<u>HIPPA Notice of Privacy Practices</u>

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective October 1, 2006

This office will only release protected health information (PHI) in accordance with state and federal laws and the ethics of the counseling profession. This notice describes policies related to the use and disclosure of client healthcare information.

Use and disclosure of protected health information for the purposes of providing services: Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes. Following are examples of ways in which health information may be used or disclosed: a) Treatment - provide, manage or coordinate care within the course of mental/medical health treatment, including consultation with specialist provider of services, counseling supervision/consultation, and referral resources; b) Payment - verification of insurance and coverage; processing of claims and collecting fees; c)Healthcare Operations - review of treatment procedures, review of business activities, certification, staff training, compliance and licensing activities. Other uses and disclosures without your consent may include: mandatory reporting (e.g., intent to harm; known abuse of minor, dependent adult, or developmentally disabled person); emergency/crisis situations; appointment scheduling; treatment alternatives; or as required by law.

<u>Client Rights</u>

Under state and federal law, you have the following rights:

- To release of your medical records to a third party upon written authorization signed by you, as well as the right to revoke a release in writing. Revocation is not valid to the extent that you have acted in reliance on previous authorization.
- To inspect and copy my medical billing records, though request may be denied by the counselor, and a fee may be charged for copy and delivery of records.
- To add information or amend medical records, within 7 days of request to review records. Although the request to add or amend information may be denied, in such case you have the right to file a disagreement statement, which will be filed with your record upon written request.
- To accounting of disclosures for a period of six years with the exception of disclosures made in relation to: treatment, payment or healthcare operations; pursuant to a signed release of information form; made to the client; or for national security or law enforcement.
- To request, in writing, restriction on uses and disclosures of healthcare information.
- To request notification of any future changes in these policies.
- To request contact information for your counselor.
- To make formal complaint without fear of retaliation, if concerned about the quality or professionalism of the care your receive here. Complaints may be made to: WA Dept. of Health, Health Professions Quality Assurance Division, P.O. Box 47850, Olympia, WA 98504-7850.

Cancellation/No Show Policy

Individuals who regularly keep their appointments are more likely to benefit from counseling than those who do not. However, it is understood that sometimes appointments cannot be kept. Please make every effort to call if you are unable to make an appointment, so that your time may be offered to someone else. Failure to show without notification (no show), or cancellation within 24 hours of scheduled appointment will be subject to full fee that would otherwise be charged for the session, or as allowable by contract and law.

Consent for Treatment

My signature below indicates my consent to receive treatment from Laura Doughty, M.S., LMHC. I understand that informed consent is an ongoing process. I will be provided information about my condition, proposed interventions, treatments, potential benefits, risks and side effects, problems related to recovery, likelihood of success, and possible alternative treatment or interventions. I have been informed that in the case of suspected abuse/neglect of a child, dependent adult or developmentally disabled person will be reported to the state as required by law. I understand that I may refuse or withdraw from any aspect of assessment or treatment at any time, as permitted by law.

Emergency/Crisis Care

Although I make reasonable efforts to be available for phone calls and last minute appointments during times of emergency, I cannot be available at all times. I will attempt to return phone calls in a timely manner for brief conferences between sessions as needed, and I check my voicemail several times a day when in town.

If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian agrees to contact the emergency services in the community (911) for those services, or go to the Emergency Room. Laura Doughty, M.S., LMHC will follow those emergency services with standard counseling and support to the client and/or the client's family.

I have read and understand these notices regarding HIPPA Notice of Privacy Practices, Client Rights, Cancellation/No Show Policy, Consent for Treatment, and Emergency/Crisis Care.

_______________________________________ _______________

Client Signature Date

_______________________________________ _______________

Client Name (please print) Phone Number

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We consent that ________________________________ maybe treated as a client. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.

Signature(s)___________________________________Date______________