Village Counseling LLC

# Notice of Privacy (HIPAA)

We are committed to providing you with high quality care and to forming a relationship with you that is built on trust. We understand that information about you is private and we are committed to protecting this information.

This notice describes how your health information may be used and disclosed by our office, your rights with regards to your health information and psychotherapy notes, and our duty to protect such information. It applies to all records of your care that we maintain, stored in writing, on a computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality.

Your health information may be used and disclosed by our office for the following purposes without your legal permission.

Treatment, Payment, and Business Purposes. We use and disclose your health information to enable our office to provide treatment to you, obtain payment for your care, and manage and administer my practice. For example, we may use and disclose your health information to your insurer, HMO, or other third party payer to obtain payment for the services that we provide you. Also, in consulting with a specialist regarding your health care treatment, we use and disclose your information.

Individuals Involved in Your Care or Payment or Notification. We may disclose your information to your family members or caregivers who are involved in your care or who assist you in paying for your care. This notification may also be for a disaster relief effort, such as the American Red Cross.

Appointment Reminders. Your health information may also be used and disclosed when my office contacts you to remind you of an upcoming appointment.

To You. We will provide you with your health information upon your request for copying inspections and accounting purposes as discussed further in this notice under “Individual Rights.”

Required by Law. We will discuss your information when we are required to do so by federal, state, or local law.

Health Oversight Activities. We may disclose your information for health oversight activities, such as the disclosure of information in the investigation of a provider’s conduct to a state licensing board official.

To Avert a Serious Threat to Health and/or Safety. We may use and disclose your information if it is necessary to avert a serious threat to health or safety of yourself or others; or to assist law enforcement authorities in identifying or apprehending an individual.

Abuse, Neglect, or Domestic Violence. We may report your health information to government authorities if we have a reasonable belief that a situation involves abuse, neglect or domestic violence.

Judicial and Administrative Proceedings. We may release your health information for judicial and administrative proceedings. Such proceedings would include responses to court orders or subpoenas.

Workers’ Compensation. We may release your health information for the purpose of processing and adjudicating Workers’ Compensation claims.

For Specialized Government Functions. We may disclose your information if you are a member of the military as required by military authorities, or to federal officials for national security reasons as authorized by law.

Law Enforcement Purposes. We may disclose your information for law enforcement purposes if requested by law enforcement officials.

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Quality and Cost of Services. We may provide your information to a nonprofit organization established by law for the purpose of ensuring quality services at reasonable prices. Such a disclosure may be to assist that nonprofit organization in determining the relative quality of services provided by one physician as compared to his peers.

Limited Treatment, Payment and Business Purposes. We may use or disclose your psychotherapy notes if it is for the purpose of defending the provider or practice against a legal action or other proceeding brought by you.

All other uses and disclosures require authorization. You may revoke an authorization in writing to prevent future use and disclosure of your health information.

## Individual Rights

Restriction on Release. You may request that we not use or disclose your health information (1) for your treatment, payment, or the administration of my practice, (2) in notifying family members and friends of your condition or location, and (3) to family and caregivers involved in your care. We will consider your request but we are not legally required to accept it. If we do accept your request, we will not use or disclose your health information except as agreed, unless it is required in emergency situations.

Confidential Communications. You may request in writing that we communicate with you at a different location, or in an alternative manner. we will try to accommodate your request provided that you specify the alternative contact and pay any additional costs related to such requests.

Access and Amendment. In most cases, you have the right to inspect or receive a copy of health information that we use to make decisions about you. Additionally, if you believe that information in your record is incorrect or if important information is missing, you have the right to request that this information be corrected or amended.

Accounting. You may request a limited list of instances where WE have disclosed your health information. The list will not include disclosures: (1) for treatment, payment or related administrative/management purposes; (2) to you; (3) to family or caregivers involved in your care or payment for your care, or for notifying your family/caregiver in situations where you indicate that you agreed to the disclosure; (4) under certain circumstances for national security or intelligence purposes; and (5) to correctional institutions or law enforcement officials having lawful custody of an inmate or information about an inmate or individual, under certain conditions. Additionally, disclosures to health oversight agencies or law enforcement officials may be temporarily suspended if such disclosures delay the activities of the agency or official.

Notice. You may obtain a paper copy of this notice from us upon request, regardless of whether you have received this notice electronically.

### Our Responsibilities

We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We must abide by the terms of the notice currently in effect. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all health information that we maintain; however, before we make a significant change in the privacy policies, we will change the notice and post the new notice for you. We will provide you with a revised notice upon request. You can also request a copy of the notice at any time by contacting our office.

### Complaints

If you feel that your privacy rights have been violated, you may inform our office by written notice. If you have additional questions, please contact our office.

# Patient Acknowledgement of Privacy

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history symptoms, test results, diagnoses, treatment, and any plans for future or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A means by which insurance companies verify that services billed were actually provided.

HIPAA (Health Insurance Portability and Accountability Act)

- Your therapy session is held in the strictest confidence. No information will be released without your written permission. Exceptions are in the HIPAA statement.
- I understand and have the right to request a copy of my HIPAA (Privacy Policy.) I understand that I have the right to review the notice prior to signing this consent.
- I have the right to request restrictions as to how my health information may be disclosed to carry out treatment, payment, or healthcare operations. I understand that I may revoke this consent in writing for future disclosures.

If you would like a copy of our HIPAA policy, please ask the admin staff and one will be provided.

# Fee Schedule

**The** following is a list of services that would not be covered under your insurance policy. These charges are payable at the time that the services are requested.

| | |
|---|---|
| Transfer of Medical Records: | |
| Search and handling: | $20 (Maryland State Statue 8.04-413) |
| Per page, first 50 | $.50/per page |
| Per page, 51 and above | $.25/per page |
| Court Appearance: | |
| Minimum two (2) hours | $150/per hour |
| Disability Forms/FMLA: | $45 |
| Standard Letters: | $45 |
| **Missed Appointments:** | $100 |
| Return Check Charge: | $50 |

Village Counseling LLC
8181 Main Street, 2nd Floor, Ellicott City, MD, 21043 (410) 505-0062 Fax (410) 650-5893
www.villageOEC.com

INFORMED CONSENT POLICY- LGPC Providers

Village Counseling, LLC
8181 Main St., 2nd Floor, Ellicott City, MD 21043

GENERAL INFORMATION

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing below.

COUNSELING PROCESS

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of therapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Therapy requires a very active effort on your part. Putting in work outside of sessions is necessary for treatment to be most successful.

PATIENT RESPONSIBILITIES

You, the patient, are a full partner in counseling. Your honesty and effort are essential to success. As we work together, if you have suggestions or concerns about your counseling, we expect you to share these with us so that we can make the necessary adjustments. If we determine that you would be better served by another mental health provider, we will help you with the referral process. If you are currently receiving services from another mental health professional, please inform us of this and grant us permission to share information with this professional so that we may coordinate our services to you.

Additionally, if during our treatment you do not follow our treatment recommendations, we may have to terminate sessions.

CONFIDENTIALITY

I practice under a provisional license, meaning I work under the supervision of a fully licensed, board approved counselor. These individuals are Gardner McCullough, LCSW-C and Amy Phillips, LCSW-C, who are also members of the Village Counseling, LLC practice. Information gathered in clinical sessions will be held with the same confidentiality laws of all patients at Village Counseling, LLC. Clinical details of your treatment will be discussed with our supervisors for the purpose of training. Exceptions to confidentiality are the same as the practice policies when there is suspected child/elder abuse, imminent danger to the patient or others, a court order, or when a patient signs a release of information. We may request to record sessions to aide in training, which you may always decline. We are happy to provide further clarification in this area, if needed.

The session content and all relevant materials to the patient's treatment will be held confidential unless the patient requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such patient held privilege of confidentiality exist and are itemized below:

1. If a patient threatens or attempts to commit suicide or otherwise conducts themself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a patient threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a patient or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a patient is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally we may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, the therapist will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize your privacy. However, if you acknowledge us first, the therapist will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

## PHONE/EMAIL COMMUNICATION

All communication should be directed to the office at (757) 651-3001. Phone numbers/email addresses are not available to contact us directly. In the event that I need to contact you via phone, it will show as "No Caller ID." In the event of an emergency and for further information regarding communication, please refer to the separate office policy guidelines.

## SOCIAL MEDIA

Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, etc). We believe that adding patients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

## TRANSFER PLAN

In the event of my incapacitation or separation from the practice, Village Counseling, LLC will continue to be the custodian of patient records and facilitating services. Contact person is Amy Phillips, LCSW-C at 410-505-0062.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process 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 you and a termination process if we determine that the therapy is not being effectively used or if you are in default on payment. We will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, we will make every attempt to provide a referral for another qualified therapist to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for two consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, we must consider the professional relationship discontinued.

# Village Counseling LLC

8181 Main Street, 2nd Floor
Ellicott City, MD 21043 410-505-0062 (Voice) 410-650-5893 (Fax)

## Consent to Participate in a Telehealth Consultation

1. I understand that my health care provider wishes for me to engage in a telehealth consultation. I hereby consent to forward my patient-identifiable information to a third party for HIPAA compliant video conferencing. I understand that it is the role of the health care provider to determine whether or not the condition being diagnosed and/or treated is appropriate for a telehealth encounter. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
2. My health care provider has explained to me how the video conferencing technology will be used and that telehealth services can include, appointment scheduling, taking payment, patient education, or psychotherapy, despite not being in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I also understand that all audio, video, file sharing, and chat features will require password protection and use the latest encryption protocols to assure that data integrity and privacy is maintained. I will hold the health care provider harmless for information lost due to technical failures. I agree to use landline or cellular telephones as an alternate means of communication should teleconference service be interrupted.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes
5. I have had the alternatives to a telehealth consultation explained to me, and in choosing to participate in a telehealth consultation, I also understand that some parts of the consultation may require an in-person office visit.
6. In an emergent consultation, I understand that the responsibility of my health care provider to notify my local providers or emergency services and that my health care provider's responsibility will conclude upon the termination of the video conference connection. It is my responsibility to notify my provider of my physical location during each meeting.
7. I understand that billing will occur just the same as in-person visits and I am responsible for all charges not covered by my insurer as per the previously signed financial agreement.
8. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits have been discussed with me in a language in which I understand.

By signing this form, I certify: That I have read or had this form read and/or had this form explained to me. That I fully understand its contents including the risks and benefits of the procedure(s). That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Please call 410-505-0062 with questions.

# Patient Acknowledgement of Policies

- I authorize Village Counseling to provide medical treatment, release medical information for insurance purposes, and to receive direct insurance payments.
- I understand that I am financially responsible for payments of all services unless other special financial arrangements are made with the office prior to service. **Insurance does not guarantee payment.**
- As a courtesy, this office will file your insurance claims for you. If your insurance company does not make a payment on your behalf, you **are responsible for the allowable amount.** If your insurance company inadvertently mails the payment directly to you, it is your responsibility to pay your balance.
- If there is a default of payment of any amount due, and the account is placed in the hands of an agency/attorney for collection or legal action, you will be charged an additional fee equal to the cost of collection, including agency and attorney fees, court cost incurred and permitted by law governing these transactions. You will be responsible for attorney fees related to collections.
- There will be a fee of $100.00 for missed/cancelled appointment without 24 hour/business day notification. There will be a fee of $50.00 for all returned checks.

## Patient Consent Information to our practice:

- To **schedule** an appointment,
  - please call (410) 505-0062 during office hours M-F 9-5pm.
- To **cancel your appointment**,
  - please notify us 24 business hours in advance.
  - A message after hours or weekend is not considered 24 hours, business day notice.
  - We do not monitor email after hours or weekends.
  - Insurance that does not allow us to charge missed fees, each missed appointment will be one strike. Two missed appointments and we refer you out of the practice.
- **Missed Appointment Fees** –
  - A $100.00 appointment fee will be charged for all appointments cancelled without giving 24 hours, Monday through Friday 9-5pm.
  - Insurance will not pay for missed appointments, or late cancellations.
  - You agree to pay for any missed appointments, or less than 24 hours' cancellation.
- After hour's **emergencies**, you can reach us at **(410) 505-0062**. **Please keep these calls to emergencies only.**
  - **Emergency** – a crisis situation that occurs after-hours and cannot wait until the following business day for a response.

    - **If this is an emergency, please go to the nearest hospital emergency room or dial 911.**
- **Texting, emailing or calling your therapist**
    - Your therapist may call from their personal cell at times.
    - Please do not call, email, or text your therapist directly.
    - Please do not provide sensitive information in an email for your therapist.
- **Payment is** collected at the time of service. Failure to pay at time of service will result in immediate cancelation of future appointments.
- **Insurance**
    - We file insurance as a courtesy to you.
    - It is your responsibility to provide current insurance information at the time of service.
    - Payment is not guaranteed by your insurer.
    - You are responsible for any amounts not covered by your insurance.
    - We require that you update insurance information annually at the beginning of each calendar year.
- **Fee Schedule** I agree and understand the fee schedule.
- There is a **return check charge** of $50.00.