Disclosure Statement, Agreement for Services, and Notice of Privacy Practice

Welcome to Resilient Child Therapy Institute, LLC! We look forward to working with you and/or your child on the personal, relationship, family, or other issues that brought you here. This document is intended to provide important information to you regarding treatment. Please read the entire document carefully and be sure to ask me any questions you may have regarding the contents.

Psychological Services

A therapy session usually consists of a 45-50 minute or 60 minute time period. During the first session, which usually takes 60-90 minutes, we will discuss the history and current issues involved in what brought you and/or your child or family to therapy. We will also spend time looking at options, strategies, and ways to achieve the goals that you have for yourself and/or your child or family.

While the benefits of a psychological evaluation, psychotherapy, or other psychological treatments are generally likely to outweigh possible risk, the outcomes and side effects cannot be predicted with certainty. Persons being evaluated or involved in therapy may experience a wide range of emotions, and it is not unusual to feel vulnerable or stressed. The therapeutic experience may arouse feelings or produce insights of which you were unaware, or which you might not wish to experience. While the goals of psychological services are generally to advance the understanding of problems and to increase adaptive functioning and positive emotional well being, it is sometimes possible that symptoms may not improve. Any problems or uncomfortable feelings you experience should be discussed in our sessions.

The length of treatment and timing of the eventual termination of therapy depend on the specifics of your treatment plan and the progress you and/or your child achieve. It is a good idea to plan for termination in collaboration with the therapist. Your therapist will discuss a plan for termination with you as you and/or your child approach the completion of treatment goals. You may discontinue therapy at any time. If you or your therapist determines that you and/or your child are not benefiting from treatment, either of us may elect to initiate a discussion of treatment alternatives. Treatment alternatives may include (among other possibilities) referral to another therapist, changing your treatment plan, or terminating therapy.

Fees and Insurance

The service fee is $150 for the initial/intake appointment.

The service fee is $140 for a 60 minute individual or family session.

The service fee is $125 for a 45-50 minute individual or family session.

Fees may apply not only to direct contact such as therapy or interviews, but may also apply to related activities such as written summaries or reports, providing professional consultation to school when requested, or extended (more than 10 minutes) telephone contacts.

I accept cash and most major credit cards as forms of payment. **Fees are payable at the time services are rendered.** Please ask if you wish to discuss a written agreement that specifies an alternative payment plan. You are financially responsible for all fees or charges arising from the services provided and charges for other utilization of my professional time related to the provision of services, now or in the future, regardless of whether the services or related use of professional time were requested by me or on my behalf, or necessitated by other circumstances including but not limited to a subpoena or other court process. Payment for any such future charges shall be made at my usual and customary rates at that point in time.

In order for me to set realistic treatment goals and priorities, it is important to evaluate what financial resources you have available to pay for treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You should carefully read the section in your insurance coverage booklet that describes mental health services and if you have questions about the coverage, call your plan administrator. I am a participating provider with Blue Cross/Blue Shield PPO and Maryland Medicaid. If you have insurance coverage other than what I accept, you will need to inquire about your out-of-network benefits. If you have out of network benefits, I will provide you with the necessary information that you can submit to your insurance company for reimbursement. However, you are responsible for full payment of our fees at the time of services. You are also responsible for any fees that are not reimbursed by your insurance company.

If for some reason you find that you are unable to continue paying for your therapy, please let your therapist know, and they will help you to consider other options that may be available.

Confidentiality

All communications between you and me will be held in strict confidence unless you provide written permission to release information about your treatment. There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person when a client is dangerous to him or herself.

Also, I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I make every effort to avoid revealing the identity of the client. The other professionals are also legally obliged to keep the information confidential. Unless you object, we will not tell you about these routine consultations except when we feel it is important to our work together.

In the future, I may employ staff that need access to Protected Health Information (PHI) for billing, scheduling, and quality assurance purposes. All staff will have received training about how to protect your privacy.

Other laws may dictate the release of confidential records and information in other specific circumstances. For example, information may not be afforded the usual confidentiality protections when professional services are provided for the purposes of child custody or visitation evaluation; in the course of a court-ordered evaluation; or, in the case of future legal action involving child custody, visitation or parental rights.

Treatment of Children, Families, and Groups

Privacy in therapy is very important, especially with teenagers. Additionally, parental involvement is also essential to successful treatment and progress. Therefore, it is our general policy that with children between the ages of 13-17 who are not emancipated, most of the details of therapy will be treated as confidential and their permission will be required to release information about treatment. Parents or guardians have the right to *general* information but not necessarily the specifics of what we talk about. If we feel that the teen is in danger or is a danger to someone else, we will notify the parents or guardians of the concern.

In family and group therapy everyone involved must have a clear understanding of the limits of confidentiality. Family and group members are asked to keep information discussed during therapy confidential, but the discretion of members cannot be guaranteed.

Professional Records

The law and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records unless we believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. I can generally prepare a summary for you, instead. If you wish to see your records, I recommend that you review them in my presence so that I can discuss the contents. If records are requested and authorization is granted for their release, an appropriate fee will be charged to the client for preparation time of the record and the cost of the copies.

Missed Appointment and Cancellations

Clients who are inconsistent in keeping their therapy appointments rarely receive benefit from their therapy. Appointments are scheduled for your therapy, and if you are unable to keep an appointment or will be late, it is your responsibility to contact this office. ***Clients will be charged full fee for not showing for an appointment or canceling with less than 24-hour notice.*** Sessions will be canceled at 15 minutes past the scheduled start time and noted as a no show. Frequent short notice cancellations or no shows may result in closing services until you are ready to make a commitment to yourself and/or your child, me, and counseling. ***It is important to note that insurance companies do not provide reimbursement for cancellations or missed appointments.***

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to your therapist's belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your therapist at any time on your therapist's confidential voicemail. If you want your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday-Friday) within 48 hours. Your therapist is not available to return calls on Saturdays or Sundays or after 5pm. If you have an urgent need to speak with your therapist, please indicate that fact in your message. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Absences/Unexpected Absences

In the event I am out of town or not available, I have an agreement with trusted colleagues for them to 'cover' and take emergency calls in my absence. I have chosen these licensed mental health care providers with great care and will share only necessary information with them that will allow them to provide appropriate care for you. This information may include a summary of your (or your child's) diagnosis, any specific areas of concern, and the treatment plan.

I am ethically and professional bound to ensure that you receive competent care in the event I am unable to continue to provide it for whatever reason. Just like you, unplanned things can happen to me including sickness, accidents, and even death. In the event I am ever unable to continue to provide my services to you, I have identified a trusted colleague who will manage my practice and act as a Bridge Therapist and other therapists who may offer continuing care if I am unable to do so. In order to accomplish this, he/she will have access to your contact information in the event something happens to me. This person will contact you to inform you of my situation and status, offer to either meet with you and/or your child and/or make referrals to other practitioners whom I have identified and trust.

Notice of Privacy Practices

I. Use and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- *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 psychologist.

- *Payment* is when we obtain reimbursement for your health care. 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.
- *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 of activities, business-related matters, such as audits and administrative services, and case management and care coordination. We may disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained.
- "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.
- "Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. You may revoke all such authorization at any time, provided each revocation is in writing. You may not revoke authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

II. Uses and Disclosures without Authorizations

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse/Neglect* - If we have reason to believe that a child has been subjected to abuse or neglect, we must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse/Neglect* - If we have reason to believe that a dependent adult has been subjected to abuse or neglect, we must report this belief to the appropriate authorities.
- *Health Oversight Activities* - If we receive a subpoena from the Maryland Board of Social Work Examiners, Professional Counselors or Psychologists because they are investigating our practice, we must disclose any PHI requested by the Board.
- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or court order. The privilege does not apply when you are being evaluated by a third party or when evaluation is court ordered. You will be informed in advance if this is the case.

III. Other Uses and Disclosures Requiring Authorization

- *Serious Threat to Health or Safety* - If you communicate to us a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health 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. (For example, you may not want a family member to know that you are seeing me. On your request, we will send your bills to another address.)
- *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. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process for PHI.
- *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. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI. 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.

Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in the notice. Unless we notify you of such changes; however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide notice to you of the changes at your first appointment following the change or by mail.

V. Questions and Complaints

- If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Kristian Owens, MSW, LCSW-C, 9500 Arena Drive, Suite 460C, Largo Maryland 20774
- If you believe that your privacy rights have been violated and wish to file a complaint, you can send a written complaint to Kristian Owens, MSW, LCSW-C, 9500 Arena Drive, Suite 460C, Largo Maryland 20774. You can also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, Hubert Humphrey Building, 2000 Independence Avenue SW, Washington, DC 20201, 202-690-7000. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

- This notice went into effect on July 1, 2015.
- We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by giving you a copy of the revised notice at a session with you or by mailing you a copy of the revision should a revision be made.

Consent Agreement Form

_____ I have received a copy of the Disclosure Statement, Agreement for Services, and Notice of Privacy Practice and have had a chance to ask questions and have them answered.

_____ I understand that I am responsible for the full payment of services should my insurance deny reimbursement for services rendered.

_____ I understand that if I am unable to reach the therapist directly in case of emergency, I should follow the emergency contact instructions on the office voicemail and/or I should contact the nearest emergency room.

_____ I understand that I **WILL** be charged the full session fee for appointments I miss unless I notify the therapist at least 24 hours in advance.

_____ I understand that frequent short notice cancellations or no shows may result in closing services until I am ready to make a commitment to myself and/or child, the therapist, and counseling.

_____ I request and authorize the therapist to provide psychological services to my child, family, and/or myself. These services may include testing, therapy, and any additional psychological services deemed appropriate for the client(s).

_____ I certify that I have legal custody and/or other required legal standing to request and authorize professional psychological services for my child.

_____ I understand that my therapist loves getting feedback from me on what is and is not working, and that my thoughts and feelings are an important part of the therapy process.

Signing this document represents an agreement between us. The signature(s) below indicates that I/we have read discussed, understand, and agree to this agreement and the points presented above.

_____ _____
Signature(s) of Client or Parent/Guardian Date

_____ _____
Parent/Guardian Printed Name(s) Child's Name

_____ _____
Witness Signature Date

For Professional use only
No signature above is for the following reason:
__ Individual(s) refused to sign
__ Communications barrier prohibited obtaining a signed acknowledgement
__ Emergency services prohibited obtaining a signed acknowledgement