ASSIGNMENT OF BENEFITS AND BILLING AUTHORIZATION FORM

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. You agree to fill out and execute any additional necessary forms that may be required for your particular insurance carrier. In some cases the exact insurance benefits cannot be determined until the insurance company receives the claim and the claim is adjudicated.

Client Name _____ Date of Birth _____

Insurance Policy Holder Name _____

Relation to client: ☐ self ☐ spouse ☐ parent

Primary Insurance _____

Secondary Insurance _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____

Primary Insurance Policy # _____ Group # _____

Secondary Insurance Policy # _____ Group # _____

Assignment of Benefits

I hereby assign all medical and mental health benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other mental health/medical plan, to issue payment check(s) directly to **Adams Clinical Services** for therapy services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Adams Clinical Services** to:

1. Release any information necessary to insurance carriers regarding my therapy and sessions. I understand that my therapist may be required to release certain information to the insurance company at their request in order to procure necessary authorizations and or process claims for payment. This information may include, but is not limited to types of

service, dates of service, times of service, diagnosis, treatment plans, progress of therapy and at times, treatment notes and/or summaries. I authorize the release of such information if necessary, understanding the limits of confidentiality regarding the use of my insurance benefits. I also acknowledge receipt of **Adams Clinical Services**'s Notice of Privacy Practices.

2. Request payment of insurance benefits be made directly to **Adams Clinical Services** for services performed.

3. If necessary, file a formal written complaint, if permitted by law, on my behalf to the state Insurance Commissioner, or other appropriate state agency, if payment for services is not timely received.

I have requested therapy services from **Adams Clinical Services** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Clinician Signature: _____ Date: _____
Ernesta Adams, LPC, M.Ed

BIOPSYCHOSOCIAL INTAKE ASSESSMENT & CLIENT INFORMATION - ADULT

Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Birthplace: _____ Gender: _____

Sexualtiy: _____ Race: _____ Ethnicity: _____

Address: _____

Phone Number(s): _____
Is it ok to leave a voicemail? *YES* *NO*

Email: _____
Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

How were you introduced to us? _____

** Please complete below for additional client*

Name: _____ Date: _____

DOB: _____ Age: _____ Birthplace: _____ Gender: _____

Sexualtiy: _____ Race: _____ Ethnicity: _____

Address: _____

Phone Number(s):_____
Is it ok to leave a voicemail? *YES* *NO*

Email: _____
Would you like to receive email communication? *YES* *NO*

Adams Clinical Services * Ernesta Adams * 803-970-7344
135 E. Main Street, Suite 208
Rock Hill, SC 29730

THERAPY CONSENT, POLICIES, & AGREEMENT
PART I: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

STRUCTURE OF THERAPY:

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaborate to identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions,

utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.

- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for minutes depending upon the nature of the presenting challenges and insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment and agree to adhere to the following policy: ***If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment within 24 hours of the scheduled appointment time. If you cancel or reschedule more than once, we may re-evaluate your needs, desires, and motivations for treatment at this time. Each insurance panel has a different policy on whether clinicians can charge for missed appointments. No call no show appointments incur a $55 charge, that will be charged to the card on file the day of the missed appointment.*** **After 3 cancellations, client will no longer be eligible for reoccurring appointment times.**

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment.

FEES: The self pay rate for sessions are $125 for 60 minute sessions, $95 for 45 minute sessions and $75 for a 30 minute session. Couples and family sessions are $150 for self pay rate per session. Payment is due at the time of service. Acceptable forms of payment are: credit/debit card or HSA cards. In the event that a scheduled appointment time is missed or cancelled less than 24 hours, please refer to the "Appointments and Cancellations" policy above.

The clinician reserves the right to terminate the counseling relationship if more than 3 sessions are missed without proper notification.

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed.

*** Review of psychological/medical/legal forms/court documents/ reports and letter completion (completed outside of appointment times)

- $50 minimum [prorated at $25/15 minutes thereafter]

Non Crisis Telephone consult/after hours consult

- $50 minimum [prorated at $25/15 minutes thereafter]

Email consult with clinician

- $50 minimum [prorated at $25/15 minutes thereafter]

Court Appearance/Court Testimony

- $250/ hour

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged a fee of FEE FOR COURT ORDERED APPEARANCE (to include travel time, court time, preparing documents, etc.) to include travel time, court time, preparing documents, etc.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, the cost is $1 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records.

PHONE CONTACTS AND EMERGENCIES: Office hours are from Monday-Thursday 9:00-5:00, Fridays-Closed. If you need to contact the clinician for any reason, please call 803-970-7344, leave a voicemail, and a return call will be made (: 24 Hours or as soon as possible). In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, dial 911.

PART II: CONFIDENTIALITY*:*

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.

- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Law Enforcement and Public health**: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.
- **Governmental Oversight Activities**: To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- **Upon Your Death**: To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about an you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/progress notes", except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the

cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.

- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to the couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.
- **Dual Relationships & Public**: Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (i.e.: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **Social Media**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.
- **Electronic Communication: If you need to contact me outside of our sessions, please do so via phone.**
    - **Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship.** Texting is not a substitute for sessions. **Texting is not confidential**. Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client's phone.
    - **Do not use email for emergencies**. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment.
    - **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.

PART III: HEALTH INSURANCE *(delete this section if you don't take insurance)*

YOUR INSURANCE COMPANY: By using insurance, I am required to give a mental health disorder diagnosis that goes in your medical record. The clinical diagnosis is based on your current symptoms even though you may have been previously diagnosed. We will discuss your diagnosis during the session. Your insurance company will know the times and dates of services provided. They may request further information to authorize additional services regarding treatment.

IMPORTANT: Some psychiatric diagnoses are not eligible for reimbursement (i.e.: marriage/couples therapy). In the event of non-coverage or denial of payment, you will be responsible to pay for services provided. **Ernesta Adams** of **Adams Clinical Services** reserves the right to seek payment of unpaid balances by collection agency or legal recourse after reasonable notice to the client.

PRE-AUTHORIZATION & REDUCED CONFIDENTIALITY: When visits are authorized, usually only a few sessions are granted at a time. When these sessions are complete, we may need to justify the need for continued service, potentially causing a delay in treatment. If insurance is requesting information for continued services, confidentiality cannot be guaranteed. Sometimes, additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not met.

POTENTIAL NEGATIVE IMPACTS OF A DIAGNOSIS : Insurance companies require clinicians to give a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to: applying for a job, financial aid, and/or concealed weapons permits.
5. A psychiatric diagnosis can be brought into a court case (i.e.: divorce court, family law, criminal, etc.).

It is important that you're an informed consumer. This allows you to take charge regarding your health and medical record. At times, having a diagnosis can be helpful (i.e.: child needing extra services in the school system or a person being able to receive disability).

EMERGENCY CONTACT:

It is necessary that **Ernesta Adams** of **Adams Clinical Services** has someone to contact on your behalf. In case of an emergency who should we contact?

_____

Full Name Relationship Phone Number(s)

Please check here that you agree and sign below. Thank you.

☐ I agree to allow **Adams Clinical Services** to contact my emergency contact on my behalf in the case of emergency

_____

Signature Date

Adams Clinical Services * Ernesta Adams * 803-970-7344
135 E. Main Street, Suite 208
Rock Hill, SC 29730

PART IV: CONSENT

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Ernesta Adams**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Ernesta Adams** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to **Ernesta Adams,** of **Adams Clinical Services**. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **Ernesta Adams,** of **Adams Clinical Services** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Ernesta Adams to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Ernesta Adams** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Your signature signifies that you have received a copy of the "Therapy Agreement, Policies and Consent" *for your records.*

Printed Name of Minor Child	DOB	Date

Clinician Signature: _____ Date: _____

Ernesta Adams, LPC, M.Ed

PART IV: CONSENT (CLIENT'S COPY)

Adams Clinical Services * Ernesta Adams * 803-970-7344

135 E. Main Street, Suite 208

Rock Hill, SC 29730

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Ernesta Adams**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Ernesta Adams** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to **Ernesta Adams,** of **Adams Clinical Services**. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **Ernesta Adams,** of **Adams Clinical Services** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Ernesta Adams to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Ernesta Adams** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Your signature signifies that you have received a copy of the "Therapy Agreement, Policies and Consent*" for your records.*

Printed Name of Minor Child	DOB	Date

Clinician Signature: _____ Date: _____

Ernesta Adams, LPC, M.Ed

Health Insurance Portability Accountability Act (HIPAA)

Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
- I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

- If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the South Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the South Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your

information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss

your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.

- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of South Carolina Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Client/Legal Guardian Signature : _____ Date: _____

Printed Name: _____ Date: _____

Signature:_____ Date: _____

Ernesta Adams, LPC, M.Ed