# Service Contract

**Side Effects:** Counseling is not always easy, and you may find yourself discussing very personal information. It is possible that you might become anxious during and after these conversations. As you learn more about yourself and your relationships, you may have increased conflicts with others and may become somewhat depressed. Counseling is meant to help alleviate your problems, but at first as you delve into your problems your symptoms may become more acute. You may be asked to try new ways of doing things and we cannot promise what results or outcomes you will experience, which depend on many factors.

**Length of Session:** The intake session is schedule for 60 minutes. Counseling sessions are scheduled for 30 minutes or 45-50 minutes. Additional time (in 30 minutes increments) may be added to a session, as appropriate, with advance scheduling. Group therapy sessions are scheduled for 45-50 minutes. Your provider will also spend time reviewing your progress notes, evaluating assessments, making new notes, phone calls, etc. If you arrive late for your session, the missed time is forfeited in order remain on time for other scheduled appointments and clinical obligations.

**Late Arrival:** Insurance companies can only be billed for the time spent in session with the provider. You will be billed for the missed portion of your appointment. If you are “self-pay” you will be billed for the time scheduled regardless of your arrival time. If you have not called and have not arrived 20 minutes after your scheduled appointment time, the provider will consider you a “no show” and may not be available for any of the remaining scheduled time. Please call if you intend to keep your appointment but are running late.

**Cancelation and No-Show Policy:** If you fail to cancel a scheduled appointment, we cannot use this time for another client, and you will be billed for the entire cost of your missed appointment. **Insurance companies cannot be billed for missed appointments. A full session fee of $145 is charged for missed appointments or cancellations with less than a 24-hour notice** unless it is due to illness or an emergency. **At the Therapist discretion, each client will be allowed one (1) sick/emergency day without being charged the full session fee. On the second cancelation with less than 24-hour notice and/or “no call/no show,”** the card you place on file will be charged at the end of the business day for any balance resulting from

**Fees:**

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| Intake Session | 90791 |  | $125 |
| Individual Therapy | 90832 (16-38 minutes) |  | $70 |
| Individual Therapy | 90834 (39-52 minutes) |  | $100 |
| Individual Therapy | 90837 (53-60 minutes) |  | $145 |
| Family Therapy | 90846/90847 (45 minutes) |  | $100 |
| Group Therapy  Life Coaching  Coaching assessment  Coaching assessment | 90853  Coach (60 minutes)  Co-as  Co-as |  | $45  $125  $75  $100 |

Therapeutic phone calls $100/hour, charged in 15 minute increments with a $15 minimum or other unscheduled contact with the client or on behalf of the client. **Not covered by insurance**

Correspondence $100/hour, charged in 15 minute increments with a $15 minimum including writing letters completing forms etc.

**Not covered by insurance**

Fees for consultation for legal purposes, court appearance and depositions are outlined below.

**Court Appearances:** In general, our providers do not provide court appearances. This is not a forensic practice, and therefore court testimony or any form of support in legal proceedings should not be the primary motivation for seeking services. If this is a service you may need at a future point, please discuss immediately with your provider.

All consultation for legal purposes, court appearances (including subpoenas to appear) and depositions must be scheduled at least one month in advance due to the provider’s full schedule. Consultation for legal purposes, court appearances and depositions are charged at a rate of $200 per hour. This hourly rate is charged for the time that the provider is unable to guarantee services to other clients, not just the time providing consultation, providing testimony or being deposed. Travel expenses will not be charged for locations within Lee County, Alabama. Outside Lee County, Alabama, the client will be billed for actual travel expenses in addition to the hourly fee for the provider’s time. A retainer of $1000 plus travel expenses will be required two (2) weeks prior to the meeting/court/deposition date. Any cancellations of such must be done two (2) weeks prior to the scheduled date. Cancellations made within 14 days of the scheduled appearance will require forfeiture of the retainer due to the disruption in the provider’s schedule. In cases where the meeting, appearance, or deposition date is revised within 14 days of the originally scheduled meeting, appearance, or deposition, a new retainer will be required to secure a new date. The expense of any non-refundable travel arrangements resulting in date revision or cancelation, regardless advance notice, will be billed.

**Appointment Reminders:** Email, text and telephone communication to remind you of your scheduled appointment is a courtesy and is NOT guaranteed. It is the client’s responsibility to attend scheduled appointments regardless of having received a courtesy reminder. You will be charged for late or missed appointments even if a reminder is not received.

**Telephone contact:** This clinic is equipped with voicemail, which is frequently checked throughout normal business hours and at least every 24 hours. Every reasonable attempt is made to respond to all messages within the same day, but it may be up to 24 hours before a call is returned. The clinic phone number does not receive text messages.

**Emergencies:** If you are in a “mental health emergency,” in which you are in need of an immediate therapeutic response, please utilize one of the following resources:

* Call 911
* Immediately go to the emergency room of the East Alabama Medical Center, 2000 Pepperell Parkway, Opelika, Alabama (334) 749-3411
* East Alabama Mental Health Crisis Line **1-800-815-0630**
* Rape Counselors of East Alabama **(334) 705-0510**
* National Suicide Prevention Hotline **1-800-273-8255**

Inform the responding clinician of your immediate mental health needs and follow their responses. Please inform the emergency clinician of your current status as a client enrolled in treatment with this clinic, and sign any consents provided so that this clinic may receive information regarding any emergency assessments and/or treatment recommendations.

**Clinic Closure/Unavailability:** When this clinic is unavailable for more than 48 hours, the clinic will arrange a “covering clinician,” who will be available to respond to your emergency needs, either by telephone or with a face-to-face session. The clinician will be provided with your first name and very basic potential clinical emergency information, so that he/she may appropriately and sensitively assist you during this time. If you have a session scheduled in the time preceding the planned closure/unavailability, this information will be discussed with you prior the closure/unavailability of the clinic. Upon reopening/availability, the “covering clinician” will inform the providers of this clinic of any contacts (telephone or face-to-face session), and will then destroy any materials &/or information obtained. Any fees which may be charged by the covering clinician will also be discussed with you in advance.

**Termination of Treatment:** Ending therapy may be initiated by you as the client, or as legal guardian of the client or the provider. In either event, a final session is strongly recommended to explore the ending process itself. This can be a useful conclusion to treatment. Referrals to other providers or other suggestions can be offered at that time.

**Non-voluntary Discharge from Treatment:** A patient may be terminated from treatment non-voluntarily if: (A) the patient exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the patient refuses to comply with stipulated practice rules, refuses to comply with treatment recommendations, and/or (C) failure to comply with our financial policy and/or (D) failure to comply with no show policies and fees. (E) frequently cancels. Reschedules or missed appointments, and/or (F) is chronically late for scheduled appointments, and/or (G) demonstrates repeated inappropriate use of afterhours/emergency contact/emergency coverage services. The patient will be notified of non-voluntary discharge by letter. Referral to another provider can be made as appropriate. The patient may appeal this decision with the program owner or request services at a later date.

**Referrals to Other Providers:** Providers at this clinic have experience in various areas of practice utilizing specific treatment approaches. In the event the patient presents with, develops, or reveals a problem that is outside the scope of the treating provider, a referral to another provider will be discussed with the patient in session (when possible) and a letter will be provided. The patient has the right to refuse the recommended referral. Doing so does not guarantee that services will continue at this clinic. In accordance with ethical standards of professional practice, providers at the clinic will not work to treat problems for which they lack competency. Additionally, providers at this clinic will not utilize treatment approaches for which they lack competency.

Financial Policy

This form must be completed before future sessions can be scheduled.

Charges for all services are due in advance or at the time of service.

Our office will file insurance on your behalf as a courtesy to you. However, insurance policies and requirements vary greatly by policy and it is the client’s responsibility to understand the requirements and benefits of his/her policy. Our office will assist you as much as possible in understanding your insurance policy and meeting its requirements. The client is responsible for obtaining and maintaining referrals from their physician and/or insurance authorizations required by insurance (when applicable). If for some reason insurance does not cover a visit, the client will be responsible for the charges.

Accounts with a balance for any portion of two or more sessions may result in cancelation of pending future appointments and/or suspension of scheduling future appointments until the balance is paid in full. Failure to follow this financial policy may result in discharge from treatment.

Legal Guardians: The parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. He/She/They will be responsible for making prior payment arrangements with the child’s/adolescent’s other parent or responsible party. This clinic assumes no responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for the child’s/adolescent’s medical care.

Consent to Receive Billing Statements by Email

Billing statement information is considered “Protected Health Information” under HIPAA.

□ By my signature below, I am waiving my right to keep this information completely private, and requesting to receive non-encrypted billings statements to the following email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Date Parent/Guardian Date**

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness Date**

□ I decline to receive non-encrypted billing statements by email. I understand this will prevent my ability to pay statements online.

Financial Policy continued

**To facilitate the handling of cancelations with less than 24 hours-notice and/or “no call/no show,” all clients are required to provide a credit/debit card that will be saved on file. In rare cases, the client may not have a credit/debit card, a check or cash in the amount of the missed full session will be expected on the following appointment.**

I understand that Soul-Affirming Counseling is NOT responsible for keeping up with insurance company’s deductible, co-pays and/or the number of visits authorized by my insurance or referring physician. I also understand that my insurance company is NOT responsible for my bill, but that I am. If my insurance company does not pay in a timely manner, I will pay the bill in full.

I, the undersigned, hereby agree to pay all amounts and charges for services rendered by Soul-Affirming Counseling no later than 30 days of the rendering of said services unless other specific arrangements are made. I am aware of the cancelation, no show, and late arrival policy.

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**Patient Date Parent/Guardian Date**

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**Witness Date**

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| For office use:  Paid by \_\_\_\_\_\_ Cash in the amount of $\_\_\_\_\_\_\_  \_\_\_\_\_\_ Check in the amount of $\_\_\_\_\_\_\_ check # \_\_\_\_\_  Staff Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Financial Policy continued

In the event your card fails to process, you will be notified by phone, email, and/or mail and provided an opportunity to update your billing information. Balances that remain past 30 days will accrue a service fee of $10 a month every month the balance remains.

Feel comfortable knowing this document is locked and secured at all times. You are welcome to change credit cards at any time by completing and signing a new form.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Amex \_\_\_\_\_Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ Discover

Name on the Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exp Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

Billing Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Soul-Affirming Counseling or representative of Soul-Affirming Counseling to charge my credit/debit card based upon the provisions listed above.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Date Parent/Guardian Date**

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**Witness Date**

**Notice of Patient Confidentiality**

The confidentiality of patient records maintained by Soul-Affirming Counseling, LLC DBA Soul-Affirming Counseling is protected by federal and/or state law and regulations. Violations of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. All counseling appointments, records, and identification information is kept strictly confidential and is destroyed after 7 (seven) years.

Support staff have limited access to information regarding clients as they make appointments and perform ordinary business operations. There may be times when your provider, may need to consult with a supervisor or with a colleague or another professional, such as an attorney, concerning issues raised by you in therapy. Confidentiality is not waived during these consultations. These professionals are bound by ethical standards including confidentiality. By signing this confidentiality notice, you give permission for your provider to consult with other professionals as needed to provide professional services to you. This permission may be revoked at any time.

When the clinic schedules to be closed/unavailable for more than 48 hours, arrangements will be made for a “covering clinician”. The “covering clinician” will be available to respond to your emergency needs, either by telephone or with a face-to-face session. By signing below, you agree to allow this clinic to provide the “coving clinician” with your name and very basic potential clinical emergency information, so that he/she may appropriately and sensitively assist you during this time. Confidentiality is not waived in this circumstance. The “covering clinician” is bound by ethical standards including confidentiality.

Generally, the practice may not say to an outside person that a patient receives treatment or disclose any information identifying a patient as a patient unless: **(1)** the patient consents in writing, **(2)** the disclosure is allowed by a court order, **(3)** the disclosure is made to medical or law enforcement personnel in an emergency, **(4)** to qualified personnel for audit, program evaluation, or **(5)** to the insurance company paying for the service.

Federal and/or state laws and regulations do not protect information as follows:

1. In cases in which the client discloses or implies a plan for self-harm, the provider is required to notify law enforcement and make reasonable attempts to notify the family/significant other(s) of the client.
2. When a client discloses intentions or a plan to harm another person, the provider is required to warn the intended victim and report this information to law enforcement.
3. If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the provider is required to report this information to the appropriate social service and/or law enforcement authorities.
4. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
5. Crimes committed by a patient either at the clinic location, against any person who works for/with/at the clinic, or about any threat to commit such a crime.
6. In the event of a patient’s death, the spouse to parents of the deceased patient have a right to access their child’s or spouse’s records.
7. Professional misconduct be a health care professional must be reported by other health care professionals, in which case, related patient records may be released to substantiate disciplinary concerns.

**NOTICE OF PRIVACY PRACTICES**

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

**OUR LEGAL DUTY:** We are required by applicable federal and state law to maintain the privacy of your health information. “Protected Health Information” is information about you, including demographic information, that may identify you that relates to your past, present, or future physical or mental health condition or related health care services. We are also required to give you Notice about your privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect 11/5/2018 and will remain in effect until we replace it. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of the Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION:** Uses and Disclosures of Protected Health Information are based upon your written consent. You will be asked by your therapist to sign an acknowledgment of receipt form. Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health care information may also be used and disclosed to pay your health care bills and to support the operation of this practice.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may treat you when we have the necessary permission from you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and/or treat you. Additionally, your protected health information may be disclosed to another physician or health care provider (e.g. a specialist or laboratory) who becomes involved in your care, to a pharmacy as part of your treatment by your therapist and may be used for research purposes.

**Payment:** Your protected health will be used as needed to obtain payment for your health care services. This may include certain activities that your health insurance company requires before it approves or pays for services we recommend for you such as; making a determination of eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

**Healthcare Operations:** We may use or disclose, as needed, your protected health care information in order to support the business activities of your therapists’ practice. These activities include, but are not limited to volunteer work, evaluating practitioner and provider performance, licensing or credentialing activities. (E.g. we may call you by name in the waiting room when your health care provider is ready to see you, or when contacting you to remind you of an appointment) Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time except to the extent that your therapist or the practice has taken action in reliance on the use or disclosure indicated in the authorization.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim or perpetrator of abuse, neglect, or domestic violence or the possible victim or perpetrator of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. We may use and disclose your protected health information in the following instances (emergencies, as required by law, or worker’s compensation). You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object, then your therapist may, using professional judgment, determine whether the disclosure is in your best interest.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your therapist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment.

**Required by Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and you will be notified, as required by law, of any such disclosures.

**Worker’s Compensation:** Your protected health information may be disclosed as authorized to comply with worker’s compensation laws and other similarly legally established programs

**YOUR RIGHTS:** The following rights are extended to every client of all ages without reservation or limitation:

1. The right to confidentiality: The client has the right to every consideration of privacy concerning his or her medical care program, including HIV status and testing. All case discussion, consultation, communications, records, and medical information pertaining to his or her care will be treated as private and confidential;

2. The right to have impartial access to treatment regardless of age, psychological characteristics, sexual orientation, physical condition, race, religion, gender, ethnicity, marital status, HIV status, criminal record, or source of financial support;

3. The right to have personal dignity recognized and respected in the provision of all care and treatment;

4. The right to religious freedom;

5. The right to receive individualized treatment including the provision of an individualized treatment plan based upon information of all assessments, active participation in the development of the treatment plan by the client with periodic review of the plan by staff, and implementation and supervision of the plan by qualified professional staff;

6. The right to make decisions about the treatment plan prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and to be informed of the medical consequences of this action. In case of such refusal, the client is entitled to other appropriate care and services that Soul-Affirming Counseling, LLC provides, or they may transfer to another facility;

7. The right to know the immediate and long-term financial implications of treatment choices, insofar as they are known.

8. The right to obtain from clinician, or other staff involved in direct care, relevant, current, and understandable information concerning diagnosis, treatment, and prognosis. The right to review the records pertaining to his/her treatment and to have the information explained or interpreted as necessary, except when restricted by law. If you request a copy of your records, we may charge you a reasonable fee for copying and mailing your record.

9. The right to know the identity of physicians, nurses, and others involved in their care, as well as when those involved are students, interns, residents, or other trainees;

10. The right to expect that, within its capacity and policies, the practice will make reasonable response to the request of a client for appropriate and medically indicated care and services. Soul-Affirming Counseling, LLC must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, or when a client has so requested, a client may be transferred to another clinician’s care. The clinician to whom the client is to be transferred must first have accepted the client for transfer. The client must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer;

11. The right to ask and be informed of the existence of business relationships among the clinic, hospital, educational institutions, other health care providers, or payers that may influence the client’s treatment and care;

12. The right to consent to or decline to participate in proposed research studies or human experimentation affecting care and treatment or requiring direct client involvement, and to have those studies fully explained prior to consent. A client who declines to participate in research or experimentation is entitled to the most effective care that the clinic can otherwise provide;

13. The right to receive prescribed services within the least restrictive but appropriate environment;

14. The right to assurance and protection of privacy and confidentiality of communication with treatment staff, and of material written in the client’s individualized record;

15. The right to be presumed mentally competent unless a court has ruled otherwise;

16. The right to a clean and humane environment in which you are protected from harm, have privacy with regard to personal needs, and are treated with respect and dignity;

17. The right to be free from mistreatment, abuse, neglect, and exploitation;

18. The right to expect reasonable continuity of care when appropriate and to be informed by clinicians and other caregivers of available and realistic client care options;

19. The right to initiate a complaint or grievance, with the assurance of no retaliation, and to be informed of the appropriate grievance process;

20. The right to be informed that Soul-Affirming Counseling, LLC has the right to terminate care with a 30-day written notification given to the client with a listing of referrals for continuity of care;

21. The right to request an amendment to your record if you believe something in your record is incorrect or incomplete. Ask for the Request to Amend Health Information form.

22. You have the right to be informed of all program rules and regulations concerning your conduct and course of treatment.

23. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. We will accommodate reasonable requests.

If you have a complaint about the services provided, you may file a grievance by doing the following:

**Step One:** Discuss the issue with your therapist or doctor. He or she is there to help you with any issue that arises. It is never an inconvenience for them to assist you.

**Step Two:** If the therapist or doctor is not able to adequately assist you with your concern and you have still not had your issues resolved, contact kerry Baharanyi, MSW, LCSW, PIP Telephone & Fax: (334) 539-8051 Address: 318 N. College Street, Suite# G Auburn, AL 36830

**Changes to Privacy Policy**: We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. If we revise our policies and procedures, we will post a copy of any revised Notice at the clinic.

**Other Uses and Disclosures**: Other uses and disclosures of you PHI not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to you or disclose PHI about you, you make revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer disclose PHI about you for the reasons covered by your written authorization. Be aware that we are unable to take back any disclosures we have already made with your permission, and we are required to retain our record of care that we provide to you.

**FILING OF COMPLAINTS AGAINST HIPAA-COVERED ENTITIES BELIEVED TO BE NON-COMPLIANT**

**WITH HIPAA PRIVACY RULE**

Complaints must be written to the Secretary of HHS, have occurred on or after April 14, 2003, and meet the following requirements:

* Be filed in writing, either on paper or electronically.
* Name the entity that is the subject of the complaint and describe the acts or omission believed to be in violation of the applicable requirements.
* Be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the ORC for good cause is shown.

Electronic complaints should be sent to ORCComplaint@hhs.gov. Mailed complaints must be addressed to the ORC regional office that is responsible for matters relating to the Privacy Rule arising in the State or jurisdiction where the covered entity is located.

Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, or Tennessee)

Office for Civil Rights - U.S. Department of Health and Human Services

Atlanta Federal Center, 61 Forsyth Street SW, Suite 3B70, Atlanta, GA 30303-8909

**Social Media Policy**

This document outlines clinic policies related to use of Social Media. Please read it to understand how our providers conduct ourselves on the Internet as a mental health professional and how you can expect us to respond to various interactions that may occur between us on the Internet.

If you have any questions about anything within this document, you are encouraged to bring them up with your provider. As new technology develops and the Internet changes, there may be times when this policy needs to be updated. A copy of the updated policy will be posted at the clinic for your review.

**Friending**: Our providers do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.) We believe that adding clients 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 with your provider

**Liking/Following/Sharing:** This practice will create a Facebook/YouTube page in the future intended for self-expression, to allow people to share blog posts, and practice updates with other users. All of the information shared on the page will be available on the practice website. You are welcome to view all the network pages and read or share articles posted there. A blog is published on the practice website. This is a commentary on relevant issues related to mental health, quality living, and self-actualization. You are welcome to view the blog and read or share the articles/videos posted there. There is no expectation that you as a client will want to follow the Facebook/YouTube page and/or blog.

You are encouraged to exercise caution when “liking” “following” “sharing” “posting” and/or “commenting” on the Facebook/YouTube page and/or blog. Your activity (“liking” “following” “sharing” “posting” and/or “commenting”) is your own voluntary action and there are potential consequences including public awareness/assumption of your status as a client, public awareness/assumption about your diagnosis, problem(s), challenges etc. Please carefully consider these and other potential consequences before you “like” “follow” “share” “post” and/or “comment”. Note that you should be able to subscribe to the page via RSS without “liking” or “following” and without creating a visible, public link to the Facebook/YouTube page or blog. You are more than welcome to do this.

**Interacting:** Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, YouTube, or LinkedIn to contact your provider. These sites are not secure, and messages may not be read in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with clinic providers in public online if we have an already established client/therapist relationship. Engaging with providers this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to make contact with your provider between sessions, the best way to do so is by phone.

**Location-Based Services:** If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. This clinic is not placed as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at this clinic. Please be aware of this risk if you are intentionally “checking in,” from the clinic location or if you have a passive LBS app enabled on your phone.

**Use of Search Engines:** It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If there is reason to suspect that you are in danger and you have not been in touch with the office via usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if our providers ever resort to such means, this will fully document it and discussed it with you when you attend session. If there are things from your online life that you wish to share, please bring them into session where we can view and explore them together.

**Google Reader:** Providers at this clinic do not follow current or former clients on Google Reader and do not use Google Reader to share articles. If there are things you want to share with your provider that you feel are relevant to your treatment whether they are news items or things you have created, you are encouraged to bring these items of interest into session.

**Business Review Sites:** You may find this practice/clinic on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find this clinic or any providers at this clinic on any of these sites, please know that the listing is NOT a request for a testimonial, rating, or endorsement from you as a client.

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, our providers cannot respond to any review on any of these sites whether it is positive or negative. You should also be aware that if you are using these sites to communicate indirectly with your provider about your feelings about our work, there is a good possibility that we may never see it. If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

Since you are working WITH your provider, we hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit.

We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. Our primary concern is your privacy. If you share this concern, there are more private ways to follow content such as using an RSS feed, which would eliminate your having any public link to the content. There are more private ways to have your concerns and feedback heard such as a direct discussion with your provider.

None of this is meant to keep you from sharing that you are in therapy wherever and with whomever you like. Confidentiality means that we cannot tell people that you are a client. But you are more than welcome to tell anyone you wish that you are in therapy, who your provider is and/or how you feel about the treatment provided to you, in any forum of your choosing.