2021 Practice and Privacy Policies

Emerging Strengths Therapeutic Services PLLC
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A WASHINGTON SERVICE PROVIDER

Kathryn Willis, MS, LMHCA is the sole therapist providing services through Emerging Strengths Therapeutic Services PLLC at this time. Kathryn Willis holds an associate license MC.60895795 in the state of Washington, and is supervised by Elizabeth Cabibi, LMFT LF00002601. This license allows for services to be provided to individuals physically located within the state of Washington. By signing this form, you are confirming that you, the client, are currently physically located within the state of Washington, and agree to be physically located within the state of Washington for the duration of all services provided by Emerging Strengths Therapeutic Services PLLC.

I agree to be physically located within the state of Washington for the duration of all services provided by Emerging Strengths Therapeutic Services PLLC.

*Signature:*_____ *Date:* _____

PRACTICE POLICIES

SERVICE, APPOINTMENTS AND CANCELLATIONS
The standard meeting time for sessions is 45-50 minutes, but modified session times are available per the agreement between the client and therapist. The client and therapist will determine the frequency, length of time for sessions, and duration of services together based on the goals for the therapeutic experience.
Currently, private pay via credit card through the client portal is the only accepted method of payment. In order to participate in services all clients must have an active credit card on file. Clients have the option to participate in auto-pay, in which the card on file is charged within 24 hours of the service, or manual pay, in which the client logs into the client portal and manually pays each invoice via credit card. If the client chooses to manually pay, this must be done within 72 hours of each service provided. Please talk to your credit card company for information regarding service charges that may apply.
Clients who schedule a session are responsible for the full fee of that session unless they cancel the appointment more than 24 hours in advance. Sessions that do not require the full amount of time allotted for the session or end early as a result of connection issues or technical difficulties on the part of the client will still be charged for the full agreed upon amount. Sessions that end early as a result of the therapist's technical difficulties or loss of connection will be charged at a prorated fee based on the amount of time the session was successfully hosted.

As of August 29, 2020, the fees for appointments are as follows:

Individual, Family or Couple's full session (45-50 minutes): $100 per session
Individual, Family or Couple's extended session (1 hour, 15 minutes): $150 per session
Individual, Family or Couple's extended session (1 hour, 45 minutes): $200 per session
Other session durations are available per the agreement between client and therapist.

For clients that came into services at a different rate, the agreed upon rate will be honored with a minimal annual rate increase. The annual rate increase will be based on increased costs associated with maintaining the business, and all clients will be given advance notice of the exact rate increase prior to its implementation. A certain amount of client openings will remain reserved for clients who face financial barriers to care, and as a result,

have become Open Path members in order to gain access to sliding scale rates. Rate caps of $60 for individual sessions and $80 for family and couple's sessions for all Open Path members will be honored during annual rate increases.
Please remember to cancel or reschedule sessions at least 24 hours in advance. Clients are responsible for the entire session fee if cancellation is less than 24 hours in advance of the session's schedule start time. This is necessary because a time commitment is made to each client, and is held exclusively for that client until otherwise stated by the client. If late for a session, the client will lose some of that session time, but will remain responsible for the full session fee.
Group therapy is available either before, concurrently with, or independent of individual, family and/or couple's sessions. Group services are currently being offered on an open bases, including weekly 45- minute sessions for $50 per group session attended. If interested in exploring group services, please ask your therapist for further information about availability, scheduling, and to discuss if this service is a good fit.

SUBSTANCE USE POLICY
Due to the nature of therapy, the potential intensity of processing thoughts, feelings and behaviors brought to session, and the potential for substance use to skew decision making, Emerging Strengths Therapeutic Services PLLC reserves the right to end session early and/or contact the client's designated support network and/or contact local and community supports, including emergency medical services, in the event of the client attending session while appearing to be under the influence of any substance. If session ends early as a result of substance use, the client is still responsible for the cost of the scheduled session. Emerging Strengths Therapeutic Services PLLC agrees to make decisions with the best interest and safety of the client as the priority, and will involve others, such as the support network and other supports as needed in an effort to promote the client's safety and wellbeing. If substance use supports and services will benefit the client, the therapist agrees to make the applicable referrals.

DOCUMENTS
The therapist is happy to coordinate with clients for certain document requests. Letters confirming participation in services, appointment confirmation letters, and letters briefly outlining recommendations for services can be provided at no charge. Please make these letter requests at least 2 business days (Monday-Thursday) prior to the date they are needed. Letters or documents other than those listed above may require more time to be organized, and a rate of $30, with an additional $30 per half hour needed to complete such document requests will be charged. Please make all other document requests at least 5 business days (Monday-Thursday) in advance of the time the documents are needed.
Emerging Strengths Therapeutic Services PLLC does not provide any services or letters regarding emotional support animals.

SPECIAL APPEARANCES
Emerging Strengths Therapeutic Services PLLC is happy to coordinate with clients for special appearance requests. This includes, but is not limited to providing court testimonies and other professional statements in person or via phone/video. All in-person and virtual appearances are charged at a rate of $150 with an additional $150 per hour for the duration of the special appearance. Please make requests for special appearances at least two weeks in advance. Please understand that if prior engagements have already been scheduled, the previously scheduled engagement will take precedence, and Emerging Strengths Therapeutic Services PLLC may not make the appearance. Therefore, please make requests for special appearances as far in advance as possible. Emerging Strengths Therapeutic Services PLLC reserves the right to decline any in-person or virtual special appearance at the discretion of the therapist.

I certify that I understand and agree to the Services, Appointments and Cancellations policies described above.

*Signature:*_____ *Date:* _____

TELE MENTAL HEALTH

The only method for services being offered at this time is tele mental health. By signing this document and engaging in services through Emerging Strengths Therapeutic Services PLLC, the client assumes all risks included in accepting tele mental health services, including but not limited to, technology user error, bugs, glitches, telecommunication service interruptions, and other risks that may apply to engaging in mental health services through telecommunication not explicitly listed here.

Clients should understand:

1. The client retains the option to withdraw consent at any time without affecting the right to future care or treatment, or risking the loss or withdrawal of any program benefits to which the client would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.
3. Dissemination of any identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without the client's consent.
4. There are potential risks, consequences, and benefits of telehealth services. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to- date information, consultations, support, reduced costs, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.
5. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the therapist.

Due to the limitations to tele mental health, there are some situations which may prompt consideration of face-to-face services with a therapist instead of teletherapy. These situations include, but are not limited to

1. active suicidal and/or homicidal ideation, or suicidal and/or homicidal ideation within the last calendar year,
2. a history with suicidal and/or homicidal ideation and/or attempts in which the client has experienced suicidal and/or homicidal ideation and/or attempts more than once throughout their lifetime,
3. hospitalization of self or others in the last calendar year due to a psychiatric impairment of any kind,
4. a history of hospitalization due to psychiatric impairment in which the hospitalization of self or others due to the client’s psychiatric impairment took place more than once throughout the client’s lifetime,
5. a history of psychosis, hallucinations and/or delusions and/or other impairments to judgement that are unsafe or pose risk of harm to self or others in which such risks have resulted in the bodily harm to self or others at least once throughout their lifetime,
6. any situation in which a client has been formally or informally advised against tele mental health services in favor of face-to-face services by a medical provider or by any other professional in a multi-disciplinary team with which the client is participating in services,
7. any situation not listed here which poses risk of harm to the self or others by the client, having taken place at least once in the last calendar year,

8. inconsistent access to telecommunication including, but not limited to, inconsistent access to a working device on which telecommunication can take place, inconsistent access to a network on which online services can take place.

Emerging Strengths Therapeutic Services PLLC reserves the right to terminate services at any time if the above stated conditions, or other applicable risk factors are discovered at any point during services. If this takes place, the therapist will make every effort to communicate the worries and risks for continuing services via teletherapy to the client, and to partner with them to identify a more appropriate option for services in the client's community.

At the beginning of teletherapy services, the client will be asked to provide their current address, including apartment or unit number, where the client is physically located during the time of session. This information will be used in case of an emergency in which the therapist must call for emergency services to reach the client's physical location during or after the session. The client will also asked to provide a phone number where the client can be reached during the time of session in case of a technical difficulty, or if the connection is lost during time of session. Due to the safety risk posed if the therapist does not have this information, the therapist has the right to end the session early if the client refuses or cannot provide such information. If this takes place, the client is still responsible for the full fee amount for the scheduled service.

Simple Practice is the Electronic Health Records (EHR) system used by Emerging Strengths Therapeutic Services PLLC to store all personal health information, notes, and details regarding your services. This is also the platform used to host secure messaging and video sessions. In accordance with HIPAA regulations, a Business Associate Agreement (BAA) exists between Emerging Strengths Therapeutic Services PLLC and Simple Practice. Other third parties Emerging Strengths has BAAs with include RingRx and GSuite. Emerging Strengths Therapeutic Services PLLC is not responsible for any breach in confidentiality pertaining to the Simple Practice system; however, if Emerging Strengths is informed of a breach that affects your confidential information, you will be informed of the steps taken to rectify the situation.

Due to HIPAA and other considerations, video and/or audio recording any session or interaction is strictly prohibited. Please do not video and/or audio record any session or interaction with the therapist or any representative of Emerging Strengths Therapeutic Services PLLC, as this may result in early termination of the therapeutic partnership. Emerging Strengths Therapeutic Services PLLC will not audio and/or video record any session or interaction with a client for training or any other purpose without the explicit written consent of the client. No client is required to provide written consent for any audio and/or video recording at any time.

I certify my understanding that the above listed, or similar situations may be cause to consider seeking face-to-face therapy instead of teletherapy. By signing this, I certify my understanding and agreement that these considerations have been made, but I am choosing to accept these limitations in favor of teletherapy. I also understand my therapist may discuss with me options for seeking face-to-face therapy.

*Signature:*_____ *Date:* _____

EMERGENCIES AND RISK

If an emergency situation arises during or in between sessions, the client should call 911 or report to the nearest local emergency room. An emergency includes any unforeseen combination of circumstances or the resulting state that calls for immediate action, including an urgent need for assistance or any situation that threatens bodily, mental or emotional harm to any individual.

Teletherapy is not always beneficial for individuals experiencing high risk, including, but not limited to active suicide and/or homicidal ideation. If there is an immediate threat to safety, please stop this form and call 911, go to your nearest emergency room, or contact the National Suicide Prevention hotline at 1- 800-273-8255. If an immediate threat to safety, or an emergency situation occurs during an active telehealth session, the therapist may end the session with the recommendation that the client immediately call 911 or report to the nearest emergency room. Emerging Strengths Therapeutic Services PLLC reserves the right to contact 911 or other

emergency services, including, but not limited to the client's identified support network, on behalf of a client at any time, per the therapist's discretion.
In the event of an unplanned absence or emergency on the part of the therapist, whether due to injury, illness, death, or any other reason, Emerging Strengths Therapeutic Services PLLC has coordinated with two mental health professionals who are willing to inform the client of the therapist's status and ensure the client's continued care in accordance with individual needs. The client may request the names and credentials for these mental health professionals at any time throughout treatment. The client authorizes these designated mental health professionals to access treatment and financial records only in accordance with the terms agreed upon between these mental health professionals and Emerging Strengths Therapeutic Services PLLC, only in the event that the therapist experiences an event that has caused or is likely to cause a significant unplanned absence from practice.

MESSAGE ACCESSIBILITY
Secure messaging through the client portal is the best way to communicate in between sessions, as it is HIPAA compliant. Please note that leaving a voicemail, email and messaging through social media accounts are not considered secure modes of communication in compliance with HIPAA. By choosing to communicate in these ways, the client assumes the risk of a confidentiality breach.
Please note, that when reaching out in between sessions, the therapist is often not immediately available. An effort to reply within 48 hours Monday-Thursday will be made. Messages left between 7pm PDT on Thursday and noon PDT on Monday will be answered as soon as possible Monday-Thursday.

ELECTRONIC COMMUNICATION
Emerging Strengths Therapeutic Services PLLC cannot ensure the confidentiality of any form of communication through electronic media, including email. If the client prefers to communicate via email for issues regarding scheduling or cancellations, the therapist will do so at the client's accepted risk. Please note, that when reaching out in between sessions, the therapist is often not immediately available. An effort to reply within 48 hours Monday-Thursday will be made. Messages left between 7pm PDT on Thursday and noon PDT on Monday will be answered as soon as possible Monday-Thursday.
Please do not use electronic communication methods to discuss therapeutic content and/or request assistance for emergencies.

SOCIAL MEDIA AND TELECOMMUNICATION
Due to the importance of confidentiality and the importance of minimizing dual relationships, Emerging Strengths Therapeutic Services does not accept friend or contact requests from current or former clients on any social networking site personal account (Facebook, LinkedIn, etc). Adding clients as friends or contacts on these sites can compromise confidentiality and client-therapist respective privacy. It may also blur the boundaries of the therapeutic relationship. Emerging Strengths Therapeutic Services PLLC has social media accounts for the purposes of sharing information about helpful resources, and clients are welcome to follow these accounts. If clients would like to communicate with your therapist however, please do not do so through social media. Secure messaging through the client portal is the safest way to communicate in between sessions.

I certify that I understand and agree to the Tele Mental Health and communication policies described above.

*Signature:*_____ *Date:* _____

MINORS
According to RCW 71.34 of Washington state law, a minor who is 13 years or older may initiate an evaluation and treatment for outpatient treatment, or disengage without consent of their legal guardian. RCW 70.02.240 governs that outpatient treatment records of a minor will be kept confidential, except under certain circumstances including, but not limited to, active risk of harm to self or others by the client or by a source reported by the client to the therapist. As a mandatory reporter (RCW 74.34.020(10)), the therapist is required to

report all reasonable suspicion of abuse and/or neglect to children or vulnerable individuals to the appropriate protective agencies and/or to law enforcement.
For therapy to be effective, trust and consent are essential. For this reason, children and adolescents cannot be forced to participate. Clients willingly choose to share their thoughts, feelings, and behaviors within the therapeutic alliance, and if forced to do so outside of their own volition, this is a violation of their dignity and is likely to cause harm. For the same reasons, therapy should never be used as a punishment or consequence of unwanted behavior.

The goal of therapy is not to undermined or disrespected a parent's and/or guardian's role in their child's life. Instead, it is to provide a space for the child to process certain thoughts, feelings and behaviors that the child may not feel comfortable bringing to the parent and/or guardian yet. It is important for parents and/or guardians to understand that this may provide opportunity for the child to develop values that differ from their family. Family support in therapy is paramount, and it is the goal of Emerging Strengths Therapeutic Services PLLC to foster the strengthening of parent/guardian-child relationships when possible. This may involve parents and/or guardians supporting the space for minor clients to make progress at their own pace without attempting to exert control over the therapeutic process, as this may hinder openness to therapy on the part of the client, and hinder overall engagement and progress. It is understandable that parents and/or guardians may want to further discuss this, and so it is encouraged that they reach out to the therapist with any questions or worries. Additionally, parents and/or guardians can be referred for additional support options when available, including individual and family therapy, books, articles, websites, parenting classes, support groups, and community resources.

I certify that I understand and agree to the Minors policy described above.

*Signature:*_____ *Date:* _____

TERMINATION
Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. The therapist may terminate treatment after appropriate discussion with the client and a termination process if the therapist determines that the therapy is not the most beneficial treatment option for the client, that the therapy is not being effectively used, or if the client are in default on payment. The therapist will not terminate the therapeutic relationship without first attempting to discuss and explore the reasons and purpose of terminating with the client. If therapy is terminated for any reason or the client requests another therapist, the therapist will provide the client with a list of qualified therapists to treat the client. The client may also choose someone on their own or from another referral source.
Should an appointment not be scheduled or attended by the client for 30 days, unless other arrangements have been made in advance, for legal and ethical reasons, Emerging Strengths Therapeutic Services PLLC must consider the professional relationship discontinued. The client will receive a closure letter via the client portal. Unless otherwise discussed prior to termination of services, the client is welcome to re-enroll at any time, and will be required to complete paperwork the client may have already completed in prior enrollments, such as consent documents, releases of information, and other relevant paperwork.

I certify that I understand and agree to the Termination policies described above.

*Signature:*_____ *Date:* _____

CLIENT BILL OF RIGHTS
As a client in therapy, you have the right to:

1. Request and receive full information about the therapist’s professional capabilities including licensure, education, training, experience, professional association membership, specializations and limitations,
2. Have written information about fees, method of payment, insurance, number of sessions, substitutions and cancellation policies, before beginning therapy,

3. Receive respectful treatment that will be helpful to you in a safe environment free from sexual, physical, and emotional abuse,
4. Ask questions about your therapy,
5. Refuse to answer any question or disclose any information you choose not to reveal,
6. Request that the therapist inform you of your progress,
7. Know the limits of confidentiality and circumstances in which a therapist is legally required to disclose information to others,
8. Refuse a particular type of treatment or to end treatment without obligation or harassment,
9. Refuse electronic recording (but you may request if you wish, and the appropriate consent document will be provided to the client for written permission),
10. Request and receive a summary of your file, including the diagnosis, your progress and type of treatment,
11. Report unethical and illegal behavior by a therapist,
12. Receive a second opinion at any time about your therapy or therapist's methods,
13. Request the transfer of a copy of your file to any therapist or agency you choose.

I certify that I understand and agree to the above Client Bill of Rights.

*Signature:*_____ *Date:* _____

THERAPIST LIABILITY

Emerging Strengths Therapeutic Services PLLC provides services to support the process in which individuals, families and couples pursue mental and behavioral health goals. The therapist will use skills, tools and knowledge developed throughout education and professional experience which can aid in the process of the client meeting their mental and behavioral health goals. The therapist is not liable for actions taken by any client which poses harm or risk of harm to self or others, including but not limited to suicide, homicide, self-harm, bodily injury or other actions which can be harmful to the client or others. By signing this document and entering into services with Emerging Strengths Therapeutic Services PLLC, you are agreeing that you and/or others will not take legal action against Emerging Strengths Therapeutic Services PLLC or the therapist in response to action taken by the client that poses harm or risk of harm to self or others, and you understand that others cannot take legal action against Emerging Strengths Therapeutic Services PLLC or the therapist on your behalf. The therapist will make every effort to promote the safety of the client by taking measures listed throughout this document, and by complying with duty to warn and reporting regulations outlined by the State of Washington, the Federal Government, and professional entities of which the therapist is a part, but is not liable for any threats or actions taken on the part of the client.

I certify that I understand and agree to the Therapist Liability policies described above.

*Signature:*_____ *Date:* _____

COMPLAINTS

If there is a conflict that can't be resolved in session and a complaint is to be made, a detailed list of unprofessional conduct is described on the Washington State Legislative page as follows: http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130.180 To learn how to file, contact the Washington State Dept of Health, 360-236-4700. The form can be printed from their website and mailed to the address below. http://www.doh.wa.gov/LicensesPermitsandCertificates/FileComplaintAboutProviderorFacility/HealthProfessionsComplaintProcess. Washington State Department of Health Systems Quality Assurance, Complaint Intake P.O. Box 47857 Olympia, WA 98504-7857.

I certify that I understand and agree to the Complaints policies described above.

*Signature:*_____ *Date:* _____

NOTICE OF PRIVACY PRACTICES

YOUR PRIVACY IS VERY IMPORTANT TO ME. THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

As a client, you have a right to privacy, as defined by HIPAA regulations, which can be found at https://www.hhs.gov/hipaa/for-individuals/index.html. I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
    1. For my use in treating you.
    2. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

3. For my use in defending myself in legal proceedings instituted by you.
4. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
5. Required by law and the use or disclosure is limited to the requirements of such law.
6. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
7. Required by a coroner who is performing duties authorized by law.
8. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care

operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding the use and disclosure of my protected health information. By checking the box, I acknowledge that I have received a copy of HIPAA Notice of Privacy Practices, and that I understand and agree to the privacy policies listed above.

*Signature:*_____ *Date:* _____

This is a partnership with the goal of working toward your improved mental health. At any time during our work together, it is your right to refuse any treatment. You have the right to choose any practitioner or treatment modality that best suits your specific needs.

THIS FINL SIGNATURE CONFIRMS THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

*Signature:*_____ *Date:* _____