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## Privacy Practices & Confidentiality Information

**General Information:** The therapeutic relationship is unique because it is both highly personal and a contractual agreement. Therefore, it's important for us to clearly understand how our relationship will function and what we can each expect from it. This consent form will provide a clear framework for our work together. Please feel free to discuss any aspect of this with your provider.

**The Therapeutic Process:** You have taken a very positive step by deciding to seek therapy. The success of your treatment largely depends on your willingness to engage in the process, which may sometimes lead to considerable discomfort. Recalling unpleasant events and becoming aware of the associated feelings can evoke strong emotions such as anger, depression, and anxiety. While there are no miracle cures, and we cannot guarantee changes in your behavior or circumstances, we can promise to support you and make every effort to understand you and your patterns. Our goal is to help you clarify what you want for yourself and work towards achieving it.

**Confidentiality:** The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person(s). Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally we may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If you and your provider happen to meet outside of the therapy office, your provider will not acknowledge you first. Your privacy and confidentiality are our top priorities, and we want to

protect them. However, if you choose to acknowledge your provider first, they will be happy to greet you briefly. To maintain your privacy, we will avoid engaging in lengthy discussions in public or outside of the therapy office.

## **NOTICE OF PRIVACY PRACTICES**

*THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

### **I. OUR PLEDGE REGARDING HEALTH INFORMATION:**

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:

- Make sure that protected health information (PHI) that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

### **II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:**

We use and disclose your health information in various ways, which fall into different categories. For each category, we will explain what we mean and provide examples. While not every use or disclosure will be listed, all permissible uses and disclosures will fit into one of these categories.

#### **For Treatment, Payment, or Health Care Operations:**

Federal privacy regulations allow healthcare providers with a direct treatment relationship with you to use or disclose your personal health information without your written authorization for their own treatment, payment, or health care operations. I may also share your protected health information for the treatment activities of any healthcare provider, also without your written authorization. For instance, if a clinician consults with another licensed healthcare provider about your condition, we are allowed to use and disclose your personal health information to assist in diagnosing and treating your mental health condition.

Disclosures for treatment purposes are not restricted by the minimum necessary standard, as therapists and other healthcare providers require access to the complete record to provide quality care. The term “treatment” includes coordination and management of health care

with a third party, consultations between providers, and referrals from one provider to another.

#### Lawsuits and Disputes:

If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to notify you about the request or to obtain an order protecting the requested information.

### **III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:**

1. Psychotherapy Notes: We keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
  - a. For use in treating you.
  - b. For use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
  - c. For use in defending ourselves in legal proceedings instituted by you.
  - d. For use by the Secretary of Health and Human Services to investigate our compliance with HIPAA.
  - e. Required by law and the use or disclosure is limited to the requirements of such law.
  - f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
  - g. Required by a coroner who is performing duties authorized by law.
  - h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes: We will not use or disclose your PHI for marketing purposes.
3. Sale of PHI: We will not sell your PHI in the regular course of our business.

### **IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION:**

Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

#### **V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:**

1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

#### **VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:**

1. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and may say "no" if we believe it would affect your health care.
2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. **The Right to Choose How We Send PHI to You.** You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.
4. **The Right to See and Get Copies of Your PHI.** Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost based fee for doing so.
5. **The Right to Get a List of the Disclosures We Have Made.** You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I

will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say “no” to your request, but we will tell you why in writing within 60 days of receiving your request.
7. **The Right to Get a Paper or Electronic Copy of this Notice.** You have the right to get both a paper copy and digital copy of this Notice at your request.

## **INSURANCE**

If you choose to use your insurance, we must provide a clinical diagnosis to your insurance company to secure reimbursement. If you prefer not to be assessed for a mental health diagnosis, you have the option to pay for services at the out-of-pocket rate.

By providing your insurance information, you are consenting to prior authorization, benefits verification, and claim submission, including the diagnosis, service type, and date of service. This information is required by your insurance company for payment.

**By signing below, you acknowledge that you have read, understood, and agree to all the terms and conditions outlined in this document.**

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