Emotional Wellness Counseling, Inc.

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New Bedford, MA 02745

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Notice of Privacy Practices and Business Policies

We would like to welcome you to our office.
This document (the Agreement) contains important information about professional services and business policies, together with client/patient rights and responsibilities. Please read this required document in its entirety as you will be asked to sign it accordingly. It also contains summary information about HIPAA: The Health Insurance Portability and Accountability Act. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

COUNSELING(THERAPY PROCESS and SERVICES: Therapy is a relationship that works in part because of the clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to facilitate and create change. Psychotherapy has both benefits and risks. Risks sometimes can include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. In time, this can lead to benefits for individuals who undertake it. Therapy can lead to a 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. There are however no guarantees about the outcome. Psychotherapy does require active effort on your part. In order to be most successful, you will have to work on things that we discuss outside of sessions. An initial evaluation is conducted. During that time, we will discuss if you would like to continue services and if this therapeutic relationship will be beneficial. Appropriate referrals will be made accordingly based on our decision at that time.

PROFESSIONAL RECORDS: We are required to keep appropriate records of the services provided. Although psychotherapy often includes discussions of sensitive and private information, in most cases brief records are kept noting that you have been here, what was done in session, and a mention of the topics discussed. Your records are maintained in a secure locked location and/or in an approved web-based behavioral health Practice Management System that has been chosen as having met security protocol standards set forth by HIPAA.

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").**

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

CONFIDENTIALITY: Sessions are confidential, and will be discussed with other people only with your written permission. Please note that confidentiality is limited in the case of a medical emergency, under a court order/subpoena, or as required by law. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are, however, several exceptions in which I am legally bound to take action even though that requires revealing some information about a patient's treatment. If at all possible, I will make every attempt to inform you when such exceptions will have to be pyt into effect. The legal exceptions to confidentiality include, but are not limited, to the following:
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 be done only 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 services due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.
For Health Care Options: 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 (eg-, billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI will be disclosed only with your authorization. **Required by Law:** Under the law, we must make disclosures of your PHI to you upon 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.

1. If there is good reason to believe that you are threatening to harm yourself or others. In this event I am required to seek hospitalization for you and/or contact the police, as well as additional means to provide protection.

2. If there is good reason to suspect, or evidence of, abuse and/or neglect toward children, the elderly or disabled persons. In such a situation, I am required by law to file a report with the appropriate state agency.

3. In response to a court order or where otherwise required by law.

4. To the extent necessary, to make a claim on a delinquent account via a collection agency.

5. To the extent necessary for emergency medical care to be rendered.

Information about Professional Services and Business Practices

Please note there are times when I find it beneficial to consult with colleagues as part of my practice for mutual professional consultation. Your name and unique identifying characteristics will not be disclosed. The consultant is also legally bound to keep the information confidential.

Insurance and/or Managed Care:

If you will be using your behavioral health insurance benefits, we will discuss with you the sessions covered, your co-payment contract, and any additional paperwork required by your insurance company. Please be aware that most managed care companies offer a limited number of sessions and we will discuss with you how to best utilize these sessions. Please note that insurance companies will require that we release certain protected health information to them, including the diagnosis, treatment plan, and progress. Even though your policy may allow for a certain number of sessions per year, your managed care company may require that the sessions be approved in advance and they will review and approve a specific number of sessions as deemed "medically necessary." The therapist is to identify and/or treat an illness that has been diagnosed. Treatment under your insurance company is for the purpose of helping the client return to an overall good level of functioning, and is not for continued "growth therapy".

Verbal Permission:

We may use or disclose information to family members that are directly in your treatment with your verbal permission.

Written Permission:

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Patient Rights:

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to your therapist at 52 Brigham Street, Suite #5, New Bedford, MA 02740:

1. Right of Access to Inspect a copy. You have the right, which may be restricted to copy PHI that may be 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 harm to you. We may charge reasonable, cost-based fee for copies.

2. 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.

3. Right to an Accounting Disclosures. You have the right to request an accounting 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.

4. 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.

5. Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

6. Right to a Copy of this Notice. You have a right to a copy of this notice.

SOCIAL MEDIA & PUBLIC EVENTS POLICY: As part of our professional relationship, clear boundaries will be maintained as follows:

INTERNET SOCIAL MEDIA: There will be no connection created on any internet social media account such as Facebook, LinkedIn, etc. Email is limited and will only be utilized for appointment changes or minimal information exchange. The only E-mail server utilized will be via my practice secure web portal or my encrypted E-mail account. This is strictly for your privacy and protection. E-mail is not to be utilized for emergencies.

Text Messaging is not accepted by this practice as appropriate for secure information exchange.

SOCIAL/PUBLIC EVENTS: If we encounter each other in the community at large, as your therapist I will not acknowledge that I know you. I am bound to keep our professional relationship confidential; therefore I will not initiate contact in public. You are free to initiate contact with your therapist. By signing this document, I acknowledge that I have read the above Agreement of Understanding and give Informed Consent to treatment services as well as agree to the policies set forth in the Agreement. I also acknowledge that I have had the opportunity to read the separate Privacy Practices/HIPAA disclosure and that I may ask for printed copies of these forms. If treatment involves your minor child, you as parent/guardian give consent and agreement to services for your child as set forth in this Agreement

COMPLAINTS:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to your therapist at 52 Brigham Street, Suite 5, New Bedford, MA 02740, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

I acknowledge that I have had the opportunity to read these Privacy Practices/HI PM disclosures.

Your signature is your acknowledgement of having been informed of these policies;

_____ ____/____/____

Client Signature (*if minor* Parent, or Legal Guardian) **Date**