**Fee Agreement/Consent to Treatment**

This agreement describes the fees and policies of **Heart to Heart Counseling, LLC.** Alterations or modifications of this agreement are not allowed. All sections requiring your acknowledgment and/or signature must be completed before therapy services can be provided. A copy of this fee agreement is available at your request.

Possible benefits derived from therapy include:

* Better ways to deal with social, familial, and occupational relationships
* Better personal adjustment and contentment
* Better ability to cope with problems and stress
* Better productivity

It is important to note that professional ethics do not permit a guarantee that you will receive these benefits. It is believed that a better life is possible for most people and that an individual’s investment and commitment in therapy can determine the outcome. Therapy may also involve some feelings of discomfort. These feelings can occur when you begin to work on changing your beliefs and/or behaviors. This discomfort is viewed as a stepping-stone to a more effective and satisfying life.

You have the right to terminate services at any time and in that case, we will be happy to provide you with the names of other therapists, or you may obtain them from your insurance company. Please discuss with us any problems that you are having with the therapy process. In addition, we reserve the right to terminate your therapy if the **Heart to Heart Counseling (THERAPIST**) feels it is appropriate.

# Client Information

## Contact Information

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_Gender:\_\_\_\_\_\_\_ Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #’s – Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment confirmations via text: Yes No

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Heart to Heart Counseling, LLC is authorized to exchange emergency information with the above person. \_\_\_\_\_\_\_\_\_\_\_\_ Initials**

**By providing the above information, you acknowledge that Heart to Heart Counseling may contact you through any of these methods.**

## Primary Care Physician Consultation

Consultation with your Primary Care Physician may be beneficial at various times during your treatment (collaborate on treatment planning, medication management, etc.). If you are using insurance to pay for therapy, a consultation with your attending/primary care physician and your insurance company may be required. Refusal to allow the release of this information may result in your insurance company denying coverage for services rendered.

**Client Name: Date of birth:**

* I **DO NOT** wish my Primary Care Physician (PCP) be contacted at this time.

If Client declines to release information to PCP, please note this here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Heart to Heart Counseling (THERAPIST)** Signature Date

* I **DO** wish my Primary Care Physician (PCP) be contacted at this time and have completed the information to be FAXED on the following form:

To: Company: (Primary Care Physician)

Address:

City: State: Zip:

Phone Number: Fax Number:

I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this consent will expire one (1) year after I have terminated treatment with this provider. If the purpose for seeing **Heart to Heart Counseling, LLC** is to generate a report to a court and/or other third party(ies), then failure to sign the authorization releasing the information to the court and/or third party(ies) may result in **Heart to Heart Counseling, LLC** refusing to see you.

Dear Doctor,

The aforementioned client has entered into therapy with me at **Heart to Heart Counseling, LLC**. The following information is being shared with you for the purpose of continuity of care:

Presenting Problem:

Treatment Plan:

Recommendations:

Medications Prescribed, Per Client Report:

Other pertinent information regarding my treatment, diagnosis, behavioral, mental and emotional functioning and behavioral health status, may be shared with you in the future (except progress notes) on an as needed basis.

FYI: NO ACTION IS REQUIRED ON THE PART OF THE RECIPIENT. This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. However, once the information is released by Heart to Heart Counseling, LLC, it may be re-disclosed by the recipient of the information and no longer protected.

BY SIGNING BELOW, I INDICATE THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION*.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian/Responsible Party Signature Date

If personal representative, relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Cancellation/No Show Policy

Your therapy session is reserved exclusively for you. If you must cancel an appointment, please notify (call or text 937-409-6156) the **Heart to Heart Counseling (THERAPIST**) at least 24 hours before your scheduled appointment.

If you miss three scheduled appointments, or are not seen for more than three months, then you will no longer be considered an “active” client in the therapist’s practice. If you wish to return for treatment, simply call and your case will become active again at the time of your first appointment, however, you will be required to fill out new forms.

## E-mail Communications

E-mail communications are two-way communications. E-mail messages on your computer, your laptop, and/or your PDA have inherent privacy risks especially when your e-mail access is provided through your employer or when access to your e-mail messages is not password protected. Protecting the privacy and security of sensitive information is one of our highest priorities. Unencrypted e-mail provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the post office. E-mail messages may be inadvertently missed, and a response is not guaranteed. Once sent, an e-mail message cannot be recalled or cancelled. Errors in transmission, regardless of the sender’s caution, can occur.

In urgent or emergency situations, do not rely on e-mail to request assistance (or describe the situation). Responses and replies to e-mails sent to or received by you or your health care provider may be hours or days apart. This could cause a delay in receiving treatment for an acute condition. You should act as though provider/client e-mail is not available to you and seek assistance by means consistent with your needs.

Your e-mail message is not a private communication. In order to forward or to process and respond to your e-mail, individuals at **Heart to Heart Counseling, LLC** other than your health care provider may read your e-mail message. E-mail messages communication between you and your health care provider becomes part of your medical record.

I certify the e-mail address I am providing is accurate and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address. I agree to hold **Heart to Heart Counseling, LLC** and individuals associated with it harmless from any and all claims and liabilities arising from or related to the Request to communicate via e-mail.

(Initial) I DO NOT wish to have the ability to communicate with my therapist via e-mail.

(Initial) I DO wish to have the ability to communicate with my therapist via e-mail, and understand the risks as outlined above.

My e-mail address is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client or personal representative Date

If personal representative, relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Emergencies

In case of an emergency, please leave a message in **Heart to Heart Counseling’s** voice mail. We will typically attempt to respond to your call whenever we receive the call and it is possible for us to return the call. If you are in an emergency situation and do not hear from one of us immediately, call your primary care physician, your insurance company, or go to the nearest emergency room so that you are safe and can receive the care you need.

# Service Fees

Fees (including co-payments are deductibles) are due at the beginning of each session and can be paid by cash, check, or charge.

## Sessions

* Initial session is $150 for a 60-minute session
* Individual session is $110 for the standard 45-minute session
* Family/Marital session is $150 for a standard 45-minute session.
* Telehealth Self-Pay Rate $110/session.
* Self-Pay Rate $150 for 60-minute session.
* Self-Pay Rate $125 for a 45-minute session.

If you would like to extend the length of your sessions, you are welcome to do so as long as our schedule allows and preferably with sufficient notice. The rate of extension is $27 per 15-minute increments. Please be aware that most insurance companies do not reimburse for sessions longer than 45 minutes.

If the client is a minor and his/her parents are divorced, unless otherwise outlined in a court order that is presented to the **Heart to Heart Counseling (THERAPIST**), the cost of any fees not covered by the insurance company will automatically be shared 50%/50% for the child(ren)’s sessions; but each parent will be 100% responsible for his/her own individual sessions and for sessions they attend with their child(ren). Each parent will be 100% responsible for any verbal or electronic communications they have with the **Heart to Heart Counseling (THERAPIST)**

## Penalties

The following penalties may be imposed on the Client or responsible party for each occurrence. Insurance does not cover these charges.

* $60 fee for failing to cancel your appointments at least 24 hours in advance.
* $80 fee for failure to arrive for your appointment.
* $50 fee for each returned check.
* 90 day past due accounts may be referred to a lawyer or collection agency, you will be responsible for any additional fees and amounts found due.

## Refunds

**Heart to Heart Counseling, LLC** refunds to clients any amounts received for all services above what has been billed. For example, if you prepaid an amount and then insurance pays on that session or where some other type of over-payment has occurred. However, if there is still an outstanding balance (client or insurance), you will not be refunded until your entire account is paid in full. Please allow 2-4 weeks after your account has been paid in full for your refund to be complete. To initiate a refund, please contact the billing department.

## Court/Attorney Fees/Conferences with 3rd Parties:

If, due to your treatment, the **Heart to Heart Counseling (THERAPIST)** issubpoenaed to appear in court, involved in any court proceedings or attends a conference with a 3rd party, you agree to pay all the associated costs and fees to include (but not limited to):

* $200 per hour (includes preparation time)
* Travel time (begins when the provider leaves the office)
* Travel expenses (Meals, lodging, etc.)
* Mileage at the Federal reimbursement rate (no charge if less than 50 miles total)
* Attorney fees
* $2000 retainer to testify or attend any court (or other legal proceeding) paid at least 1 week prior to proceeding.

In the event that billing and costs exceed $750, you agree to advance additional amounts in $500 increments, depending on the **Heart to Heart Counseling (THERAPIST)** estimate ofexpected costs and fees.

The **Heart to Heart Counseling (THERAPIST)** may be asked to provide the court and/or the officers of the court with an interest in this case information about the therapy. Any such report may occur in writing or verbally, or could be delivered in the form of depositions, affidavits, or testimony. Any such report would be provided only to reflect the facts of the treatment and the clinical opinions regarding the response of each person to the treatment. No opinions will be given beyond clinically derived opinions relevant only to the treatment, and those opinions will be limited to opinions about treatment. The **Heart to Heart Counseling (THERAPIST)** will not make recommendations to the court.

## Other Expenses: (Insurance does not pay for these services.)

The **Heart to Heart Counseling (THERAPIST**) will be reimbursed at a rate of $110 per hour (minimum fee $27.50 for 15 minutes) for the following expenses incurred in connection with providing the therapy services, and need for record keeping. Exceptions will be made for brief contacts about scheduling at the discretion of the **Heart to Heart Counseling (THERAPIST**).

##### Paperwork completed outside of session and recommendations to schools for 504 Plans or IEPs.

* Phone calls (Note: phone sessions may or may not be covered by your insurance, something you will need to verify with your insurance company).
* Reading or writing e-mails (Note: you must read and sign Section 1D E-mail Communications Form).

##### Reading any reports (i.e., psychological, legal, medical, or personal written narrative, etc.).

* More complex reports, professional opinions, treatment summaries, etc., are $125, including postage. \*We reserve the right to adjust report fees according to individual circumstances. (This fee must be paid before the report can be released to you or to any other party.)

# Payment

As the client, you are ultimately responsible for payment of fees. There are two options for your counseling services: Self-payment for services and utilizing your health insurance. If you chose to self-pay, payment is due at the time of service. If you choose to use your health insurance, co-payments and deductibles are due at the time of service (required by insurance company). Please make checks payable to **Heart to Heart Counseling, LLC.**

## Credit Card Guarantee

Heart to Heart Counseling, LLC requires a credit card guarantee in the event that your insurance company fails to pay for services or you fail to pay your bills as outlined in this fee agreement. We will bill your credit card only if your account becomes more than 30 days overdue or if you request, we automatically charge your credit card for fees incurred. **Heart to Heart Counseling, LLC** will notify you of any charges to your credit card via an invoice.

### CREDIT CARD GUARANTEE

**Client/Subscriber and/or Guarantor Information**

#### I acknowledge after having read the Fee Agreement/Consent to Treatment Form that I am obligated to pay any outstanding fees based on the terms listed, and I hereby authorize Heart to Heart Counseling LLC to charge my credit/debit card for such fees.

Name on Credit/Debit Card:

Credit Card #: CV2 Code:

Expiration Date (MM/YY): / Circle One: Visa MasterCard Discover

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder Signature Date

If personal representative, relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorize Heart to Heart Counseling LLC to automatically charge your credit card, Health Savings Account or Financial Savings Account for copays. Yes No**

## Insurance Agreement

**Please provide a copy of your insurance card**

Your health insurance is an agreement between you and your insurance company. Your mental health benefit, as authorized by your insurance company, will pay for a portion or all of your therapy sessions. To minimize your out-of-pocket costs, it is important that you understand your plan and keep track of coverage. If your insurance company requires an authorization for your initial visit(s), please make sure that you have obtained this authorization no later than your first visit and then keep track the number of sessions allowed.

* You should notify your **Heart to Heart Counseling (THERAPIST)** two weeks prior to the expiration date of the current authorization allowing enough time to request more sessions if needed.
* If you exceed the authorized number of sessions under your current authorization, or the date of the therapy session is outside the parameters of the current authorization, you will be responsible for payment of any session fees not covered by your insurance company.

Insurance benefits quoted by your insurance company are not a guarantee of payment and may change or be denied later by the insurance company, depending on your health insurance coverage and the insurance company’s policies.

If your **Heart to Heart Counseling (THERAPIST**) is **NOT** acredentialedprovider for your insurance provider, you are responsible for all fees (see Section 3) and must pay all charges at the time of service. Our billing department will assist you in submitting insurance forms.

*Please inform us immediately of any change in insurance, personal address or phone numbers changes, as well as any employment changes*.

***Your signature below indicates your willingness to disclose the needed information to your insurance company so that you may use those benefits.***

### INSURANCE INFORMATION

**Client/Subscriber and/or Guarantor Information**

Member/Subscriber ID Group#

Insurance Company

Number of sessions allowed per year: Annual renewal date:

Co-pay amount per session: $

Deductible $ Amount met $

Insurance Authorization #:

Dates of Authorization (start/end): /

Number sessions authorized:

Name of Benefit Holder:

Benefit Holder’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Benefit Holder’s SS#:

Relationship: (Used for billing purposes only)

Benefit Holder’s Place of Employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_

Benefit Holder Information (if different from Client’s):

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone – Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client or personal representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If personal representative, relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Confidentiality

All information you disclose to your **Heart to Heart Counseling (THERAPIST**) is held in the strictest of confidentiality and may not be released without your written consent EXCEPT AS REQUIRED OR ALLOWED BY LAW. Some exceptions to confidentiality include, but are not necessarily limited to, situations where there is:

* A danger to yourself or another person, which requires or allows us to provide protection to you and/or the other person(s).
* Actual or suspected abuse or neglect of children/minors, developmentally disabled/mentally retarded individuals, and/or the elderly. **Heart to Heart Counseling (THERAPIST**) is mandated or allowed by law to disclose this information to the proper authorities and/or other appropriate agencies.
* Presentation of a valid court order.

You agree that **Heart to Heart Counseling (THERAPIST)** may need to discuss clinical situations/issues with the practice attorney. For any account that has gone unpaid for 90 days, **Heart to Heart Counseling, LLC** may be required to send information on unclaimed funds to the appropriate state agency, and may need to reveal information about you if a collection action if filed. **Heart to Heart Counseling, LLC** will reveal only the minimum amount of information necessary to accomplish each task.

You agree that **Heart to Heart Counseling (THERAPIST)** may disclose and/or obtain information about you for treatment purposes, i.e. with another therapist from whom THERAPIST seeks advice about your case and/or with another professional who is treating you or has treated you in the past. Please see our Notice of Privacy Practices for more information on confidentiality.

# Acknowledgement of Agreement

The Client, Guardian, or Responsible Party hereby give(s) permission for **Heart to Heart Counseling (THERAPIST**) to treat the client on the terms and conditions as set out in this agreement. I/we fully understand the above agreement and freely agree to the above conditions:

Print client’s name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian/Responsible Party Signature Date If personal representative, relationship to client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Heart to Heart Counseling (THERAPIST)** Signature Date

# Notice of Policies & Practices to Protect the Privacy of Your Health and Medical Information

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

We (the therapists at Heart to Heart Counseling, LLC), which consists of therapists affiliated with Heart to Heart Counseling, LLC as either employees or independent contractors may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes in most instances without your consent under HIPAA, but we will obtain consent in another form for disclosing or receiving information outside of our practice, except as otherwise outlined in this Policy. In all instances we will only disclose the minimum necessary information in order to accomplish the intended purpose. To help clarify these terms, here are some definitions:

* “*PHI”* refers to information in your health record that could identify you.
* *“Treatment, Payment and Health Care Operations”*
* *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist.
* *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage, which would include an audit.
* *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
* “*Use*” applies only to activities within our practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
* “*Disclosure*” applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.

**II. Uses and Disclosures Requiring Authorization**

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization”* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information, including uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Examples of disclosures requiring an authorization include disclosures to your partner, your spouse, your children and your legal counsel. Any disclosure involving psychotherapy notes will require your signed authorization, unless we are otherwise allowed or required by law to release them.

**III. Uses and Disclosures Requiring Neither Consent nor Authorization**

We may use or disclose PHI without your consent or authorization as allowed by law, including under the following circumstances:

* **Serious Threat to Health or Safety:** If we believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we may take one or more of the following action s in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s). We will inform you about these notices and obtain your written consent, if we deem it appropriate under the circumstances.
* **Worker’s Compensation:** If you file a worker’s compensation claim, we may be required to give your mental health information to relevant parties and officials.
* **Felony Reporting:** We may be required or allowed to report any felony that you report to us that has been or is being committed. **For Health Oversight Activities:** We may use and disclose PHI if a government agency is requesting the information for health oversight activities. Some examples could be audits, investigations, or licensure and disciplinary activities conducted by agencies required by law to take specified actions to monitor health care providers, or reporting information to control disease, injury or disability.
* **For Specific Governmental Functions*:*** We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, and for national security reasons, such as for protection of the President.
* **For Lawsuits and Other Legal Proceedings*:*** If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by law. We cannot provide any information without your (or your personal or legal representative’s) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information. If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
* **Abuse, Neglect, and Domestic Violence*:*** If we know or have reason to suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child or developmentally disabled individual under 21, the law requires that we file a report with the appropriate government agency, usually the County Children Services Agency. Once such a report is filed, we may be required to provide additional information. If we have reasonable cause to believe that a developmentally disabled adult, or an elderly adult in an independent living setting or in a nursing home is being abused, neglected, or exploited, the law requires that we report such belief to the appropriate governmental agency. Once such a report is filed, we may be required to provide additional information. If we know or have reasonable cause to believe that a patient or client has been the victim of domestic violence, we must note that knowledge or belief and the basis for it in the patient’s or client records.
* **To Coroners and Medical Examiners*:*** We may disclose PHI to coroners and medical examiners to assist in the identification of a deceased person and to determine a cause of death.
* **For Law Enforcement:** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
* **Required by Law.** We will disclose health information about you when required to do so by federal, state or local law.
* **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, non-accidental physical injuries, reactions to medications or problems with products.
* **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Other uses and disclosures will require your signed authorization.

**IV. Patient's Rights and Our Duties**

**Pati e nt’s Ri ghts:**

* ***Right to Request Restrictions and Disclosures****–*You have the right to request restrictions on certain uses and disclosures of protected health information about you for treatment, payment or health care operations. However, we are not required to agree to a restriction you request, except under certain limited circumstances, and will notify you if that is the case. One right that we may not deny is your right to request that no information be sent to your health care plan if you pay in full for the health care plan service ahead of time. If you select this option then you must request it and you must pay in full each time a service is going to be provided. We will then not send any information to the health care plan for that session unless we are required by law to release this information.
* ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. If your request is reasonable, then we will honor it.
* ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record, except under some limited circumstances. This does not apply to information created for use in a civil, criminal or administrative action or proceeding. We may charge you reasonable amounts for copies, mailing or associated supplies. We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to your PHI, you may ask that our denial be reviewed.
* ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request, but will note that you made the request. Upon your request, we will discuss with you the details of the amendment process.
* ***Right to an Accounting*** – With certain exceptions, you generally have the right to receive an accounting of disclosures of PHI, not including disclosures for treatment, payment or health care operations, for paper records on file for the past six years and for an accounting of disclosures made involving electronic records, including disclosures for treatment, payment or health care operations, for a period of three years. On your request we will discuss with you the details of the accounting process.
* ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.
* ***Right of Involvement in Care*** – Your or your child’s goals/treatment planning and therapy

**Our Duties**:

* We are required by law to maintain the privacy of PHI, to provide you with this notice of our legal duties and privacy practices with respect to PHI, and to abide by the terms of this notice.
* We reserve the right to change the privacy policies and practices described in this notice and to make those changes effective for all of the PHI we maintain.
* If we revise our policies and procedures, which we reserve the right to do, we will make available a copy of the revised notice to you on our website, if we maintain one, and one will always be available at our office. You can always request that a paper copy be sent to you by mail.
* In the event that we learn that there has been an impermissible use or disclosure of your unsecured PHI, unless there is a low risk that your unsecured PHI has been compromised, we will notify you of this breach.

**V. Complaints**

If you are concerned that we have violated your privacy rights, or you disagree with a decision we make about access to your records, you may file a complaint with us and we’ll consider how best to resolve your complaint. Contact our Privacy Officer, listed below, if you wish to file a complaint with us. In the event that you aren’t satisfied with our response to your complaint, or don’t want to first file a complaint with us, then you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. or to:

Region V, Office for Civil Rights

U.S. Department of Health and Human Services 233 N. Michigan Ave., Suite 240

Chicago, IL 60601. Ph. (312) 886-2359,

Fax (312) 886-1807, TDD (312) 353-5693.

There will be no retaliation against you for filing a complaint.

**VI. Effective Date:**

This notice is effective as of May 1, 2014.

**NOTICE OF PRIVACY PRACTICES**

I, (Print your name) hereby acknowledge that I have received the Notice of Privacy Practices from **Heart to Heart Counseling, LLC**.

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Client/Guardian/Responsible Party Signature Date

If personal representative, relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Client declined to sign, please note this here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Heart to Heart Counseling (THERAPIST)** Signature Date