Gold Counseling Services

Client Service Agreement and Notice of Privacy Practices and Client Rights

Welcome to Gold Counseling Services, P.C. This notice describes information about the professional services and business policies of this practice, as well as how your medical information may be used and/or disclosed to carry out treatment, payment or health care operations and for other purposes permitted or required by law. 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 we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA") and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI. It also describes your rights to access and control your PHI in some cases.

Our practice is strongly committed to protecting the confidentiality and security of your protected health information. The Health Insurance Portability and Accountability Act (HIPAA) law requires that we maintain the privacy of your protected health information, provide you with notice of our legal obligation and privacy practices with respect to your protected health information, and follow the terms of the notice that is currently in effect. We reserve the right to change the terms of this Notice at any time. A revised notice of privacy practices will be effective for all protected health information that we maintain. If the practice revises this Notice, a current revised copy of the Notice may be obtained upon request or by accessing the practice's website at: www.goldcounselingservices.com.

The law requires that your signature be obtained acknowledging that you have been provided with this information before the end of today's session. Please be sure to read this document carefully and raise any questions you may have so we can discuss them. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. Such a revocation will be binding on us unless action has been taken in reliance on it; if there are obligations imposed by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

THERAPEUTIC SERVICES AND APPOINTMENTS

Psychotherapy is a complex, interactive process that varies depending on the needs and problems the client or family may be experiencing as well as the relationship between the therapist and client. There are many different methods and approaches that may be used to address the problem(s) for which you are seeking therapeutic services. However, in order for psychotherapy to be successful, it requires your active participation in therapy sessions and the development of a positive working relationship between us. It involves your work on identified issues both during and outside of therapy sessions.

Appointments are 50-minutes in length. The frequency of sessions may vary depending on your individual needs and circumstances. The first 2-4 sessions typically involve an evaluation of your/your child's needs. During this time, we can both decide whether we are compatible to provide the services you need in order to meet your treatment goals. By the end of the evaluation, we will offer first impressions of what our work will include and treatment recommendations, if you decide to continue

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with therapy. If you have questions about the therapy process or procedures, please share them whenever they arise so that we can discuss them.

CANCELLATION POLICY

Appointments must be cancelled **at least 24 hours in advance** of the scheduled session. If you do not call to cancel and/or fail to show, you will be charged the full fee for that appointment. The therapist reserves the right to charge the full fee to your credit card on file at the time of the missed appointment. Extenuating circumstances are considered when appropriate. When possible, we will try to find an alternate time to reschedule the appointment. It is important to note that insurance companies do not provide reimbursement for missed sessions.

PROFESSIONAL FEES AND PAYMENT

The fee for each hourly session is $160.00, unless another fee is agreed upon with your therapist. There is no additional charge for an initial evaluation. In addition to therapy sessions, you will be billed for other professional services you may need; services lasting longer than 15 minutes will be billed at a prorated hourly rate. Other billable services may include, but are not limited to: report writing, telephone conversations, consultation and/or attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing other services you may request. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. The hourly fee for preparation and attendance at any legal proceeding is $160.00.

Payment is expected at the time of each session, unless another arrangement is agreed upon in advance. If you experience difficulty making payment due to financial hardship, please speak with your therapist, who may be willing to negotiate a temporary fee adjustment or payment installment plan. You may stop treatment at any time; however, you will still be responsible for payment of services you have already received. Fees are subject to increase at any time; you will be notified verbally or in writing 30 days in advance of the fee increase.

If your account balance has not been paid for more than 60 days and arrangements for payment have not been agreed upon or been successful, we reserve the right to use legal means to secure payment. Services may also be terminated. This may involve hiring a collection agency or going through small claims court; we will only disclose the minimum amount of PHI necessary for purposes of collection. In no instance will such action be undertaken without what we consider to be reasonable attempts to reconcile your account with you. You will be notified in writing prior to collection actions. If such legal action is necessary, collection and related costs will be added to the claim.

INSURANCE REIMBURSEMENT

Although your therapist does not accept insurance and is an out of network provider, this Practice offers to submit claims to your insurance company for all services provided, with your consent, to facilitate your insurance reimbursement. In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. Most health insurance policies provide some coverage for mental health treatment. Your therapist and/or the billing specialist for Gold Counseling Services, P.C. will provide whatever assistance possible in order to help you receive the

benefits to which you are entitled. However, you (not your insurance company) are responsible for full payment of services provided. We strongly encourage you to be informed about the specific mental health benefits that your insurance policy covers; you may request the assistance of the billing specialist with Gold Counseling Services, P.C. or contact your insurance company directly to obtain this information, including pre-certifications, pre-authorizations, pre-notifications, deductibles, co-pays, coinsurance, and total sessions allowed. If you do not consent for this Practice to submit claims directly to your insurance company, you will receive a monthly statement of services provided and the clinical information necessary for insurance reimbursement. Please be aware that insurance companies do not reimburse for missed appointments.

It is important to note that using insurance companies for reimbursement requires that you authorize us to provide information relevant to the services provided, including a clinical diagnosis and additional treatment information that may be required. Every effort will be made to release only the minimum amount of information necessary for the intended purpose.

CONTACTING YOUR THERAPIST

You may leave a confidential voicemail at the number provided to you by your therapist. Regarding voicemail messages, please understand that messages are retrieved regularly Monday through Friday. Every effort will be made to return voicemail messages within 24 hours, except for messages left over the weekend and holidays, which will be retrieved the next business day. Although email and text messaging may be used for purposes of scheduling or other communications, it is recommended that clients not use electronic communication to regularly share personal information, as it is not completely secure nor confidential. In order to maintain your confidentiality and our respective privacy, we do not interact with clients on social networking websites and will not respond to friend requests or messages through these sites.

You will be informed in advance if your therapist will be unavailable due to vacation or other circumstances and will provide you with the name of a colleague to contact, if necessary. In the event of an emergency, call 911 or go to the nearest emergency room. If it becomes evident that the nature of the presenting concerns exceeds the availability of your therapist and/or this practice, referrals will be offered.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Communications between a client and psychotherapist are privileged (confidential) and may not be disclosed without the written authorization of the client or the parent or legal guardian of the minor client, except under specific, limited circumstances permitted by the IL Mental Health and Developmental Disabilities Confidentiality Act and/or HIPAA.

- **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 with your authorization.
- **Consultation:** As part of continuing education and providing the highest quality of care and therapeutic services, your therapist may discuss cases with other qualified professionals as needed. During a consultation, every effort will be made to withhold identifying information about the client. Colleagues and supervisors are legally bound to keep the information confidential.

- **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, or quality assurance. All staff are bound by the rules of confidentiality and trained about protecting your privacy.
- **Health Care Operations:** We may use or disclose, as needed, your PHI in order to support 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

As social workers licensed in this state and as members of the National Association of Social Workers, it is our practice to adhere to the most stringent privacy requirements for disclosures without an authorization. The following language addresses these categories of uses and disclosures without an authorization to the extent consistent with the *NASW Code of Ethics* and HIPAA.

- **Child Abuse or Neglect:** If there is reasonable cause to believe that a child under 18 who is known to us in our professional capacity may be abused or neglected, the law requires that we file a report with the Illinois Department of Children and Family Services. Once such a report is filed, we may be required to provide additional information.
- **Abuse/Neglect of the Elderly:** If there is reason to believe that an adult over the age of 60 living in a domestic situation has been abused or neglected in the preceding 12 months, the law requires that, as mandated reporters, a report be filed with the agency designated to receive such reports by the Department of Aging. Once such a report is filed, we may be required to provide additional information.
- **Duty to Warn:** If a client makes a specific threat of violence against another or if your we believe that you present a clear, imminent risk of serious physical harm to another, we may be required to disclose information to the appropriate person(s) in order to take protecting actions. These actions may include notifying the potential victim, contacting the police, or seeking your hospitalization.
- **Risk of Self-Harm:** If we believe that you present a clear, imminent risk of serious physical or mental injury or death to yourself, we may be required to disclose information in order to take protective actions. These actions may include disclosing your PHI to: a) medical personnel in order to prevent serious harm or b) family members or others as necessary to prevent serious harm.
- **Legal Proceedings:** If you are involved in a legal proceeding and a request is made for information concerning your diagnosis and/or treatment, such information may be protected by the IL Mental Health and Developmental Disabilities Confidentiality Act and/or HIPAA. Health

information about you cannot be disclosed without a court order or a written authorization signed by someone with authority. Once a court order is issued, we must comply or challenge the court order. By signing this Notice, you agree not to attempt to engage your therapist in a legal proceeding, such as a divorce or post-decree proceeding, in order to further your legal position.

- **Health Oversight Activities:** We may be required to disclose your protected health information to a government agency conducting health oversight activities, such as audits or investigations.
- **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.
- **Verbal Permission:** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.
- **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.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and will only disclose the minimum amount of information necessary. Clients are encouraged to discuss any questions or concerns about the limits to confidentiality at any time during the course of treatment. The laws governing confidentiality are complex; formal legal consultation will be utilized as needed.

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: a) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; b) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications;

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

PROFESSIONAL RECORDS AND CLIENT RIGHTS

A clinical record will be maintained of your PHI and the therapeutic services received. This record includes mental health/medical information, billing and insurance records, and any other records that are used to provide services and make decisions about your care. You have the right to access and review your record and the right to receive a copy of your record. Requests to review and/or receive a copy of your clinical record must be made in writing and submitted to your therapist. If requested, you will be provided with a copy of your records within 30 days of the request. Because professional records can be misinterpreted by untrained readers, it is recommended that you initially review them in our presence or have them forwarded to another mental health professional so you can discuss the contents.

You have the right to:

- **Request a copy of your clinical record**, as described above. Your right to inspect and copy PHI will be restricted in situations where there is evidence that access may cause harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. You may also request that a copy of your record be provided to another person.
- **Request that your record be amended** if you feel that the PHI we have about you is incorrect or incomplete, although we are not required to agree to the amendment. If we disagree with your request, we will explain why in writing usually within 30 days. Please contact the Privacy Officer if you have any questions.
- **Request restrictions** on what information from your clinical record may be used or disclosed to others for treatment, payment, or health care operations. We are not required to agree to your request. However, if you have paid for services out-of-pocket in full, you can ask us not to share PHI for those services to a health plan for the purpose of payment or health care operations and your request will be granted.
- **Request an accounting of disclosures** or list of those with whom protected health information has been shared.
- **Request confidential communications** by having us contact you in a certain way or at a certain location (for example, a preferred phone number or alternate mailing address).
- **Breach notification:** If there is a breach of your health information that was not properly secured, you have the right to be notified, including what happened and what you can do to protect yourself.
- **Request a copy of this Agreement and Privacy 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 in writing at **3000 Dundee Road, Suite 111, Northbrook, IL 60062**. You also have the right to file a complaint 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.

Gold Counseling Services

MINORS

The treatment of a minor must be authorized by a parent or guardian. For minors under 12 years of age, parents/guardians have the right to access their child's treatment records and authorize the release of information related to their child. Minors between the ages of 12 and 18 have the right to limit access by their parents/guardians and others to their mental health records. Parents/guardians of children between the ages of 12 and 18 may examine their child's record so long as the child consents and the therapist does not find any compelling reasons for denying the access. Parents/guardians of minors are entitled to information concerning their child's therapy, including current physical and mental condition, diagnosis, treatment needs, and services provided and needed, including medication, if any. The guardian of a client age 18 or older is also entitled to such information. When a child client turns 18, control of treatment as well as the clinical record information reverts to the client as a legal adult.

Since parent/guardian involvement is often crucial to successful treatment, we may ask that minor clients allow parents/guardians' access to certain additional treatment information, such as their therapy progress, attendance, or other relevant information with the child's authorization. The limits of confidentiality, as outlined in this Notice, are clearly explained to all minor clients and parents/guardians when services begin.

The effective date of this Notice is December 1, 2016; Revised April 2017.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT TO SERVICES

I acknowledge that I have received and reviewed the Service Agreement for Gold Counseling Services, P.C. My signature below indicates my acceptance of and agreement to its terms during our professional relationship. My signature also services as an acknowledgement that I have received the Notice of Privacy Practices described above.

A signature is required from the parent(s) or guardian(s) who have legal responsibility for medical decisions for children in treatment.

Client Signature (if age 12 or older)	**Date**
Witness Signature	**Date**
Parent/Guardian Signature	**Date**
Witness Signature	**Date**

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