

Notice of Privacy Practices

This notice describes how medical information about you may be used by Great Basin Behavioral Health (GBBH) and disclosed and how you can get access to this information. **Please read this section carefully.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form are kept properly confidential. HIPAA gives you the right to understand and control your protected health information (PHI). There are penalties when PHI is misused.

GBBH is required to maintain the privacy of your health information and can release PHI only for the purposes of treatment, payment, or health care operations. Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. Payment means obtaining reimbursement for services, confirming coverage, billing and collections, and utilization review. Health Care Operations includes conducting quality assessments and improving activities, auditing, cost management analysis, and customer service. GBBH may also release PHI for law enforcement or other legitimate reasons.

We may also create and distribute de-identified health information by removing all references to PHI. We may contact you to provide appointment reminders via email, phone or text, information about alternative treatments, health-related benefits and services, and fundraising communications that may be of interest to you.

Disclosure of PHI will be made following written authorization from you. This may include disclosure of psychotherapy notes, marketing materials, sales of PHI under HIPAA, or other disclosures not included in this notice. You can revoke such authorization and we will abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You have the right to request restrictions on certain uses and disclosures of PHI, including those related to family members, other relatives, personal friends, or any others identified by you. We are, however, not required to honor a request restriction except in limited circumstances, which we shall explain if you ask.

You have the right to reasonable requests to receive confidential communications of PHI by alternative means and locations. You have the right to copy and inspect your PHI. You have the right to amend your PHI. You have the right to receive an accounting of disclosures of your PHI. You have the right to obtain a paper copy of this notice upon request. You have the right to be advised of your unprotected PHI that is disclosed.

If you pay for services privately, you have the right to request that we do not disclose PHI related to your health plan. We will accommodate this request, except where required to disclose by law.

This notice is effective as of January 1, 2014 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms and to make the new notice provision effective for PHI that we maintain.

If you feel that handling of your PHI has been violated, you have the right to file a formal, written complaint with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Confidentiality in Therapy

Professional ethics and state laws prevent therapists from telling anyone else what is shared in therapy without written permission. There are exceptions to this rule, when therapists must break confidentiality. These exceptions are outlined below for your review.

When you or other individuals are in physical danger, I must report this. Specifically, I will report if I believe:

- You are threatening serious harm to another person.
- You are seriously threatening to harm yourself. And/or your life or health is in grave danger.
- You may be abusing a child, an elderly person, or a disabled person. "Abuse" means to neglect, hurt, or sexually molest another person.

If you become involved in a court case or proceeding, you can prevent me from testifying in court about what you have told me. However, there are some situations where a judge or court may require me to testify:

- Child custody or adoptions proceedings, where your fitness as a parent is questioned or in doubt.
- In cases where your emotional or mental condition is important information for the court's decision.
- During a malpractice suit filed against me or another professional.
- In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.
- When you are seeing me for court-ordered evaluations and treatment.
- If you were sent to me for an evaluation by worker's compensation or Social Security disability.

In terms of insurance, money, and confidentiality:

- If you use your health insurance to pay part of my fees, the insurance company, managed care organization, or your employer's benefits office can require me to provide information about your functioning in many areas of your life, your social and psychological history, and your current symptoms. I will also be required to provide a treatment plan for your problems and information about your progress in therapy.
- It is against the law for insurers to release information about our office visits to anyone without your written permission. Although I believe the insurance company will act legally and morally, I cannot control who sees this information after it leaves my office.
- If you have been sent to me by your employer's employee assistance program, the program's staffers may require some information. Again, although I believe they will act legally and morally, I cannot control who sees this information after it leaves my office.
- If your account with me is unpaid and we have not arranged a payment plan, I can use legal means to get paid. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due.

Children, families and couples have some special considerations:

- When I treat children under the age of 12, I tell their parents or guardians whatever they ask me. As children get older, they assume legal rights. Between the ages of 12-18, most of the details will be treated as confidential. However, parents or guardians do have the right to general information, including therapy progress. I may also have to tell parents or guardians information about others that I am told, especially if I am concerned about harm to the child.
- When I treat several members of a family, confidentiality can become very complicated. At the start of treatment, we must all have a clear understanding of our purpose and my role. Then we can further discuss confidentiality.
- If you tell me something your spouse does not know, and knowing this could harm him or her, I cannot promise to keep it confidential.
- If you and your spouse have a custody dispute, I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluations.
- If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify.
- In couple's treatment, the medical record "belongs" to the member who's chief complaint brought the couple to treatment. This member has primary control over the contents of the record and who may or may not have access to its contents.

There are a few other things you should know about confidentiality:

- I may sometimes consult with another healthcare professional about your treatment. The other individual is also required to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist will be available to help my clients. In these situations, I must give the individual some information about my clients.
- I am required to keep records of your treatment.
- I will not record our therapy sessions on audiotape or videotape without your written permission.
- Confidentiality in group therapy is a special situation because members involved in the group are not therapists. They do not have the same ethics and laws, so you cannot be certain that they will not share information you say in a group setting.
- If you want me to send information about our therapy to someone else, you must sign a "Release of Information" form.
- A court will not consider any information you tell me and also share outside of therapy, willingly and publicly, protected or confidential.
- If unethical behavior is noted by another behavioral health professional, I may be required to report said behavior to their licensing board.
- Cell phones and email are less secure forms of communication. If you choose to use these forms of communication to communicate with our practitioners, we cannot assure your privacy as well as we can through "landline" based communication or fax.

The rules of confidentiality are complicated! Please keep in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you speak with a lawyer to protect your interests legally.

Client Rights and Responsibilities

In the course of care, a client has both rights and responsibilities. Clients have the right to:

- Be treated with respect and recognition of their dignity and right to privacy
- Receive care that is considerate and respects their personal values and belief system
- Personal privacy and confidentiality of information
- Receive information about their insurance carrier's services, practitioners, clinical guidelines, quality improvement program and consumer rights and responsibilities
- Reasonable access to care, regardless of their race, religion, gender, sexual orientation, ethnicity, age, or disability
- Participate in an informed way in the decision making process regarding their treatment planning
- A candid discussion with their treating professionals about appropriate or medically necessary treatment options for their condition regardless of cost or benefit coverage
- Participate in treatment planning (if over the age of 12) and have family members participate in such planning
- Individualized treatment, including
 - Adequate and humane services regardless of the source(s) of financial support
 - Provision of services within the least restrictive environment possible
 - An individualized treatment or program plan
 - Periodic review of the treatment or program plan
- Designate a surrogate decision maker if they are incapable of understanding a proposed treatment or procedure or are unable to communicate their wishes regarding care
- Be informed, along with their family, of their insurance carrier's rights in a language they understand
- Voice complaints or appeals about their insurance carrier, their provider of care or privacy practices
- Make recommendations regarding their insurance carrier's rights and responsibility policies
- Be informed of the reason for any utilization management adverse determination including the specific utilization review criteria or benefits provision used in the determination
- Have utilization management decisions based on appropriateness of care. Their insurance carrier does not reward practitioners or other individuals conducting utilization review for issuing adverse determinations for coverage or service
- Request access to their Protected Health Information (PHI) or other records that are in the possession of their insurance carrier
- Request to inspect and obtain a copy of their PHI, to amend their PHI or to restrict the use of their PHI, and to receive an accounting of disclosures of PHI

Clients are responsible for:

- Providing (to the extent possible) their treating clinician and their insurance carrier with information needed in order to receive appropriate care
- Following plans and instructions for care that they have agreed on with their treating clinician
- Understanding their health problems and participating, to the degree possible, in developing, with their treating clinician, mutually agreed upon treatment goals

Professional Services Agreement

Treatment Expectations:

Great Basin values your trust in our services and we value building a strong, healthy relationship between our clientele and our practitioners. In order to maintain this trust and to build this foundation, we believe in maintaining full transparency and accountability. The following expectations are clarified in order to maintain a strong working relationship and avoid misunderstandings and potential conflict in our relationship.

Professional Fees and Billing:

All fees are expected at the time services are rendered. Great Basin accepts cash, check, and credit cards for payment. A receipt is available for your records and may be printed or sent electronically through email. Great Basin is able to keep a credit card on file for billing purposes and bill services automatically for your convenience. The below rates are billed to insurance. **"In Network" rates are typically lower, as these rates are negotiated with each insurance carrier and vary by insurance company.**

- **Psychotherapy**
- Initial Consultation \$250
- 45-60 Minute Individual/Family Session \$200
- Group Session \$50/group
- Grad Student Intern \$50/session

***Please note that there is an administrative fee of \$.60 per page, plus postage and handling, for copies of medical records, other than those sent to other health practitioners for coordination of care purposes. Furthermore, there are "add on" codes that are occasionally used in treatment, such as "Interactive Complexity" that is billed in addition to our per-session fees for cases involving the use of additional resources, time and/or effort, such as those that require contact with outside practitioners (e.g. Probation Officers for example) or individuals other than the client (e.g. parental involvement that is required due to communicative deficits of a child). Fees related to returned payment (e.g. insufficient funds; credit card chargeback fees) will be forwarded to the responsible party for payment. All available means may be utilized to collect on debts, to include use of credit cards on file, collection agencies and legal action via small claims court. Prompt payment discounts and/or courtesy credits may be applied if/when applicable in cases involving clients paying for services at the full cash rate. Balances due may be written off at our discretion and on a case by case basis.

Insurance Reimbursement:

Most of Great Basin's practitioners are contracted with insurance carriers as "in network" providers. If and when this is the case, we will attempt to verify benefits at the time of your initial appointment. However, it is ultimately the client's responsibility to understand the limitations of insurance reimbursement. **Any amount denied by the client's insurance carrier would be the financial responsibility of the client. If and when a collections agency becomes involved due to non-payment for services, a \$50 "administrative fee" may be assessed and forwarded with your statement to said collections agent.**

If Great Basin is not contracted with your insurance, our agency is able to provide you with a super-bill that you may submit to your insurance carrier for "out of network" reimbursement.

Insurance Credentialing and Billing:

Some of our practitioners bill through their own NPI and/or professional license, whereas others bill insurance through their supervisor and/or our group practice. At times, Explanation of Benefits (EOB's) may come from your insurance company with a rendering provider name being our group practice name and/or one of our supervising clinicians. If and when this causes concern or is confusing, please contact our office for verbal clarification.

Attendance and Cancellation Policy:

Great Basin values your time and we strive to be available for as many members of our community as possible. In order to do this, we hold a high standard for our staff and our clientele as it relates to attendance and cancellations.

Great Basin expects clientele to be present for services as agreed and in a timely manner. For treatment to move forward and be viable, consistent attendance is necessary and will be determined as part of the treatment planning

process. Treatment and adherence is always “at will” and voluntary, however, effective treatment is at the discretion of each practitioner and their treatment plan is expected to be followed accordingly in order to attain positive results.

***** A minimum of 36 hours notice is expected for ALL cancelations or rescheduled appointments*****

- Late Cancelations, defined as any cancelation that occurs **under 36 hours** prior to the beginning of a session and more than an hour prior, will be assessed a **\$50 fee (may be reduced for grad student interns)**
- A “Last Minute Cancel/No Show” is defined as **canceling a session within 60 minutes prior to a scheduled session** (e.g. not canceling by 1:00pm for a 2:00pm appointment) and when contact was not made with our office prior to the start time of the appointment. **There is a “Last Minute Cancel/No Show” fee of \$100**
- After any of the following have occurred, your case will be staffed by our administration and/or treatment team and you **may be terminated for services**:
 - Two (2) concurrent weeks of either late cancelation or “Last Minute Cancel/No Show” appointments
 - Three (3) late cancelations or “Last Minute Cancel/No Show’s” in any 90 day period
 - One (1) “No Show” may lead to removal from a standing appointment and appointments will be made on a week by week basis

Excessive cancelations may lead to the termination of services. If and when this is the case, a termination letter or email may be sent to the address on record and referrals will be provided for continuation of care. After a missed appointment, if you do not contact our office within ten business days to reschedule, Great Basin will accept that as your notice that you have terminated services with our office.

When an appointment is scheduled with Great Basin, you are holding a time on a clinician’s calendar that cannot be used in treating another person. This is time reserved for you and it is expected this time will be well utilized. “No Shows” to appointments impact our ability to serve others well and will not be tolerated.

A reminder contact will be attempted 1-2 days prior to appointments via email, text and/or phone and clientele are expected to be available for services when scheduled. This reminder is for your convenience and should not be relied upon. **Late cancelations and “No Shows” are billed a fee of \$50 - \$100 (See above; \$20 for groups; a minimum of \$10 and up to \$50/full cash rate for grad student interns)**, which will either be charged to a credit card on file or billed accordingly. **If a client presents more than 15 minutes late to services, the session may be considered canceled and billed the “No Show” rate specified above.** When this agreement is complete and on file prior to your initial appointment and you either late cancel or fail to present for services, you will be responsible for a late cancel or no show fee.

Credit/Debit Card on File:

When an appointment is made with a Great Basin clinician, this time is set aside and reserved solely for you and your family. Because this time is reserved, it may not be held for other members of our community who are also in need of our services and, at times, may have been referred to other clinicians or placed on a wait list for services.

Please, note that the reason behind this policy is to **protect the provider’s time, not to penalize you financially**. If you are wondering why you should pay for the services you have not received, please, consider the fact that when you make an appointment with the provider, you are booking the provider’s time that is no longer available for scheduling. Your session time is reserved/booked for you. We are rarely able to fill a cancelled session unless we know in well in advance. Please, note that your insurance will not cover this charge.

As a condition of reserving/scheduling sessions, Great Basin requires a credit or debit card be kept on file. This information is kept on an encrypted, offsite server and is made part of your medical record.

A card number is required to be kept on file. This number will only be used to collect fees related to late cancelations and/or “no show” fees, coinsurance, deductibles or other monies due during and/or after services are

rendered/completed. Another form of payment may be used during treatment as an adjunct or in place of this credit/debit/HSA card.

***** The credit card will be inputted into our secure database and may be changed at any time*****

By signing below, I attest that I have provided a credit card that I am authorized to use at the time of initiation of services with Great Basin Behavioral Health and this card may be used at the time of services and/or thereafter to pay for copays, co-insurance, deductibles and fees associated with the services I have been offered or provided. I also agree to provide a new card if and when needed as a means of securing my appointments with Great Basin Behavioral Health and will inform Great Basin Behavioral Health staff if/when a replacement card may be needed to secure said services.

Printed Name

Signature

Date

Contact Outside of Session:

Great Basin may be contacted outside of regularly scheduled sessions by phone, mail, or email. Great Basin practitioners strive to be available within a reasonable timeframe, which we define as within 24 business hours (e.g. during the traditional M-F workweek, during daytime hours, and closed for major holidays). **Emergencies that cannot wait for a return call should be directed to the Crisis Call Center at 800-273-8255, West Hills Hospital at 775-323-0478, or 911. Great Basin Behavioral Health does not have clinicians "on call" outside of regular hours, typically weekdays from 8am to 6pm.**

Excessive contact or requests for significant out of session support services beyond a 5-10 minute time obligation will lead to the expectation for reimbursement at a prorated rate of **\$2 per minute**, which may not be covered by insurance, and at the discretion of each practitioner. If requested for legal consultation or court appearance, the expected reimbursement rate is **\$300/hour for both preparation and presentation/testimony**, plus travel expenses beyond 25 miles.

Telehealth Services and Confidentiality

Great Basin is proud to offer Telehealth mental health services. This is an option for many of our client's who cannot present in person for a variety of reasons, including illness or injury, weather, work/scheduling limitations, geographical distance (e.g. living in another county), or severe panic/agoraphobia. Some restrictions apply, please consult our office staff for details if you are interested in this service line.

I understand that Telehealth services include consultation and treatment using interactive audio, video, and data communications. I understand that my rights are no different than if I were attending therapy in person and are reflected in the initial consent to treatment however some exceptions exist:

- We utilize a HIPAA compliant Telehealth service that is secure and encrypts file sharing, video and audio
- You are responsible for ensuring privacy and confidentiality on your end of the transmission. This is best accomplished by finding a quiet, private room for your session. We cannot guarantee your privacy based on where you decide to conduct the session
- The laws that protect the privacy and confidentiality of your medical record also apply to video based counseling services
- You agree to be in the state of Nevada at the time Telehealth services are rendered
- In an effort to reduce technical issues you agree that you will be required to download and test your device and internet connection with the approved HIPAA compliant software (Thera-LINK) prior to your first session
- If a session is interrupted by technical difficulties, every effort will be made to reconnect the transmission immediately, however, please understand that the session may need to be rescheduled

- Sessions are not to be recorded in any way without prior written consent by yourself and/ or your therapist
- You agree and understand that during the first Telehealth session, you will be asked to provide information that allows your therapist to get appropriate emergency personnel to your location if needed. This information includes, but is not limited to:
 - o Emergency Contact Person(s)
 - o Your physical location
 - o Assurance that you're located in a comfortable, private place of your home/office

Therapeutic Lifestyle Change:

Great Basin clinicians and other professionals often recommend Therapeutic Lifestyle Change (TLC) as part of our treatment approach. This includes, but is not limited to:

- Changes in frequency, intensity and/or duration of physical activity
- Modifications to ones diet and/or eating habits
- Changes in substance use (e.g. caffeine, alcohol, tobacco, drugs, and etcetera)
- Inclusion in activities outside in natural settings (e.g. walking outside near a river; hiking in the foothills)
- Involvement in social activities with local and/or online entities

It is the responsibility of the individual client and/or guardian to assure medical oversight is obtained via a primary care physician, family practice physician, pediatrician, nutritionist/dietician, or other medical professional prior to and while engaging in TLC. GBBH is not liable for damages, injuries or ailment in relation to client engagement in said activities outside of session and/or outside of the scope of each individual practitioner and their professional area of expertise.

I have read and understand the sections above, including those on HIPAA, Privacy, Confidentiality, Client Rights and Responsibilities, Attendance and Cancellation Policy, Credit/Debit Card on File Policy, and the Professional Services Agreement of Great Basin Behavioral Health and have been offered a copy of this agreement at the time of signing.

Client Printed Name

Client Signature and Initials

Date

Guardian Signature and Initials (if applicable)

Date

If/when a couple presents for services, please initial all forms above and sign below:

Partner Printed Name

Partner Signature and Initials

Date

RELEASE OF INFORMATION OR AUTHORIZATION (OPTIONAL)

Client Name: _____ Client DOB: ____/____/____

I give my permission for health care information to be exchanged between Great Basin and the following:

Agency/Organization/Person	Phone #	Fax #
----------------------------	---------	-------

Agency/Organization/Person	Phone #	Fax #
----------------------------	---------	-------

Agency/Organization/Person	Phone #	Fax #
----------------------------	---------	-------

Information may consist of **(Circle AND initial all that apply):**

- | | | |
|--------------------|---------------------------|---------------------|
| All Records | Progress Notes | Discharge Summaries |
| | Mental Health Evaluations | Treatment Updates |

- I understand that this disclosure is for the purpose of treatment/coordination of care
- GBBHW must offer to and/or provide me with a copy of this authorization.
- I understand that, unless lined through and initialed, information to be released/authorized may include information regarding the following: Substance Use, Psychiatric Conditions/Treatment, HIV/Auto Immune Deficiency Syndrome or other health related conditions.
- I understand that by releasing this information to other parties, it may not be protected by HIPAA regulations.
- I understand that I may revoke this release/authorization at any time by giving written notice to GBBH, except to the extent that action has already been taken to comply with it. Without such revocation, this release/authorization will expire on ____/____/____ (date), or if left blank, **one (1) year** from the date of my signature.
- I understand I must be given a copy if this is an authorization or release of alcohol and drug information. If applicable, an assessment of the minimum necessary amount of information required has been applied to this release/ authorization.

Signature of Client/Parent/Legal Representative

Print Name and Relationship of Legal Representative (if applicable)

Date Signed: ____/____/____