

**SALEM PASTORAL COUNSELING CENTER**  
OFFICE POLICIES/INFORMED CONSENT

Prior to beginning treatment, it is important for you to familiarize yourself with your counselor's approach to treatment, your rights and responsibilities, and Salem Pastoral Counseling Center's (SPCC) office policies. This document, along with your counselor's Professional Disclosure Statement and our Notice of Privacy Practices, discusses these topics. Please take the time to review the information contained in these three documents and ask any questions you may have. After your questions and concerns have been answered, please sign and date on the reverse side of this page.

**Approach to Treatment:** To provide the best care possible, it is important that your counselor has a clear understanding of what brings you to treatment. In order to gain that understanding about your past and current functioning, a thorough assessment will be completed. Following the assessment, a treatment plan will be formulated and together with your counselor you will work towards the goals established. It is crucial that you are an active participant in therapy and candidly express with your counselor your treatment needs.

**Risks and Alternatives to Treatment:** It is important for you to know that there are risks involved in therapy. For example, some people experience an increase in stress particularly during the early stages of therapy. In some instances, discussing longstanding, unresolved problems can seem to aggravate rather than help with a problem. It is normal and understandable that it will be uncomfortable facing difficult feelings and situations. Keep in mind that, often, "the best way out is through", and your counselor will endeavor to walk through it with you. Your counselor may ask, "what will be different if counseling is successful for you?" You get to define that, and to a large degree are in charge of the pace and progress of your healing journey. If you or your counselor feel at any time that the professional relationship is not a good fit, your counselor will be willing to assist you in finding other options.

**Appointments and Cancellations:** Counselors work variable hours Monday through Friday with some evening appointments available. Counseling sessions are typically 45-55 minutes in duration. Please try to keep appointments you make, even if it is inconvenient. Appointments may be canceled or rescheduled by calling the voice mail of your counselor at 503-370-8050 and entering their extension. Because our counselors do their own scheduling, your counselor will contact you to reschedule. There is no charge for appointments canceled more than 24 hours in advance. However, except for genuine emergencies or illness, missed appointments and those canceled with fewer than 24 hours notice will be billed up to the usual fee (\$165) for the time scheduled. Insurance companies will accept billing only for appointments actually kept, the client is billed directly the full amount for missed sessions.

**Phone Calls and Emergencies:** Salem Pastoral Counseling Center has a 24-hour/day, 7-day/week-voice mail system that can be reached by dialing 503-370-8050. All calls are routed through our confidential voice mail system. If you have a life-threatening emergency, please dial 911. If you are a current client and have an urgent situation, the on-call counselor can be reached by dialing 503-918-2180. A counselor will return your call as soon as they are able and will make effort to contact your specific counselor directly.

**Confidentiality:** Sessions are confidential with the following exceptions: (1) A report of suspected child abuse; (2) Threats to commit suicide; (3) Threats of violence against another person, (4) Abuse of elderly persons; (5) An acknowledged waiver of the privilege by the client; (6) By court order (7) When contacting a collection agency for nonpayment of fees. Written permission from you is necessary in order for your counselor to release information to another person. Please refer to our Notice of Privacy Practices for a more complete outline of how your confidential information is handled.

**Communications and Your Privacy:** Please know that despite all security efforts, email, cell phone including text messages, and fax communication can be relatively easily accessed by unauthorized people, which can compromise the privacy and confidentiality of such communication. If you convey sensitive personal information by cell phone, email, or fax, your counselor and SPCC assumes that you have made an informed decision accepting this risk. To protect your privacy, we strongly suggest communicating sensitive information in person or on your counselor's confidential voice mail and limiting email or cell phone communication to scheduling issues only. Please also understand that any requests for contact related to social networking will not be confirmed or acknowledged to protect your privacy.

**Legal Issues: ALL COUNSELORS of Salem Pastoral Counseling Center are unwilling and unavailable to testify or advocate in legal situations, disability determination and custody studies.** If you need a court evaluation, testimony in court, or any legal support, your counselor will assist you in finding someone who can provide those services.

**Insurance:** Please review your insurance policy for coverage of outpatient mental health services. Sometimes insurance companies will require pre-authorization and it is your responsibility to obtain this prior to treatment or the insurance will not pay. SPCC will file insurance claims for you, however, this is a courtesy on our part. You are personally responsible for the entire insurance process. We cannot guarantee that the insurance company will reimburse and it is important to understand that you, as the client, remain responsible for whatever portion of the bill your insurance company does not pay. Should there be an overpayment, we will refund the difference either to you or your insurance company, depending on who has overpaid.

**Payment and Billing: You are expected to pay your fee or co-pay at each office visit unless other arrangements are made in advance.** Our first session intake fee is \$195.00 and all subsequent fees are \$165.00 per session. All balances past due 60 days will be assessed a monthly 1.5% finance charge.

**Adjusted Fee Schedule** An income-dependent adjusted fee schedule is also available for those **without insurance**. If you believe you may qualify for the **adjusted fee schedule** (and are willing to provide documentation upon request) please complete the following:

1) Total family gross monthly income: \_\_\_\_\_  
(Include all income before taxes, including child support, spousal support, school grants, and state-assistance programs.)

2) Number of persons this income supports: \_\_\_\_\_  
Please keep your counselor informed of any changes in your financial status, as an increase or decrease of income will affect your adjusted fee.

Additional office information: (to be entered by therapist): \_\_\_\_\_  
If you have any questions, please don't hesitate to ask your counselor or the office staff.

**Consent to Treatment:** I have read the above information and have had the opportunity to ask questions about it. I understand my rights to privacy and the risks associated with treatment. If there are children involved in treatment, I hereby give consent for their treatment and affirm that I am the legal guardian with the authority to consent to treatment. I also agree to the payment and billing policies outlined above and accept full responsibility for any and all fees incurred. I consent to participate in treatment and I understand that I may refuse services at any time. I hereby authorize the Salem Pastoral Counseling Center to provide all information necessary to process all insurance claims. I am also aware that my counselor may periodically consult with other counselors at SPCC and/or with clinical supervisors on client issues. **My signature below indicates I have received a copy of my therapist's Professional Disclosure Statement, Notice of Privacy Practices, and have read, understand and agree to abide with the policies outlined on both sides of this document, and have obtained copies of these documents for future reference.**

1) \_\_\_\_\_  
Client (Legal Guardian) Signature

2) \_\_\_\_\_  
Client (Legal Guardian) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**SALEM PASTORAL COUNSELING CENTER  
CONFIDENTIAL INFORMATION SHEET**

**First Appointment Date** \_\_\_\_\_ **Counselor** \_\_\_\_\_

**Client: Full Name** \_\_\_\_\_

**\* Appointment reminders will be sent to the email and cell ph# listed below.**

**\* Cell Ph#** \_\_\_\_\_ **Ok to Contact and leave message?** **Please Initial Yes** \_\_\_ **No** \_\_\_

I authorize SPCC to send information/correspondence via text message. **Please Initial Yes** \_\_\_ **No** \_\_\_

**\* E-Mail** \_\_\_\_\_ **Ok to Contact by e-mail?** **Please Initial Yes** \_\_\_ **No** \_\_\_

**Client Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

Ok to mail correspondence to this address? **Please Initial Yes** \_\_\_ **No** \_\_\_

**Client Age** \_\_\_\_\_ **Client Birth Date** \_\_\_\_\_ **Social Security# (opt)** \_\_\_\_\_

**Marital Status** \_\_\_\_\_ **Occupation** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Emergency Contact:**

**Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Name/Address of person responsible for your payment (if not the client) \_\_\_\_\_

Names/Ages of Children \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

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**Person #2/Legal Guardian: Full Name** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

Ok to mail correspondence to this address? **Please Initial Yes** \_\_\_ **No** \_\_\_

**Cell Ph#** \_\_\_\_\_ **Ok to Contact and leave message?** **Please Initial Yes** \_\_\_ **No** \_\_\_

I authorize SPCC to send information/correspondence via text message. **Please Initial Yes** \_\_\_ **No** \_\_\_

**E-Mail** \_\_\_\_\_ **Ok to Contact by e-mail?** **Please Initial Yes** \_\_\_ **No** \_\_\_

**Age** \_\_\_\_\_ **Birth Date** \_\_\_\_\_ **Social Security#(opt)** \_\_\_\_\_

**Marital Status** \_\_\_\_\_ **Occupation** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Names/Ages of Children** \_\_\_\_\_

# SALEM PASTORAL COUNSELING CENTER

## AUTHORIZATION FOR INSURANCE BILLING

Counselor: \_\_\_\_\_ Client: \_\_\_\_\_

**Please check with your insurance company prior to receiving services to answer the following questions:**

\$ \_\_\_\_\_ Deductible Amount- How much of your deductible have you met for the current year? \$ \_\_\_\_\_

\$ \_\_\_\_\_ CoPay Amount

\_\_\_\_\_ Does your insurance require pre-authorization? Authorization Number \_\_\_\_\_

\_\_\_\_\_ Anniversary date of Coverage

\_\_\_\_\_ Copy of insurance card has been (or will be) provided (copy of card is preferred)

\_\_\_\_\_ Will payments for services be issued directly from a health spending account?

**(Fill out the following ONLY if copy of card is NOT provided.)**

**Client's Primary Insurance Company** \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber (Name on policy) \_\_\_\_\_ Subscriber DOB \_\_\_\_\_

Subscriber Employer \_\_\_\_\_

**Client's Secondary Insurance Company** \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber (Name on policy) \_\_\_\_\_ Subscriber DOB \_\_\_\_\_

Subscriber Employer \_\_\_\_\_

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I authorize that the above information is accurate and true to the best of my knowledge. I authorize my insurance company to pay Salem Pastoral Counseling Center directly for services rendered according to my mental health coverage. I authorize Salem Pastoral Counseling to provide all information my insurance company(ies) request(s) concerning my treatment. I understand that I am responsible for pre-authorization or doctor's referral if required. I understand that I am financially responsible for services performed whether or not paid by insurance. I understand that any money received in excess of my charges will be refunded when my bill is paid in full. **I understand I am responsible for full payment for any missed sessions, or sessions canceled without 24 hour notice.**

Signature of client or responsible party \_\_\_\_\_

# SALEM PASTORAL COUNSELING CENTER

2001 Commercial St. SE, Suite 200

Salem, OR 97302

503-370-8050 - [www.salempastoralcounseling.org](http://www.salempastoralcounseling.org)

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## Telemental Health Informed Consent Form

I \_\_\_\_\_ [name of client(s)] hereby consent to engaging in telemental health as part of my mental health counseling. I understand that "telemental health" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of mental health data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to telemental health:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my mental health information also apply to telemental health. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards self and/or an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

**In case of emergency my location is** \_\_\_\_\_

**and my emergency contact and phone number is:** \_\_\_\_\_

I understand my counselor may contact my emergency contact and/or appropriate authorities in case of emergency.

I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemental health, including, but not limited to, the possibility, despite reasonable efforts on the part of my counselor, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or limited ability to respond to emergencies.

In addition, I understand that telemental health based services and care may not be as complete as face-to-face services. I also understand that if my counselor believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a counselor who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of mental health counseling, and that despite my efforts and the efforts of my counselor, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from telemental health, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my mental health information and copies of mental health records in accordance with Oregon law.

I have read and understand the information provided above. I have discussed it with my counselor, and all of my questions have been answered to my satisfaction.

\_\_\_\_\_  
Signature of patient/parent/guardian/conservator

\_\_\_\_\_  
If signed by other than patient indicate relationship

\_\_\_\_\_  
Date

**SALEM PASTORAL COUNSELING CENTER  
CONFIDENTIAL PERSONAL HISTORY FORM**

In order to help us provide the best care, please complete this form. If you are not sure about any item, or feel uncomfortable answering, please leave that part blank. Answer what you are able, and speak with your counselor about any areas of concern.

Client information:

Today's date \_\_\_\_\_ Counselor's Name \_\_\_\_\_

Client full name \_\_\_\_\_ Date of birth \_\_\_\_\_

Church Affiliation \_\_\_\_\_

Please describe your reasons for seeking counseling:

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What do you want to accomplish as a result of your counseling here?

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Current Situation:

Relationship status: Married  Separated  Divorced  Single

Long term relationship  How long? \_\_\_\_\_

If in a committed relationship, how would you describe your relationship?

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Children: Names and Ages \_\_\_\_\_

How would you describe your relationship with your children? \_\_\_\_\_

Other people living with you: names and relationship

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Areas of concerns: please check all that apply:

<b>Emotional issues</b>	<b>current problem</b>	<b>problem in past</b>	<b>no problem</b>
anxiety (worry, fear, excessive guilt)			
depression (unhappiness, lack of energy, drive)			
thinking problems (disorganized, confused, unable to focus)			
uncontrolled repetition in thinking and/or behavior			
mood swings (change quickly, hard to control, feeling "numb")			
anger (hard to control, inappropriate anger, resentment)			
grief (feelings of loss, sadness, crying)			
suicidal thinking or action			
nightmares/sleep disturbances			
withdrawn/few friends			
panic attacks			
nervous or repetitive habits			
<b>Behavioral issues</b>			
employment			
legal problems			
gambling			
stealing			
lying			
sexual problems			
obsessions/compulsions			
problems with attention			
eating problems			
learning problems			
pornography			
Alcohol and/or Drugs			
Tobacco			
Setting Fires			
Trauma and/or Abuse			

Have you been in therapy before? No  Yes

Counselor's name \_\_\_\_\_ when ? \_\_\_\_\_

Counselor's name \_\_\_\_\_ when ? \_\_\_\_\_

Have you ever been hospitalized for psychiatric problems? No  Yes

If so, when? \_\_\_\_\_

Medical background:

Name of primary care physician \_\_\_\_\_

Are you currently under medical care? \_\_\_\_\_ Please

describe \_\_\_\_\_

Are you currently on prescription medication? \_\_\_\_\_ Please describe \_\_\_\_\_

Do you take over-the-counter medicine? \_\_\_\_\_ Please describe \_\_\_\_\_

Have you ever had a head injury? No \_\_\_\_\_ Yes \_\_\_\_\_ If so, when \_\_\_\_\_

List any serious medical concerns you are having currently or any medical conditions you've had in the past. \_\_\_\_\_

Family History:

<b>Parent Information</b>	<b>Mother</b>	<b>Father</b>
Alive or deceased?		
Age		
If alive where do they now live?		
Use of alcohol/other drugs now or in the past		
Abusive to you or other family members? (physically, sexually, mentally, spiritually)		
History of mental illness in the family?		
Medical problems? If so what?		

Siblings: names and ages \_\_\_\_\_

Are you adopted? \_\_\_\_\_ Your highest level of school completed \_\_\_\_\_



How would you describe your family when you were a child (example: how parents got along, were they available to you, significant problems, finances, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you describe your current relationships with your family of origin?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Social History:

Describe briefly where you receive emotional or social support (example: church, social events, family, work, hobbies, clubs?) \_\_\_\_\_  
\_\_\_\_\_

Describe briefly your history of making and keeping friends (easy? difficult? many friends? a few close friends? No friends?) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional Information:

Is there any other information you think would be helpful for me to know?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# **Professional Disclosure Statement**

**Sarah Pluister, M.A., LPC**  
**Licensed Professional Counselor**

Salem Pastoral Counseling Center  
2001 Commercial St. SE, Suite 200  
Salem, OR 97301  
503.370.8050 ext. 104  
[Sarah@salempastoralcounseling.org](mailto:Sarah@salempastoralcounseling.org)

## **Philosophy and Approach to Counseling**

Your willingness to seek counseling is a bold and brave decision. As your counselor, I will welcome you with warmth and tenderness and honor your story. I will walk alongside you as you explore and make sense of your experiences, move toward a deeper understanding of yourself and your relationships and begin a process of wholeness. I believe that interpersonal relationships provide the ability to transform and heal our lives. I hope that in working together, our relationship can be one of safety and healing.

I received a Master's Degree in Clinical Mental Health from George Fox University Graduate School of Counseling. I am trained to assist individuals, couples and families that are hurting, in transition or weighed down by life stressors. I work from a systematic perspective, always considering one's family of origin and important relationships. My style is slow and purposeful, with pacing led by you. It would be a true privilege to join you in your journey of transformation, empowerment and freedom.

## **Formal Education and Training**

I have completed my Masters Degree in Clinical Mental Health from George Fox University. My course work has included a variety of classes in Counseling: Human Growth & Development, Spirituality, Sexuality, Couple & Family Therapy, Play Therapy, Sand Tray Therapy, Group Theory & Therapy, Personality & Theory, Psychopathology & Appraisal, Addictions, Cultural Foundations & Social Justice, Lifestyle & Career Development, Neurobiology & Pharmacology. I am also certified with PREPARE/ENRICH couple's assessment and counseling resources. To maintain my license I am required to participate in annual continuing education, taking classes dealing with subjects relevant to my profession.

## **Fee Schedule**

Fees for counseling services are \$195.00 for the initial session and \$165.00 for each subsequent individual session. Some adjustment in fees is possible in cases of need and when discussed in advance with the counselor.

## **Ethics**

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapist, I abide by its Code of Ethics as well as the Code of Ethics of The American Counseling Association and the National Board for Certified Counselors.

## **Client Rights**

As a client of an Oregon licensee, you have the following rights:

1. To expect that a licensee has met the minimal qualifications of training and experience required by state law;
2. To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
3. To obtain a copy of the Code of Ethics;
4. To report complaints to the Board;
5. To be informed of the cost of professional services before receiving the services;
6. To be assured of privacy and confidentiality while receiving services as defined

- by rule and law, including the following exceptions: 1) Reporting suspected child abuse; 2) Reporting imminent danger to client or others; 3) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies; 4) Providing information concerning licensee case consultation or supervision; and 5) Defending claims brought by client against licensee;
7. To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender, race, religion, sexual orientation, marital status, or socioeconomic status.

**Professional Affiliation:** I am a member of the American Counseling Association.

### **Licensing Board**

If you have concerns about the services you have received from me, you may contact the **Board of Licensed Professional Counselors and Therapists at: 3218 Pringle Rd. SE #120, Salem, OR 97302-6312.**

**Telephone: (503) 378-5499**

**Email: [lpct.board@oregon.gov](mailto:lpct.board@oregon.gov) Website: [www.oregon.gov/OBLPCT](http://www.oregon.gov/OBLPCT)**

**Emergencies:** If you are experiencing a mental health emergency, please dial 911.

By my signature, I acknowledge that I have read and understand this therapist disclosure statement. I consent to therapy with Sarah Pluister, according to the terms described here. I have read the preceding information and understand my rights as a client.

# Notice of Privacy Practices

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.***

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how Salem Pastoral Counseling Center (SPCC) may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (“HIPAA”), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

## **Our Obligations**

SPCC is required by State and Federal law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. SPCC is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. SPCC will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

**Uses and Disclosure.** SPCC may use and disclose protected health information without your consent in the following ways.

***For Treatment.*** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment.** We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Without Authorization.** Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

**Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

**Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

**Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

**Medical Emergencies.** We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

**Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

**Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

**Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

**Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

**Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

**Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Research.** PHI may only be disclosed after a special approval process or with your authorization.

**Fundraising.** We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

**Verbal Permission.** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization.** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications;

(iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

## **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at \_\_\_\_\_:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

## **COMPLAINTS**

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at \_\_\_\_\_ or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

**The effective date of this Notice is September 2013.**