INFORMATION FOR MY CLIENTS ABOUT MY PRACTICE

(Professional Disclosure Statement)

Welcome! I appreciate your trust and the opportunity to be of assistance to you. This letter is designed to answer some frequently asked questions about my practice and our relationship, so please read all of it before you sign it at the end. As you read it, please jot down any questions that come to mind so we can discuss them at our next session. This document is yours to keep for future reference. If you have not already received this document ahead of time and had time to read it, *the next time we meet I would ask that you be willing to sign my copy of this document* so as to indicate your understanding of office procedures and your willingness to abide by these policies.

1. My approach to Psychotherapy: You can only make the best decisions if you have enough information and understanding of how psychotherapy works. Let me discuss some aspects of psychotherapy as I see it. I embrace a solution-focused approach to counseling. My style is a combination of many techniques, some of which include cognitive or rational behavior therapy, solution-focused therapy, short-term psychodynamic therapy, traumatic incident reduction therapy, as well as others.

Therapy can be a large commitment of time, money, and energy, so a counselor should be carefully chosen. I strongly believe you should be comfortable, encouraged and optimistic with the counselor you choose.

You have the right to ask me about other treatments for your condition and their risks and benefits. If you could benefit from any treatments I know about that I cannot provide, I have an ethical obligation to assist you in obtaining those treatments. If at any time you wish another professional's opinion and wish to consult with another counselor, I can assist you in finding someone qualified and provide them with any information needed, included a summary of the services you have been provided.

Psychotherapy is not like visiting a medical doctor in that it requires your very active involvement and efforts to change your thoughts, feelings and behaviors. I will ask for your feedback and views on your therapy, the efforts and progress we are making, and other aspects; and I will expect you to be open about these. Offering your views and responses when they are important to you, even if I don't ask, is one of the ways you can be an active partner in your therapy. There are no instant, painless, or passive cures, no "magic pills." Instead, there may be homework assignments, exercises, practice sessions, and record-keeping, and perhaps other projects. Probably, you will have to work on relationships and make long-term efforts. Change will sometimes be easy and swift but more often it will be slow and frustrating with a need for repetition. If treatment is not progressing, I cannot ethically just keep working with you. I may then suggest that you see another counselor or professional in addition to or instead of me. For example, I may suggest that you see a physician for evaluation or prescription of medications, or attend self-help group meetings. In that event, I would fully discuss my reasoning and recommendations with you ahead of time so that we can come to an

agreement.

I see therapy as a collaborative process -- one which defines the problem areas to be worked on and where assistance is offered in making the desired changes. Periodically, together, we can evaluate our progress and goals and, if necessary, design a treatment plan, goals and methods.

As with any powerful treatment, there are both benefits and risks associated with psychotherapy. Risks might include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness; recalling unpleasant aspects of your history; missing work or school; or appearing or being judged as mentally disturbed or inadequate. Difficulties with people important to you may occur; family secrets may be disclosed; and, despite our best efforts, therapy may not work out well. Some changes may lead to worsening of your problems or even losses (for example, therapy may lead to the decision to separate or divorce).

Despite this, you should know that psychotherapy has been repeatedly scientifically demonstrated to be of benefit for most people and in most situations. Benefits might include the lifting of a depression or no longer feeling afraid or angry or anxious. You will have the opportunity to "talk things out" fully and completely until you are satisfied. Relationships and skills may improve dramatically. You may be better able to cope with social or family relationships, and so receive more satisfaction from them. You may better understand your personal goals and values and thus grow as a person and become more mature.

I do not take on clients whom, in my professional opinion, I cannot help using the techniques I have available. I will, therefore, enter our relationship with optimism and an eagerness to work with you.

2. Meetings

I usually schedule 90 minutes for the first introduction/assessment and information-gathering session; future meetings are usually in 50 to 60 minute intervals. We will schedule our meetings cooperatively for our mutual convenience. Since I typically do solution-focused brief therapy, we will meet more often over the first three or four months and then less often over several more months. A typical schedule is as follows: once a week for the first couple of weeks; then once every two weeks for the next few meetings; then spaced to three or four weeks in between sessions.

An appointment is a commitment to our work and a contract between us - we each agree and promise to be here and on time. On occasion, I may not be able to start on time. For this I ask your understanding and assure you that you will receive the full time agreed to. If you are late, we will probably be unable to meet for the full time scheduled as it is likely that I have another appointment scheduled after yours.

Your session time is reserved for you. Reality does not always allow us to keep our promises, but a canceled appointment is an interruption in our work, which will delay completing it. I am rarely able to fill a canceled hour unless I have a week's notice. I will make our meetings a first priority and ask you to do the same to keep missed hours to a minimum. If they exceed one every three months or so, I will have to charge you for the lost time unless I am able to fill it (your insurance will not cover this charge).

I do not have available personnel to supervise children in the reception area while we are meeting. Therefore, I request that you do not bring children with you *that need supervision* unless you have someone who can sit with them.

4. Fees

In any professional relationship, payment for services is an important issue. This is even more true in therapy, where clarity of relationships and responsibilities is one goal of treatment. You are responsible for assuring that services are paid for; this demonstrates your seriousness, sincerity and maturity. My current regular fee for assessment services is $150 for a 90 minutes session; and therapy services are $125 per hour for individual sessions and $140 per hour for family sessions. For clients who have insurance, there are specific contract rates, deductibles, co-pays and/or co-insurance amounts, and if you don't know the specifics of your policy, I can try to help you figure out those details. In unusual circumstances we may, before the end of our first meeting, negotiate other arrangements. In addition, I charge $100 per hour for those using my consultation service. The fees applicable to you will be outlined on your Agreement to Pay form.

I will assume that our agreed-upon financial relationship will continue in effect as long as I provide services or until you inform me that you wish to end it. I will expect you to pay for any services rendered to you until the time our relationship is terminated.

5. Billing, insurance and payments

Unless we have other arrangements, I would greatly prefer that you pay for each session (or any approved co-pay) at the end of the meeting. Please do not interpret this as any distrust of you or lack of faith in your responsibility and maturity. In my experience, I have found that this arrangement keeps our attention focused on our goals and makes it most productive. If paying by check, I suggest that you make out your check before each session begins so that our time will be used most productively.

If you have health insurance, which may pay a portion of my fee if I am not already an approved provider, I will help you with your insurance claim forms or provide you an insurance form known as a 'superbill.' However, please bear in mind that you are responsible and not your insurance company, for paying the fees we agreed upon. If I have agreed to bill a third party for your services and they do not make timely payment after being appropriately invoiced, then payment will be expected from you (the client). If there is any problem with my charges, billing, your insurance, or any other point, please bring it to my attention and I will do the same with you. Such problems can interfere greatly with our work and must be resolved openly and without delay.

6. Insurance coverage and reimbursement

As a Licensed Clinical Mental Health Counselor, my services for evaluation and psychotherapy are partly reimbursable to you under many health insurance plans. For some plans you may need to get a physician's referral for psychotherapy, which must be dated before we meet; so read your plan carefully. Because health insurance is written by so many companies, I may not be able to tell what your plan covers. Please read your plan's booklet under coverage for "Out-patient Psychotherapy" or

"Behavioral Health coverage" and call their office to find out the information you need. You are responsible for verifying your insurance coverages, deductibles, reimbursement rates, co-payments, and other aspects because the contract is between you and the company - not between me and the insurance company.

You can apply for reimbursement by simply mailing them my Statement (something called a 'Superbill' which is similar to a HCFA 1500 form) and a completed copy of their Claim Form, which you can get from your employer's Benefits Office or by calling the insurance company. You will know the information sought on the front of the form and my Statement meets their information needs, so just attach it to the back of their Claim Form and send it to them. Insurance companies are now guided by HIPAA regulations and only if requested should only receive a Designated Record Set (DRS) which includes your name, social security number, dates of first/last sessions and number of sessions, billing code, test results (if any), a symptoms and functionality checklist, and your provisional diagnosis (along with my fees/billing). This DRS becomes part of your permanent medical record, and although my experience indicates that a negative reflection is not at all a likely result, its possible influence on your future should be discussed with me if you are concerned. Basically, my policy is to provide the minimum information necessary for you to obtain reimbursement.

If you belong to an HMO or any other managed health care programs they will have rules, limitations and procedures, which we should discuss. Please bring your health insurance card with you to our first meeting so that I can have my medical biller check out the limits and specifics of your policy. By signing this statement, unless otherwise discussed, you give me permission to allow my medical biller to contact your insurance carrier to check on policy details and to file medical claims for you.

7. Contacting me: Out of consideration, I usually do not take calls when I am with a client; I will note the call and, as soon as I can, pick up any messages left on my answering machine. I cannot always be reached by phone immediately, but the office number is (603) 361-5043. If you leave a message, calls are usually returned by the end of that business day. In the event of emergency or if you have the need to reach me quickly, call my office line and let me know in the message that you would appreciate a return call as urgently as possible. Generally, messages are picked up and calls returned daily except on weekends and holidays. In emergencies, however, your calls will be returned as quickly as possible. In a dire emergency, if you cannot reach me, you might call your personal physician, go the nearest emergency room and ask for the psychiatrist, psychiatric resident or house officer on call, or call the ER at 9-1-1. Other possibilities include free 24/7 texting support for those in crisis: text 741741 from anywhere in the US to text with a trained Crisis Counselor; the Disaster Distress Helpline, which is a national hotline dedicated to providing immediate 24/7 crisis counseling for people who are experiencing emotional distress related to any natural or human-caused disaster (call: 1-800-985-5990); and the Veterans Crisis Line, which is free to Veterans and their loved ones (call: 1-800-273-8255). If you ever choose to reach out to a crisis service, please follow up with me on the next business day.

8. Confidentiality

I regard the information you share with me with the greatest respect so I want us to be as clear as possible about how it will be handled. In general, I will tell no one what you tell me. The confidentiality of our conversations, including your records, is legally

protected by federal and state law, including HIPAA, and by my profession's ethical principles, in all but a few rare circumstances. These are outlined in my handout on *Confidentiality and Psychotherapy,* which is also being provided to you.

Also, as outlined in my Confidentiality document, communication through electronic communication is generally not secure. By signing this document, you consent to the use of unsecured email and mobile phone text messaging to transmit information relating to scheduling appointments, and information on billing and payment.

9. My way of doing therapy

Each counselor has been taught and has expanded upon a way of doing therapy, where we have developed rules or methods, which have worked well. I will be happy to explain or clarify these if you would like more information.

I often lend books, which you may keep as long as they are of use to you; but (unless otherwise instructed) I ask you to return them so that I may lend them to other clients. I may also give you photocopies of articles or informational handouts, which are yours to keep.

I often take notes and sometimes ask my clients to take notes, both during the session and at home. Periodically I will also negotiate homework assignments with you. These can be a crucial component of personal change and if you are willing to fully participate with these tasks, you will maximize your therapy dollars.

10. Your case records

You have the right to review your medical record (see limitations in HIPAA section of Confidentiality handout) in my files at any time, to request additions or corrections, and to obtain copies (with your written permission) for other professionals to use.

11. Termination

Termination is inevitable. It should not be done casually, as it can be made a most valuable part of our work. If you would like to take a "vacation" from therapy, we should discuss this so as to make it most productive.

12. Evaluation of treatment

If at any time, you feel dissatisfaction with any aspect of therapy, please discuss your views, reasons, concerns or plans or whatever is troubling you with me as soon as possible so we can resolve the problem.

13. Contact person

If, during our work together there is an emergency or I become concerned about your personal safety or the possibility of your injuring someone else, I am morally and legally obliged to contact the person you identified upon completion of your intake information.

14. My background

Because we all need to know we are in good hands, I indicate my credentials below. If you wish more information on my background or training, please feel free to ask. I am a Licensed Clinical Mental Health Counselor, a National Certified Counselor, a Licensed Professional Counselor, and I have a Master's Degree in Mental Health Counseling from the University of Massachusetts Boston. I have worked within agency settings (Mental Health), residential treatment centers, schools, and have been in private practice. I have training and experience in individual, family, and marital therapy and also in many specialty areas. I am a member of the American Mental Health Counselor Association and many other organizations and have received training from MUSC's Trauma Informed Cognitive Behavioral Therapy Program. I am certified in Trauma-Focused Cognitive Behavioral Therapy with children and adolescents aged 4-17 and a second trauma-informed treatment, Child Parent Psychotherapy, aimed for treatment with younger children.

15. Complaint procedures

If you are dissatisfied with any aspect of my work, please raise your concerns with me immediately. Dissatisfactions will make our working together slower and more difficult if not resolved. If you feel that you have been treated unfairly or even unethically, by me or any other counselor, and cannot resolve this problem with me, you can contact the N.H. Board of Mental Health Practice (121 S Fruit Street Concord, NH 03301, phone: (603) 271-2702 and speak to the Chairperson of the Ethics Committee for clarification or to lodge a complaint. There may be other options, which I would be glad to expound upon if you so desire.

16. Additional points

Private Practitioner: I sometimes allow another counselor to share my office space, however each of us operates independently and is solely responsible for the quality of the care he or she provides.

Tele-Health: Please note that my services will be the exact same whether they are provided face-to-face or via a HIPAA compliant tele-health platform (doxy.me). You should expect my undivided attention and expertise during a tele-health session, the same as you would in my office. I will always do everything I can to ensure the protection of your health information when services take place via an online platform. Please feel free to ask any additional questions related to safety and online (utilizing a secure WIFI network, password securing devices, etc.).

Code of Ethics: Like any health care professional, I have an ethical responsibility and am also available to answer professional questions, which you have the right to raise. I fully abide by the Ethical Principles of the American Mental Health Counselor Association and the S.C. Board of Mental Health Practice.

Out-of-Office Contact: As a result of our special, professional relationship, one frustration of being a counselor is that I cannot now nor will I ever be your "friend." I will not see you socially or enter into any business or other relationship besides the therapeutic one, no matter how rational or beneficial it may seem at the time. For this reason, my licensure board advises that we not request or accept friend requests on social media sites like Facebook. If we happen to cross paths on the street or socially, I

will minimize our conversation so as not to run any risk of breaching confidentiality in an open environment. I will never introduce you to someone I may be with as "a client." You are welcome to approach me if you wish to, but please know I will not initiate any contact in respect for your privacy. Also, I will never betray your trust nor could we ever enter into or pursue a sexual relationship, as this would be highly unethical.

Recovering Memory Work: People often approach me to help them recover memories of past traumas. I do not employ hypnosis as part of the techniques I use. I will be happy to work with you to sort out troublesome memories, intrusive thoughts, dreams, etc., however memory work often does not have concrete resolution. Regardless of whether we can prove that a memory or dream is based on fact, we can work with the feelings associated with the same.

Limitations: I am not licensed or trained to practice law, medicine, social work or another profession and am not willing, nor capable of giving you trustworthy advice from other professional points of view.

Non-Discrimination: In my professional practices, as counselor, consultant and teacher, I do not discriminate in accepting and treating patients, clients, students or others on any of these bases: age, gender, marital status, race, color, religious beliefs or creed, belief, ancestry, national or ethnic origin, ethnicity, location of residence, physical or mental disability or handicap, veteran status, sexual orientation, health status, having a criminal record unrelated to present dangerousness, or in violation of federal, state or local laws or executive orders. This is both a personal commitment and is made in accordance with federal, state and local laws and regulations. If you believe you have been discriminated against please bring this matter to my attention immediately.

17. Agreement

I have read (or had read to me) the issues and points stated above, discussed them where I was not clear about those points, had my questions fully answered, and understood and agree to comply with them, I hereby agree to enter into psychotherapy with this counselor as indicated by my signature below.

_____ _____

Client Date

I, the counselor, having interacted for a suitable period of time, find no reason to believe that client(s) is/are not fully competent to give full consent to treatment. Furthermore, believing the issues raised above are fully understood, and because I have personally informed the client(s) of the above-stated issues and points, discussed them, and responded to all questions raised, I agree to enter into psychotherapy with client(s) as indicated by my signature below.

_____ _____

Andrea Cotone, LCMHC, Clinician Date

I truly appreciate the opportunity you have given me to be of professional service to you and am happy to receive your questions, comments, suggestions or concerns at any time.

Consent to Treatment

I acknowledge that I have received and understand the "Information for Clients" brochure and/or other information about the therapy I am considering, and I have had an opportunity to have all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of Client (or person acting for client) Date

_____ _____

Printed name Relationship to client (*if not self)*

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Therapist Date

CLIENT INFORMATION SHEET

Date: _____

Name: _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

E-mail: _____

Date of Birth: _____ **SSN:** _____

Occupation: _____

Employer: _____

Name of Spouse or Significant Other: _____

Children? If yes, names and ages: _____

_____

Referral Source: _____

Are you currently working with another therapist? (If so, who?)

_____

Have you had any therapy experiences before? (If so, when?)

_____

Are you on any medications at this time? If so, list them:

_____

Contact in case of emergency: _____

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DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM I MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

_____

NOTE: you may revoke or modify an authorization with regard to any family member or other individual but such revocation or modification must be in writing.

_____

HIPAA Notice of Privacy Practices

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

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website **(if applicable).** You may also request a copy of this Notice from me, or you can view a copy of it in my office or on my website, which is located at **www.AndreaCotoneLCMHC.com**.

III. HOW I WILL USE AND DISCLOSE YOUR PHI. I may use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to state or federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the NH Dept of Social Services.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by Adult Protective Services.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.

15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. NOTE: in cases where only a subpoena is issued, this provider will require a court order or the signature of a Release.
17. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
18. **If disclosure is otherwise specifically required by law.**

C. 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 individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email. You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

Andrea Cotone
N.H. Bypass 28
Auburn, NH 03032
(603) 361-5043
AndreaCotoneLCMHC@gmail.com

VII. NOTIFICATIONS OF BREACHES In the case of a breach, **ANDREA COTONE** requires to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was

caused by a business associate, **ANDREA COTONE** is ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website. **ANDREA COTONE** bears the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

VIII. PHI AFTER DEATH Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. **ANDREA COTONE** may disclose deceased individuals' PHI to non-family members, as well as family members, who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

IX. Individuals' Right to Restrict Disclosures; Right of Access To implement the 2013 HITECH Act, the Privacy Rule is amended **ANDREA COTONE** is required to restrict the disclosure of PHI about you, the patient, to a health plan, upon request, if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. (OCR clarifies that the adopted provisions do not require that covered healthcare providers create separate medical records or otherwise segregate PHI subject to a restrict healthcare item or service; rather, providers need to employ a method to flag or note restrictions of PHI to ensure that such PHI is not inadvertently sent or made accessible to a health plan.)

The 2013 Amendments also adopt the proposal in the interim rule requiring **ANDREA COTONE** to provide you, the patient, a copy of PHI to any individual patient requesting it in electronic form. The electronic format must be provided to you if it is readily producible. OCR clarifies that **ANDREA COTONE** must provide you only with an electronic copy of their PHI, not direct access to their electronic health record systems. The 2013 Amendments also give you the right to direct **ANDREA COTONE** to transmit an electronic copy of PHI to an entity or person designated by you. Furthermore, the amendments restrict the fees that **ANDREA COTONE** may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access, from up to 90 days currently permitted to 30 days, with a one-time extension of 30 additional days.

X. NOTICE OF PRIVACY PRATICES (NPP) **ANDREA COTONE** must contain a statement indicating that most uses and disclosures of psychotherapy notes, marketing disclosures and sale of PHI do require prior authorization by you, and you have the right to be notified in case of a breach of unsecured PHI.

XI. EFFECTIVE DATE OF THIS NOTICE **I acknowledge receipt of this notice on the date written below.**

Signature: _____

Date: _____

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I, the undersigned, request that ANDREA COTONE, LCMHC provide professional services to me/or _____ as a client, and I agree to pay this therapist's fee ($150 for initial assessment; $125 per hour for individual office / tele-health visits and $140 per hour for family office / tele-health visits) for these services. NOTE: These rates may be less if insurance is being processed and any special rates have been agreed upon with the insurer.

I have been provided with this therapist's Information for Clients brochure and agree to cooperate with and abide by all of its provisions as indicated by my signature there.

If the client is a minor, I understand that while I have a right to general information on issues and progress, some information shared in this professional relationship will be held in confidence by the therapist and the minor child.

If, at any time, I am dissatisfied with this therapy I will fully discuss my views, reasons and plans with the therapist (and if the patient is a minor, with the patient named above).

Andrea Cotone, LCMHC

I agree that this financial relationship will continue in effect with the above named professional as long as this therapist provides services or until I inform her, in person, by telephone or by certified mail, that I wish to end it. I agree to pay for services rendered to this patient up until the time I terminate the relationship.

I understand that I am responsible for charges for services provided by this therapist to this client, although other persons or insurance companies may make payments on this client's account.

Signature: _____

Printed name: _____

Relationship to the patient: o Self o Other: _____

Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I, _____, (hereinafter "Client") hereby authorize ANDREA COTONE (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client, to:

_____
_____
_____
_____

Please include the provider's / individual's name, address, phone number, and fax number

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has already taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider.

This disclosure of information and records authorized by Client is required for the following purpose: treatment collaboration only when deemed relevant / necessary by Provider AND Client and only when alerted to Client prior to disclosure (outside of emergent needs).

The specific uses and limitations of the types of medical information to be discussed are as follows: Assessment, diagnosis, and treatment as deemed relevant

Such disclosure shall be limited to the following specific types of information: such information necessary to be released for designated purpose above.

Therapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state law may protect such information.

This authorization shall remain valid for one year from date of signature.

_____ _____

Client Signature **Date**