**Privacy of Information Policies**

**This form describes the confidentiality of your medical information, how this information is used, your rights, and how you may obtain this information.**

**Our Legal Duties**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your physical or mental health condition is referred to as Protected Health Information (“PHI”). Under the Health Insurance Portability and Accountability Act (“HIPPA”), HIPPA privacy and security rules, and the NASW Code of Ethics, we commit to regulations regarding the privacy of your information.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices. Any changes to our policies will be immediately updated on our form.

**Use Of Information**

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. Both verbal information and written information about a client cannot be shared with another party without the written consent of the client, client’s legal guardian, or personal representative.

Your PHI may also be disclosed so that we can receive payment for the treatment services provided to you. This will be done with your authorization.

It is the policy of this practice not to release any information about a client **without a signed release of information** except in certain emergency situations or exceptions in which your information can be disclosed to others without written consent. Some of these exceptions are listed below.

***Duty to warn and protect***:

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to the proper legal authorities. Intent to harm could also include an intent and plan to harm oneself. (suicidal ideations, thoughts, or threats) In this case, our professional duty would be to assess the appropriate level of care needed which could include a recommendation for hospitalization for stabilization.

***Public Safety***:

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.

***Abuse or Neglect***:

If a client states that he or she is abusing a child or vulnerable adult or has recently done so, the health care professional may disclose your PHI to a state or local agency that is authorized by law to receive reports or abuse or neglect.

***In the Event of a Client’s Death***:

In the event of a client’s death, the spouse or parents of a deceased client have the right to access their child’s or spouse’s records.

***Professional Misconduct***:

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional’s actions, related records may be released in order to substantiate disciplinary concerns.

**Judicial Proceedings**:

We may disclose PHI to a law enforcement official as required by law in compliance with a subpoena or court order.

***Minors/Guardianship***:

Parents or legal guardians of minor clients have the right to access the minor client’s records.

**Your Rights**

You have the right to request to review or receive your medical record. You may request your record in writing with an original signature.

You have the right to cancel a release of information at any time by providing a written notice.

You have the right to restrict which information might be disclosed to others. However if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

**Breach Notification**: If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

**Complaints**

If you have any complaints or questions regarding these procedures, please contact Shawnette Miller, LCSW. You may also submit a complaint to the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists. We will not retaliate against you for filing a complaint.

**Case Closure**

Please note that if you do not initiate a follow-up appointment within 90 days of your last session, your case will be closed. You may reinitiate services at any time.

**Communication**

Please note that normal communication will be between 9:00am to 5:30pm Monday through Friday. If you text after these hours your call or text may be returned on the next business day. If the therapist is in session calls and texts will not be answered while in session. If you ever have a mental health emergency please go to your local emergency department.

**The effective date of this notice is March 27, 2020**.

**Signature Page for Connect Four Counseling LLC Privacy of Information Policies**

**FMLA/Disability Paperwork Policy**

**Please note that all new clients must have at least 3 sessions before FMLA/disability paperwork can be completed. There is a $40.00 administrative fee for initial FMLA or other disability paperwork. Subsequent paperwork will be at an administrative fee of $25.00. Paperwork exceeding an hour to complete will be assessed at a higher fee and disclosed prior to completion.**

**Informed Consent for Telemental Health Services**

**Your signature below also acknowledges that you understand the benefits and risks of telemental health services including phone and video virtual sessions. Benefits include flexibility, convenience and access to services. Risks include security and technology interruptions. Further not all clients are appropriate for telemental therapy. Some may require a higher level of care. Expectations of virtual sessions: Therapy will only be done with the client and clinician in private rooms at each location not accessed by others during the duration of the session. Client and clinician will dress appropriately. Sessions will begin at designated appointment time. Sessions will not be recorded by either party. All payments will be made online prior to services using a credit card after receiving a square invoice.**

**Cancellation Policy**

**It is understood that appointments not rescheduled or cancelled within 24 hours of scheduled time will be billed via electronic invoice in the amount of $25.00 per session.**

**I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications. I have received a copy of Connect Four Counseling’s privacy of information policies and have been given the opportunity to ask questions about said policies.**

**I also understand that by signing this form, I authorize Connect Four Counseling LLC to disclose my Protected Health Information for the purpose of receiving payment for the treatment services provided to me and/or my family.**

**I also understand that by signing this form I do authorize evaluation and treatment from Connect Four Counseling LLC. It is agreed that either of us can discontinue treatment at any time.**

Client’s Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_