows for certain specified uses and/or disclosures of your PHI.

These consist of the following:

- . •Uses and/or disclosures related to your treatment, the payment for services, or for health care operations:
- . •For treatment, I might conceivably use and/or disclose your PHI to psychologists, psychiatrists, physicians, nurses and other health care personnel involved in providing health care services to you, but only with your specific Authorization. The only conceivable reason that a specific Authorization might not be obtained would be in the case of a medical emergency.
- . •For payment, I may use and/or disclose your PHI for billing and collection activities without your specific Authorization.
- . •For health care operations, I may use and/or disclose your PHI in the course of operating the various business functions of my office. For example, I may use and/or disclose your PHI to do third party or insurance billing without your Authorization.

Uses and/or disclosures requiring your Authorization: Generally, my use and/or disclosure of your PHI for any purpose that falls outside of the definitions of treatment, payment, and health care operations identified above will require your signed Authorization. If you grant your permission for such use and/or disclosure of your PHI, you retain the right to revoke your Authorization at any time except to the extent that a disclosure might already have been made.

The Rule provides that I may use and/or disclose your PHI without your Authorization when the law requires that I report information including any of the following areas:

- . •In cases of suspected abuse, neglect, or domestic violence including reporting the information to law or social service agencies.
- . •In response to an order of a court, a warrant, subpoena, discovery request, or other lawful process.
- . •In order to avert a serious threat to health or safety. For example, if I believe you are at imminent risk of harming a person or property, or of hurting yourself, I may disclose your PHI to prevent such an act from occurring.

The HIPAA Privacy Rule grants you each of the following individual rights:

In general, you have the right to review your PHI in my possession or to obtain copies of it. You must request it in writing. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, such as if I believe the information may be harmful to you, I may deny your request. If your request is denied, you will be given in writing the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you

not more than \$.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree in advance to it, as well as to the cost.

You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

It is your right to ask that your PHI be sent to you at an alternate address or by an alternate method, e.g., email. I am obliged to agree to your request providing that I can give you the PHI in the format you requested without undue inconvenience.

You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, e.g., those for treatment, payment, or health care operations. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, to whom PHI was disclosed (including their address if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable fee for each additional request.

If you believe there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request in writing if I find that the PHI is:

- . a) correct and complete

- . b) forbidden to be disclosed

- . c) not part of my records

d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosure of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

You have the right to get this notice by email. You have the right to request a paper copy of it as well.

If you believe that I may have violated your individual privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint by submitting a written complaint to me. Your written complaint must describe the acts and/or omissions you believe to be in violation of the Rule or the provisions outlined in this Privacy Practices section. If you prefer, you may file your written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C., 20201. However, any complaint you file must be received by me, or filed with the Secretary, within 180 days of when you knew, or should have known, that the act or omission occurred. I will take no retaliatory action against you if you make such complaints.

ACKNOWLEDGEMENT SIGNATURES

I understand that I will be receiving (circle one or more):

Individual Psychotherapy

Couple/Family Psychotherapy

Psychoanalysis

I have read and understand this Agreement, Consent to Receive Psychotherapy Services and the Description of Privacy Practices. I agree to comply with the conditions as set forth in this agreement. I understand that Federal regulations (HIPAA) allow health service providers to disclose PHI from my records in order to provide treatment services, obtain payment for the services provided, or for other professional activities known as “health care operations”. How, why, and where my PHI might be released was described above. I consent to the use and/or disclosure of my PHI as specified. This consent is voluntary and I am aware that I may refuse to sign it now or revoke it later.

Patient Name (print)

Patient Name (signature)

Date

Glenda Corstorphine, Psy.D.

Date