KALAMAZOO BEHAVIORAL SERVICES BUILDING SOLUTIONS TOGETHER

Informed Consent, Information, and Privacy Policies

You, or a member of your family, are about to become involved in counseling or psychotherapy with a trained, limited licensed psychologist at Kalamazoo Behavioral Services, PLC. We wish to welcome you and take this opportunity to state some basic principles we believe are essential in establishing a good counseling relationship between us. Please read through this information and ask questions if needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:

   a. Type of therapy needed (individual, family, group, etc.)

   b. Frequency of therapy sessions (weekly, biweekly, monthly, etc.)

   c. Goals of therapy (what you hope to gain from this process)

   d. Treatment mode (Cognitive Behavior Therapy, supportive, etc.)

2. APPOINTMENTS: Each appointment is approximately 45-55 minutes. At the end of each appointment you can discuss future appointments with your therapist.

3. EMERGENCY PROCEDURES: If you, or a family member, are experiencing a crisis after normal business hours, please call Gryphon Place at (269) 381-4357 to speak with a crisis counselor. If you have a life-threatening emergency, please call 911 or go to the nearest emergency room for immediate psychiatric evaluation.

4. LATE CANCELLATIONS AND NO-SHOWS: If you find that you need to cancel an appointment, you must call the office and/or leave a message at least 24 hours in advance to avoid a Late Cancellation Fee unless you are able to fill a vacant appointment time within the same week. If you do not show for a scheduled appointment, you are subject to a No Show Fee. The Late Cancellation and No Show Fee is $65 for appointments after 3:30 pm and $35 for appointments before 3:30 pm. This will be billed to you directly as this is not reimbursed by insurance companies. If you need to cancel due to illness, your fee will be waived. However, more than three cancelled appointments in a three-month period without a fee may prevent my ability to schedule future appointments with you due to the loss of income from being unable to fill those hours.

5. PAYMENTS: Fee for individual (60 minute) outpatient psychotherapy visits are $195 per clinical hour. You are responsible for payment of all fees unless your insurance has agreed to pay a different amount or as negotiated. Payment is expected in full for each office visit when you come in for your appointment. If you do not pay in full at the time of service, we expect your approval by signature to allow the insurance payment to be sent directly to us from your insurance company. If there is a co-payment required, you will be responsible for payment at the time of service or to establish other arrangements. Statements will be emailed, or you will be asked to provide a credit or debit card which will be securely stored in our electronic records to cover any out-of-pocket costs. Personal checks returned due to non-sufficient funds will be billed to the client at a rate of $25.00 per returned check. In the case of minor children, the parent or guardian bringing the child in for treatment and signing below will be held financially responsible for all payments.

Fees for Services Not Paid For by Insurance Plans

Telephone/Text Consultation with client, parents, doctor's office, school, attorney, etc.

- 1 -15 minutes No Charge Over 16 minutes $2 per minute Letter written on behalf of client to attorney, school, doctor's office, etc.
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$30 Off-Site Meeting

- $100 per hour travel time plus meeting

Court Proceedings

- $200 per hour travel time plus time spent in court proceedings.

6. INSURANCE: Most insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company to find out specific requirements and limitations of this coverage. We will be happy to assist you with billing your insurance company; however, payment for services received through Kalamazoo Behavioral Services are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the preauthorization process, i.e., contacting your primary care physician or insurance company. Failure to obtain the necessary preauthorization for outpatient mental health services will result in your being held 100% responsible for all charges.

7. CONFIDENTIALITY: Normally, everything we discuss will be held confidential unless you provide me with a signed authorization allowing me to communicate with other parties. **Law and professional ethics either mandate or permit therapists to break client confidentiality under certain circumstances. Some 'exceptions to confidentiality' include situations in which there is reasonable suspicion that any of the following has ever occurred or is occurring now:

- You or your child/minor present a danger to self or others
- A child/minor or dependent adult is the victim of emotional, sexual or physical abuse, neglect or unjustified mental suffering
- A dependent adult or any person over the age of 65 years is the victim of physical abuse, emotional abuse, abandonment, forced isolation, fiduciary abuse, or neglect.

. **If you are taking part in DBT) or are on the wait-list for DBT, information pertaining to your treatment and progress will be regularly discussed by members of Kalamazoo DBT (Tom Cunningham, Victoria Cane, Gary Snapper, Dawn Bouaouad, Kim Yore, David Lawrence, Andre Wayne, and Heather Roe) as part of the treatment. If you are seeing a KDBT therapist while waiting, they will be included in DBT communications.

SUPERVISION: Supervision for Tom Cunningham, MA. LLP, CAADC is provided by George Starrett, Ed.D., LP. Information pertaining to your treatment and progress will be regularly discussed during supervision with Dr. Starrett.

8. COPY OF MEDICAL RECORDS: There is a medical records handling charge of $25.00 per request to release records to cover the cost of time, copies, and postage for closed charts. This fee is not reimbursed by insurance companies. An Authorization to Release Medical Records form is required in order to release records.

9. EMAIL: By providing your email address, you consent to receive general communication between you and Kalamazoo Behavioral Services for nontherapy communication (i.e. practice information and paperwork). Your email address will never be sold or shared with any other parties.

10. ONLINE ACCOUNT STATEMENTS AND BILL PAY: You will receive monthly account statements via email and/or pay your bill online through our website www.kalamazoobehavioralservices.com. Click on Account Access, enter your therapist's name, and then enter your login name and password identified below. I understand that this is considered "Protected Health Information" under HIPAA and therefore by my signature (below), I am waiving my right to keep this information completely private and requesting that it be handled as I have noted below.

PLEASE PRINT CLEARLY — Case sensitive

Requested login name (letters and numbers only): I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I

Requested password (letters and numbers only): I__I__I__I__I__I__I__I__I__I__I__I

11. Treatment Termination

Ideally, therapy ends when we agree your treatment goals have been achieved. Additional conditions of termination include:

- Legal or ethical circumstances that compel the termination of treatment.
- Issues arising in treatment that are outside the recognized boundaries of my competence.
- A client regularly becoming enraged during session; making threats towards me or my family, making inappropriate requests of the therapy relationship, bringing a weapon onto the premises; persistent drug abuse; arriving under the influence of drugs or alcohol; disclosing illegal intentions or actions.
- A change in level of care-related needs such as an increase in behaviors that compromise the client's health & safety.

If at any time during the course of your treatment it is determined that therapy cannot continue, this will be discussed in detail and every effort will be made to assist in linking to the appropriate service. You have the right to stop treatment at any time. If you make this choice, referrals to other therapists can be provided and you will be invited to attend a final 'termination' session.

12. Risks Associated with Psychotherapy

Like many things in life, psychotherapy has inherent risks. Some of these risks to you are:

- Disruptions in your daily life (such as relationship conflicts) that can occur because of therapeutic changes.
- Emotional pain due to exploring personal issues and family history.
- Although therapy begins with the hope that your life and relationship(s) improve, there is no guarantee that this will occur.

13. Authorization to Commence Psychotherapy

I acknowledge that I have read and understand all the foregoing statements and that my signature below indicates that I agree to abide by all the above conditions.

☐ Yes ☐ No I have received a copy of the HIPAA Privacy Notice.

☐ Yes ☐No I authorize the release of any medical information necessary to process my insurance claims and I authorize benefits to be paid directly to Kalamazoo Behavioral Services, PLC.

☐ Yes ☐ No I consent to the exchange of treatment information between Kalamazoo Behavioral Services, PLC and my primary care physician.

☐ Yes ☐ No I consent to my credit or debit card being charged for my out-of-pocket obligation unless other arrangements have been made.

Client Physician's Name/Office and Phone Number: _____

_____ _____ _____

Client/Responsible Party Signature Printed Name Date

Informed Consent, Information, and Privacy Policies

Kalamazoo Behavioral Services, PLC Privacy Notice

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

HIPAA & RECIPIENT RIGHTS

A federal act called the Health Insurance Portability and Accountability Act (HIPAA) gives you some additional rights to what you have through state laws. This notice gives you information on these additional rights through HIPAA.

UNDERSTANDING THE TYPE OF INFORMATION WE HAVE

We obtain information about you when you receive services through Kalamazoo Behavioral Services, PLC. It includes your date of birth, gender, Social Security Number and other personal information.

OUR PRIVACY COMMITMENT TO YOU

We care about your privacy. The information we collect about you is private. We are required to give you a notice of our privacy practices. Only people who have both the need and legal right may see your information. Unless you give us permission in writing, we will only disclose your information for purposes of treatment/services, payment, business operations or when we are required by law to do so. We are required by law to maintain the privacy and security of your protected health information. We will promptly let you know if a breach occurs that may have compromised the privacy or security of your information.

- Treatment/Services: We may disclose information about you with your written consent to coordinate your services. For example, we may give information to your other healthcare providers.
- Payment: We may also use and disclose information so the care you get can be properly billed and paid for. For example, we will submit bills to your insurance company or other entities.
- Business Operations: We may need to use and disclose information for our business operations. For example, we may use information to review the quality of the services you receive.
- Exceptions: For certain kinds of records, your permission may be needed even for release for treatment, payment and business operations.
- As Required By Law: We will release information when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, workers' compensation claims, medical examiner or funeral direction if an individual dies, subpoenas or other court orders, communicable disease reporting, review of our activities by government agencies, to avert a serious threat to health or safety, reporting suspected abuse, neglect or domestic violence, or in other kinds of emergencies.
- With Your Permission: If you give permission in writing, we may use and disclose your personal information. If you give permission, you have the right to change your mind and revoke it. This must be in writing also. We cannot take back any uses or disclosures already made with your permission.

YOUR PRIVACY RIGHTS

You have the following rights regarding the health information that we have about you. Your requests must be made in writing.

- Your Right to Inspect and Copy: In most cases, you have the right to look at or get copies of your paper or electronic health records. We will provide a copy or a summary of your health information, usually within 30 days of your request. You may be charged a fee for the cost of copying records.
- Your Right to Amend: You may ask us to change your records if you feel that there is a mistake. We can deny your request for certain reasons, but we will give you a written reason for our denial within 60 days.
- Your Right to a List of Disclosures: You have the right to ask for a list of disclosures of your health information prior to the date you ask, who we shared it with and why. This list will not include the times that information was disclosed for treatment, payment, or business operations. This list will not include information provided directly to you or your family, or information that was sent with your authorization.
- Your Right to Request Restrictions On Our Use or Disclosure of Information: You have the right to ask for limits on how your information is used or disclosed. We are not required to agree to your request if it would affect your care. If you pay for your services out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer unless a law requires us to share that information.
- Your Right to Request Confidential Communication: You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. You do not have to explain the basis for your request.

- Your Right to Choose Someone to Act on Your Behalf: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure that person has this authority and can act for you before we take any action.
- Your Right to Share Health Information: You have both the right and choice for us to share information with your family, close friends, or to others involved in your care or share information in a disaster relief situation. We never share psychotherapy notes unless you give us written permission or in response to a complaint filed against the counselor. We never market or share personal information.

CHANGES TO THIS NOTICE

We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published on our website at www.kalamazoobehavioralservices.com. If the changes are material, a new notice will be mailed to you before it takes effect.

HOW TO USE YOUR RIGHTS UNDER THIS NOTICE

If you have questions or would like more information, you may contact our Privacy Officer at 269-998-0887. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or the Department of Health and Human Services. You will not be penalized for filing a complaint.

COMPLAINTS TO THE FEDERAL GOVERNMENT

You may write: Office of Civil rights Dept. o Health & Human Services 200 Independence Ave. SW Washington, DC 20201 Phone: (877) 696-6775 Website: www.hhs.giv/ocr/privacy/hipaa/complaints/

COPIES OF THIS NOTICE

You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to use to request a copy