Confidentiality - Privacy Policy - HIPAA and Fee Disclosures - Informed Consent

It is important to be informed about who could access your information and how psychotherapy works.

Sharon Valentino

California LMFT 51746, Behavioral Therapy, Psychotherapist, 100 Shoreline Highway, Bldg. A, Suite 100, Mill Valley, CA 94941, 415.215.5363, sv@valentinotherapy.com Psychotherapy Practice of Sharon Valentino, Licensed Marriage and Family Therapist, MFT

Welcome to this practice. This required document contains important information about professional services and policies. Although therapy documents are long and sometimes complex, it is very important that you understand them. When we both sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them, before or at any time in the future.

I, __________ ______________Client/Patient, fully accept and assume all risks whether before, during or after completion of services. These include without limitation, risk of physical or mental injury, emotional distress, trauma, contact with other participants and the effects of weather, power outages or other conditions at the place where services are rendered or elsewhere. Psychotherapy has both benefits and risks.
Risks may include experiencing uncomfortable feelings, such as sadness, guilt, frustration and more because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it and research indicates it often leads to a significant 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. But, there are <u>no guarantees</u> about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, Client will have to work on things we discuss outside of sessions.

As client or patient, I agree that I, my heirs, guardians, legal representatives and assignees will not make any claims against, law suits, complaints, attach the property of or prosecute Sharon Valentino by reason of any injury, damages or misconduct resulting from my participation in therapy modalities with Therapist.

This Agreement includes the waiver and discharge of any and all liabilities, damages and claims, including those not known; arising out of any contact the client has with Therapist. The Agreement terms will not be affected by any facts which may later appear, come up, arise or become known. By signing this Document, below, Client/Patient does so voluntarily and not because of any distress, threat, or undue influence made by Therapist or anyone else. Client has had ample opportunity to read, discuss and consider this Agreement. Client fully understands the meaning and effect of this Release including the fact that by signing this document, Client is giving up any and all legal claims Client may have against Therapist. With said meaning and effects in mind, Client knowingly and voluntarily intends to be bound by all the terms of this Document.

MATTERS OF NOTE:

- ✓ If Client is having Family or Couples therapy, please be aware that Therapist will not take sides, and has a No Secrets Policy. That means that Client should have no expectation that Therapist will treat extra-therapeutic conversations with Couples and/or Family therapy participants as confidential between another member(s) of the group.
- ✓ Availability: Therapist is not available 24/7. If Client has a life-threatening emergency, Client should immediately call 911.
- ✓ Therapist is often not immediately available by telephone when with clients or otherwise unavailable. At these times, leave a message and your call will be returned as soon as possible, but may take a day or two

for non-urgent matters. Therapist will endeavor to return calls and e-mails in a reasonably prompt manner and will charge at the percentage of time used (at the normal session rate) if any telephone calls, reading and/or answering of e-mails requires more than 15 minutes time. This is to encourage issues be discussed within the therapeutic session and framework unless of a critical manner that needs immediate and brief attention.

- ✓ Therapist has a 24-Hour Sobriety policy. This means that should Client choose arrive in session under the influence of any substances not currently prescribed by their physician and taken in the proper, prescribed amounts, the session will not take place, but will be billed for.
- ✓ Therapist does not accept insurance for payment of services, However, any an insurance ready statement is available, if requested at the end of each month. It is the Client's responsibility to determine what, if any, coverage his policy provides. Client should also be aware that most insurance companies require you to authorize Therapist to provide them with a clinical diagnosis.

CONFIDENTIALITY: Client is entitled to Confidentiality subject to certain conditions and exceptions:

- ✓ If Client is under 16 and a victim of crime and "the psychotherapist has reasonable cause to believe that the patient has been the victim of a crime and that disclosure of the communication is in the best interest of the child" then California Evidence Code 1027 negates privilege (confidentiality) and it must be reported.
- ✓ Child Abuse Reporting: If Therapist has reason to suspect that a child is abused or neglected, Therapist is required by California law to report the matter immediately in a specific manner to a designated reporting agency. Failure to do so invokes serious penalties and consequences to any Therapist.
- ✓ Elder or Dependent Abuse Reporting: If Therapist has reason to suspect that an elderly or dependent, incapacitated adult is abused, isolated, neglected or exploited financially or otherwise, Therapist is required by law to immediately make a report and provide relevant information to the designated agency.
- ✓ Suicidality, Danger to Self or Others: Each of these circumstances requires Therapist takes certain prescribed (and/or allowed actions in some cases) to attempt to protect, help and/or warn others of serious threat to Client and others' safety, most of which would break Client's right to confidentiality. Under Duty to Warn and Protect, in cases where the client discloses or implies a plan for suicide, Therapist is required to make reasonable attempts to help ensure the safety of the client and may notify the family of the client, emergency contact, those living with Client and/or authorities. When Client discloses intentions or a plan to harm another person, the medical/mental health professional (Therapist) is required to warn the intended victim and report this information to legal authorities. Some additional Codes apply to property destruction.
- ✓ Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis, treatment and/or the records thereof, such information is privileged under state law and Therapist will not release information unless you provide written authorization or a judge issues a Court Order. If I receive a subpoena for records or testimony, Therapist will assert Privilege, then notify you so you can file a motion to quash (block) the subpoena. (This does not apply to Legal Clients.)
  In Court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, <u>in cases in which your mental health is an issue</u>, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." Protections of privilege may not apply if Therapist does an evaluation for a third party or where the evaluation is court-ordered.
  If Therapist knows in advance that pending or future Court actions may involve Therapist, I will abstain from taking you as a Client to avoid a dual relationship which may damage our work and Therapist will endeavor to provide Client with referrals for other treatment professionals.
- ✓ Therapist's Incapacity or Death: Client acknowledges that, in the event the Therapist becomes incapacitated or dies, it will become necessary for another licensed professional to take possession of my file and records. By signing this consent form, Client consents to allowing another licensee selected by the Therapist to take possession of your file or to deliver them to a new Therapist of Client's choice.
- ✓ Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access Clients' records in certain circumstances unless Therapist deems it detrimental.

ACCESS TO RECORDS: California Health & Safety Code 123100 provides the following. Clients may make a written request for records and then the Therapist has 4 options at her discretion. Either:

Allow an inspection with 5 business days.

Produce a treatment summary within 10 days from receipt of the written request, unless the report is extensive, wherein the time is increased to 30 days, with a reasonable fee for Therapist's time. Produce a copy within 15 business days at an allowable charge of 25 cents per page.

Refuse access when Therapist deems there is a risk of detrimental consequences to Client seeing the records.

Right to Amend or Correct the record is subject to several limitations. If Client feels that protected health information Therapist has is incorrect or incomplete, Client may ask Therapist to amend the information. The request must be made in writing. Client must provide a reason that supports the request. Therapist may deny the request if asked to amend information that was not created by Therapist, is not part of the medical information kept by Therapist, is not actually part of the record, is not part of the information which Client would be permitted to inspect and copy, or that is accurate and complete.

HIPAA 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 IT CAREFULLY.

I. Uses and Disclosures of Protected Health Information:

The Practice may use or disclose your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the Practice has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA Privacy Rule or State law.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes if you sign a Release. We may also disclose protected health information to physicians who may be treating you or consulting with the Practice with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider, again with a Release or in dire emergency.

Payment. Your protected health information will be used and disclosed, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurer to get approval for the treatment that we recommend. For example, if a certain level of service is recommended, we may need to disclose information to your health insurer to get prior approval for the level of service. We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the services or to demonstrate that required documentation exists. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

Other Uses and Disclosures. As part of treatment, payment and healthcare operations, we may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment including the use of post cards and/or messages left on answering machines.
- To inform you of potential treatment alternatives or options
- To inform you of health-related benefits or services that may be of interest to you.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object:
The HIPAA Privacy Rule also allows us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:
When Legally Required. We will disclose your protected health information when we are required to do so by any Federal, State or local law.
When There Are Risks to Public Health. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to employer information about an individual who is a member of the workforce as legally permitted or required.

To Report Abuse, Neglect or Domestic Violence. We may notify government authorities if we believe that a consumer is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the consumer agrees to the disclosure.
To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information if you are the subject of an investigation and your health information are not directly related to your receipt of health care or public benefits.
In Connection with Judicial and Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a signed authorization. **For Law Enforcement Purposes.** We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the Agency has a suspicion that your death was the result of criminal conduct.
- In an emergency in order to report a crime.

In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.
For Worker's Compensation. The Agency may release your health information to comply with worker's compensation laws or similar programs.
Other: If you choose to enter your mental state into a Court proceeding, your confidentiality is generally waived by that action. In this circumstance, you should contact your attorney for advise as to how you want to proceed.

III. Uses and Disclosures That You Authorize:
Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.
IV. Your Rights:
In addition to other rights you may have under State law, you have the following rights under HIPAA regarding your health information:
The right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information which is a limited term. We may deny your request to inspect or copy your protected health

information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, not be therapeutic for you, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

The right to request a restriction on uses and disclosures of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. Your request must state the specific restriction requested and to whom you want the restriction to apply. The Practice is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the Practice does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction.

The right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request.

The right to request amendments to your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. For example, if we believe that the information is correct as is. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

V. Our Duties:

The Practice is required by law to maintain the privacy of your health information and to provide you with this Notice. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain.

VI. Complaints: You have the right to express complaints to the Practice and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VII. Contact Person: The Practice's contact person for all issues regarding patient privacy and your rights under HIPAA is Sharon Valentino, LMFT. Information regarding matters covered by this Notice can be requested by contacting Sharon Valentino.

VIII. Fees & Insurance

Therapy is an investment in you and in your relationships. The gains of the counseling relationship add up over time as you put your energy and your attention into growth and change. It is important to consider whether you are entering counseling to get clarity on one problem or whether there is a more long-standing situation requiring a longer commitment of time and resources. I will be happy to explore this with you in the initial phone call with me.

Regarding insurance: If you have insurance or aa PPO policy that pays for mental health services out of network I will provide you with receipts or a "super-bill" monthly, which includes diagnosis codes and dates and fees for services for you to submit to your insurance company for partial reimbursement.

I accept credit cards, cash, checks and electronic payments such as Venmo and PayPal and charge as follows as of the above signed date. Fees are subject to review and change annually.

- In Office or Zoom: $250. for 50 minutes. Consider using this only if you prepare your thoughts and objectives for the session well beforehand so you are getting the maximum help and improvement.
- In Office: $325. per 70 minute session for those who have concerns they want to address in depth without being rushed by the clock, persons struggling with trauma or addiction or for those who travel some distance.
- In Office: $500. for 2 hours for those clients with special circumstances or who drive a long distance, fly in, or families/friends needing intervention help and support, or for those who just want more time for themselves. This pricing is also a savings for couples who need joint time but also need private time each and don't want to drive back for solo sessions.

* Please note that Online Therapy/Telemedicine is billed at different rates and not everyone is a good candidate for Online Therapy which is at the discretion of Sharon Valentino MFT. Online rates are not available for existing or returning clients. See website for fees: www.valentinotherapy.com
* Fees for legal cases involving trauma, memory loss and PTSD which require significant paperwork and documentation, thus the fees are higher for greater services rendered. Call or email for a detailed listing of costs.

IX. Effective Date as of signing this agreement:

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY FOR WHATEVER CAUSES OR ACTIONS THAT MAY OCCUR DURING MY SESSIONS AND/OR TREATMENT WITH SHARON VALENTINO, THERAPIST, AND THAT THIS IS ALSO A CONTRACT BETWEEN MYSELF AND SHARON VALENTINO AND I DO HEREBY SIGN OF MY OWN FREE WILL AND CONSENT, UNDERSTANDING THIS APPLIES TO THERAPY, COACHING AND/OR WORKSHOPS.

Client name: Today's Date: Date of Birth:

Address:

Phone and email:

Emergency Contact:
(Name, phone, email- Please print legibly)

Client signature and date:

Therapist's signature with date: