____ ______________________
Client Printed Name Date of Birth

NOTICE OF PRIVACY PRACTICES – 2022

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

MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I 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 I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:
• Make sure that protected health information ("PHI") that identifies you is kept private. • Give you this notice of my legal duties and privacy practices with respect to health information. • Follow the terms of the notice that is currently in effect. • I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.
For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.
Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.
Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do 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 my use in treating you. b. For my 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 my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my 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. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION:

Subject to certain limitations in the law, I 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 counter-intelligence 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.

CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:

1. Disclosures to family, friends, or others. I 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.

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 me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I 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 I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I 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 I have about you. I 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 I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I 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 I correct the existing information or add the missing information. I may say "no" to your request, but I 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 get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

RECORD PROTOCOL COMPLIANCE

Secure Record Storage

1. Simple Practice – this therapist uses a practice management software called "Simple Practice".

Below is Simple Practice's description of their Secure Document Storage:

*Simple Practice always transmits account information securely with multiple layers of encryption. *Therapist's password is encrypted and not accessible to anyone but that therapist. *Simple Practice's servers are housed in a secure facility protected by proximity readers, biometric scanners, and security guards 24 hours a day, 7 days a week, 365 days a year. *Bank-level security. *Simple Practice attempts to hack their own site. Simple Practice runs thousands of tests on its own software to ensure security. They scan their ports, test for SQL injection, and protect against cross-site scripting. *Simple Practice has received the VeriSign security seal. *Web pages and APIs are

secured with 128-bit Secure Socket Layer encryption. *Simple Practice's cloud infrastructures uses multi-factor authentication. *They use advanced key management and transparent data encryption. *Application level monitoring and intrusion protection. *HIPAA compliant encryption. *HIPAA compliant hosting architecture on enterprise level hardware. *HIPAA compliant system architecture with separate web and database environment. *Application and Database server isolation. *Firewall management. *Log retention with detailed audit trail. *Managed and secure backup and disaster recovery. *Managed patching, version control, and security updates. *Credit card transactions processed using secure encryption on a PCI compliant network.

2. Hageman Counseling

*Keeps the computer and browsers current with the latest software and security updates. *Installs and updates anti-virus software. *Uses personal firewalls to protect computer and network. *Computer is password protected. *Does not enable automatic login to the Simple Practice account. *Passwords are not used for any other accounts.

Transfer and Access to Medical Records

1. If Hageman Counseling terminates or sells, the therapist will notify each patient by their last known mailing address in order to inform the patient of the future location of the patient's medical records and how the patient can access those medical records.
2. Medical records will be stored for at least seven years following the last date of service
3. Therapist shall respond in a timely manner (i.e., within two week) to requests from patients for copies of their medical records.
4. Written request must be made by the patient in order to get a copy of their medical record. There may be a fee associated with record requests.
5. Patients must complete a Release of Information when requesting that therapist release their medical records to another individual/entity. Please refer to the consent paperwork for more information about what is required to release records and limits of confidentiality.
6. According to A.R.S. 12-2293 a health care professional may deny a request for access to or copies of medical records to the patient if:

· Access by the patient is reasonably likely to endanger the life or physical safety of the patient or another person.

· The records make reference to a person other than a health professional and access by the patient or the patient's health care decision maker is reasonably likely to cause substantial harm to that other person.

· Access by the patient's health care decision maker is reasonably likely to cause substantial harm to the patient or another person.

· Access by the patient or the patient's health care decision maker would reveal information obtained under a promise of confidentiality with someone other than a health professional and access would be reasonably likely to reveal the source of the information.

· If the health care provider denies a request for access to or copies of the medical records or payment records, the health care provider must note this determination in the patient's records and provide to the patient or the patient's health care decision maker a written explanation of the reason for the denial of access. The health care provider must release the medical records or payment records information for which there is not a basis to deny access under the above subsection.

7. In the event of the therapist's incapacitation, illness, or emergency another mental health professional, Cheryl Sexton LMFT, will have access to this therapist's client records and will inform patients of their treatment options and how to access medical records as needed. Cheryl Sexton's contact number is: 480-215-7395.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on January 1, 2022

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

____   ________________________

Client Signature   Date

____   ________________________

Client Signature   Date

Informed Consent for Psychotherapy – 2022

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important to have a clear understanding about how the relationship will work, and what can be expected. This consent will provide that framework. Feel free to discuss any of this information with the therapist. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. The therapist cannot promise that your behavior or circumstance will change. The therapist will, however, support you and do the very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to your treatment will be held confidential unless you (the client) request in writing to have all or portions of such content released to a specifically named person/persons. It is important to note that if you have agreed to include another individual(s) in your sessions, I will not provide complete case records without the consent of all adult parties who have participated at any point. When working with a minor, unless all parties who have legal custody have agreed to and signed a release of information form, I will not provide case records. 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 him/her self 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. Please note that in the state of Arizona, there is no statute of limitations for an incident of abuse for a minor that was under the age of 15 when the abuse occurred or if the perpetrator was a parent, step-parent, guardian, teacher or clergy. In addition, there is a statute of limitations (7 years) for reporting abuse when it occurred for a child who was 15 years old or older at the time when the abuse occurred (unless the perpetrator was a parent, step-parent, guardian, teacher or clergy).
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 the therapist 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 the therapist see each other accidentally outside of the therapy office, the therapist will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance, and the therapist does not wish to jeopardize your privacy. However, if you acknowledge the therapist first, the therapist will be more than happy to speak briefly with you, but feels it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

About the therapist:

I am a Licensed Marriage and Family Therapist in the state of Arizona, and in my practice, I follow the AAMFT Code of Ethics. I received my Master's Degree in Marriage and Family Therapy from ASU in 2004. I have extensive experience working with couples, families, children/adolescents, and individuals.

Areas of specialization include:

- marital/relationship difficulties (such as divorce, break-ups, conflict)
- individual struggles (such as anxiety, depression, work and/or academic concerns)
- parenting/child behavior problems (such as oppositional-defiant, aggression, compliance, school performance)

I work collaboratively in sessions to utilize people's strengths to accomplish their treatment goals. I believe everyone goes through difficult times in their life. My goal is to empower clients to identify the insight, tools, and skills necessary to make positive changes at times in their life when they are feeling "stuck".

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

______________________________ ____________________

Client Signature Date

______________________________ ____________________

Client Signature Date

PRACTICE POLICIES - 2022

FEES/BILLING/PAYMENTS

Payment for each session is due at the time of the session, unless other arrangements have been agreed upon. You will be asked to put a card on file for session fees and late cancellation/no show fees. This card will automatically be used to collect fees owed, unless other arrangements have been made. You can change your card on file at any point throughout treatment.

Please be aware that I am not an in-network provider with insurance.

Rates per **50 minute** session: **-Individual sessions = $140** **-Couple / family sessions = $150**

If requested, I do have the ability to provide you with a "super-bill" if you wish to explore out of network reimbursement options through your insurance company on your own.

Please be aware the full cost of the session is ultimately your responsibility. Any dispute over payments/out of network benefits with regard to your insurance company are your responsibility to resolve. Please educate yourself prior to your first session on the specifics of your out of network benefits if you want to explore that option.

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule 24 hours in advance. Email or voicemail is the only way to notify me of the need to cancel/reschedule. My practice does not utilize texting (outside of automated reminders). Failure to cancel or reschedule at least 24 hours in advance of your session time will result in a $70 fee. Providing at least 24 hour notice allows me the opportunity to attempt to fill the time slot that has been reserved for you. No showing your appointment will result in the full fee of the session ($140 or $150).

By agreeing to this, you are giving permission for your credit card to be charged the day of the scheduled session in accordance with these fees. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you will lose some of that session time. After 20 minutes, I will consider you to have no-showed the appointment unless you have notified me in advance that you are running that late. The standard meeting time for psychotherapy is 50 minutes. Requests to change the session length need to be discussed with the therapist in advance, and applicable fees will be discussed.

Frequent cancellations/no-shows may result in (1) not being able to schedule reoccurring appointments (i.e., not having a weekly, reoccurring day/time reserved for you) (2) not being able to schedule later afternoon appointments (these appointment times are highly sought and will be reserved for clients with consistent attendance) (3) a discussion about treatment and the possibility of treatment needing to be postponed until sessions can be attended regularly, as inconsistent attendance can affect progress towards treatment goals.

You have the ability to choose appointment reminders to help you avoid the fees above. Please choose this option on the portal if you would like these reminders activated.

The following related services are also billed at the following rates:

Unscheduled/Ad-Hoc/Crisis Sessions: $140 (Individual); $150 (Couple/family) per 50 minutes

Consultation Phone Calls > 10 mins= prorated @ $150/50 mins Requested Provider Documentation = prorated @ $150/50mins

Requested Documentation to Include Treatment Summary, Request of Medical Records, Other Provider Consultation, Written Letters, or

If court ordered to participate in any court proceedings (including preparation, transportation, attendance) = prorated @ $150/50 mins

No Contact / No Show to Scheduled Appointment – **Full Session Fee: $140 (Individual); $150 (Couple/family)**

Late Cancelled Appointment **< 24 Hours Notice = $70**

GOOD FAITH ESTIMATE:

You have the right to receive a "Good Faith Estimate" explaining how much your mental health care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

COLLECTIONS/CHARGING CARDS ON FILE

If at any time during or after the completion of treatment there is a balance on your account, I will use one of the cards you provided on your account to resolve the payment (unless other arrangements are made). If the funds are not available using the card/s on file, I will contact you about alternative payment options. If you are non-responsive about payment after 1 month involving 3 contact attempts, I will take the appropriate steps to involve a collection agency to rectify the balance.

TELEPHONE ACCESSIBILITY

If you need to contact the therapist between sessions, please leave a voice mail message at 480-336-0571. Do not utilize texting as a way of contacting therapist. The therapist is often not immediately available and an immediate response should not be expected. However, the therapist will attempt to return your call within 24-48 business hours, although this is not a guarantee. Moreover, a quick or immediate response in one situation does not constitute a commitment of rapid response in another situation. The therapist cannot respond to crisis situations by phone, text, or email. If you or someone you know is in crisis, please call the Maricopa County 24 hour crisis line at 602-222-9444.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, the therapist will not accept friend or contact requests from current or former clients on any social networking site.

ELECTRONIC COMMUNICATION

The therapist cannot ensure the confidentiality of any form of communication through electronic media, including text messages and email. Please be aware that the therapist will not communicate with you through text (beyond the automated text reminders which you can give consent for). If you choose to communicate via email regarding scheduling or cancellations, the therapist will do so. While the therapist may try to return messages in a timely manner, the therapist cannot guarantee immediate response and requests that you do not use any of these methods of communication to discuss therapeutic content and/or request assistance for emergencies. Please call the Maricopa County 24 hour crisis line at 602-222-9444 for any mental health crisis situations. By giving the therapist your email, you are consenting to be contacted through this email throughout treatment and after termination of treatment as would be necessary to discuss the balance on your account. If this is not the way you want to be contacted, it your responsibility to directly inform the therapist and to provide your preferred means of contact.

MINORS

In order to treat a minor, permission is required from the parent/guardian. It is preferable that both parents give consent. In situations where there is a custody arrangement, the therapist needs either the signature of both parents, or a copy of the custody paperwork (for the therapist's records) indicating that the parent providing consent has sole guardianship. Be aware that the therapist's role is to provide therapy to the family/child. The therapist's role is not to be an expert witness or to be used in any legal proceedings. By signing this consent, you are agreeing to not involve the therapist in any legal proceedings, and you are acknowledging that the therapist will not provide opinion about custody and/or visitation. If your adolescent comes to sessions without you present, the credit card on file will be charged the session fee. Providing your consent on this form allows the therapist to charge that card on the day of service. If you are a minor, your parents may be legally entitled to some information about your therapy. The therapist will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

COVID-19

I currently offer both in-person and tele-session options due to the current pandemic. These options may change at any time based on the pandemic or needs of my practice. If you choose to come into the office for in-person sessions during the COVID-19 pandemic, you are assuming the risk for exposure to COVID-19 or other public health risks. Clients should consult with their physician on public and personal health risk prior to making this decision. Clients are under no obligation to attend in-person therapy sessions and you may choose telehealth sessions at any time. I reserve the right to terminate any in-person sessions if it becomes unsafe during the COVID-19 pandemic. By signing below, you are indicating that you understand and agree to follow current CDC guidelines. I am fully vaccinated, but happy to wear a mask if requested! If you have tested positive for COVID-19 or have any symptoms, you agree to immediately notify me and agree to cancel the in-person appointment. You will not be charged a cancellation fee. Telehealth will remain as an alternative option for therapy.

You agree to not bring any additional people into the building that will not be participating in sessions. This decreases unnecessary exposure and allows for easier social distancing in the waiting room. I reserve the right to cancel our appointment and require you to leave the office immediately if you or another person in the office has a fever or any other symptoms. If I am sick, I will notify you so you may take necessary precautions. I reserve the right to amend, add, or abrogate any of the foregoing precautions according to any published federal, state, or local health guidelines. I will notify you of any changes to the agreement. In certain circumstance, I may be required to notify federal, state, or local health authorities that you have been in the office. This may occur if you have tested positive for COVID-19. If I am required to report this I will discuss this with you first and will only report the minimum information necessary for them to perform their health duties.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. The therapist may terminate treatment after appropriate discussion with you and a termination process if it is determined that the psychotherapy is not being effectively used or if you are in default on payment. The therapist will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason, or you request another therapist, I recommend the following options:

- Contact your insurance company for a list of contracted providers
- Psychology Today (website with local providers)
- GoodTherapy.org (website with local providers)
- Community Information and Referral- Dial 211 (for the state of Arizona)
- You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive months, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

__________________________________ ____________________
Client Signature Date

__________________________________ ____________________
Client Signature Date