

## HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

- **CONFIDENTIALITY PLEDGE.** We are committed to protecting your medical information. All information shared in treatment is confidential except in the circumstances as described below. This notice describes how we may use and disclose medical information.
- **TREATMENT.** We may use or disclose your medical information to provide you with treatment or services, for coordination of treatment with other professionals, to recommend other treatment options, or in life threatening situations. In non-life-threatening situations, we will obtain your written consent to speak with other professionals or persons about your treatment.
- **PAYMENT & INSURANCE COORDINATION.** We may use or disclose your medical information so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, and or a third party.
- **HEALTHCARE OPERATIONS.** We may use or disclose your medical information for our office operations. For example, after your intake appointment, another staff member may be responsible for data entry and or verifying your insurance benefits. We may also review clinically relevant information to evaluate and assess treatment you are receiving.
- **COMMUNICATION WITH YOU.** We may use or disclose your medical information to communicate with you. We may communicate with you by calling you, leaving a voice message, sending you a text message, and or sending you an email. It is your responsibility to let us know your preferred method of communication as well as which methods of communication you do not give consent.
- **REQUIRED REPORTING.** We may use or disclose your medical information to report suspected abuse and/or neglect of a minor person, elderly person, or disabled person as required by law. *We are not required by law to notify you of such disclosures. We will use our professional discretion to decide if we will share such disclosures with you.*
- **LIFE THREATENING SITUATIONS.** We may use or disclose your medical information to avert a serious threat to your life or the life of another. For example, if we suspect you are experiencing thoughts and behaviors related to suicide, homicide, self-harm, or harm towards another, we will use our professional discretion to disclose this information to keep you and the public safe as required by law.
- **COURT ORDERED REPORTING.** We may use or disclose your medical information to comply with court orders, judicial proceedings, or other legal processes related to law enforcement, national security, and or legal and administrative actions.
- **STATE AND OTHER FEDERAL LAWS.** *The Nourish Place* will comply with all applicable state and federal laws. For example, under state law, there are more limits on the disclosures of medical information and the revocation of consent.
- **WRITTEN CONSENT FOR DISCLOSURES.** Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written consent. If you provide us written consent to use or disclose medical information, you may revoke that consent, in writing, at any time. You understand that we cannot take back information already disclosed prior to the written revocation of consent.

## YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have many rights with regard to your medical information. If you wish to exercise any of these rights, you must submit your request in writing, unless otherwise noted. **The fee for each records request is \$50.**

- **RIGHT TO INSPECT AND COPY.** You have the right to inspect and copy medical information that may be used to make decisions about your care. We charge a \$50.00 administrative fee for the cost of releasing your records, regardless of format or reason released. Mailing or other supplies associated with your request will be handled on a case by case basis.
- **RIGHT TO AMEND.** If, after inspecting your records, you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to add a statement. You must provide a reason supporting your request for an amendment. The amendment will be included in your records.
- **RIGHT TO AN ACCOUNTING RECORDS.** You have the right to request your accounting records, to requests statements as needed, and to review payments made by insurance companies and or any other third party payer. We keep insurance payments in your records. If more detailed insurance records are needed, we ask that you contact your health plan directly.
- **RIGHT TO REQUEST RESTRICTIONS.** You have the right to request a restriction or limitation on the medical information we use or disclose about you. For any services for which you **paid out-of-pocket in full**, we will honor any request you make to restrict information about those services from your health plan, provided that such release is not necessary for your treatment. In all other circumstances, we are not required by law to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS.** You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. If we maintain medical information about you in electronic format, you also have the right to obtain a copy of such information in electronic format and to direct us to transmit such information directly to an entity or person clearly, conspicuously, and specifically designated by you. We will not ask you the reason for your request. You may make this request in writing or verbally.
- **REQUESTING RECORDS.** Records may only be released if you provide a formal written request **and** sign a “Consent for Release of Confidential Information” form **and** provide a copy of your driver’s license. Records will be available within 14 business days from the receipt of the written request. If records are subpoenaed, this does not indicate an automatic release of records. In order to provide the best service for our clients, The Nourish Place reserves the right to schedule a consultation at the initial request for the release of records to discuss the risks and benefits of releasing any records. If the client is a child and one parent requests the records, the co-parent will be notified of the request by the counselor.

- **RIGHT TO PAPER COPY OF THIS NOTICE.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.
- **RIGHT TO FILE A COMPLAINT.** Counseling services at The Nourish Place will be rendered in a professional manner consistent with up to date legal and ethical standards as stipulated by the Texas State Board of Examiners of Licensed Professional Counselor and state and federal HIPAA security and privacy rules. **If at any time and for any reason you are dissatisfied with the services provided by the counselors at The Nourish Place, please notify us so existing concerns may be worked through.** If your concerns are unable to be resolved, you have the right to make a formal complaint to the Complaints Management and Investigative Section of the Texas Department of Health Services, P. O. Box 141369, Austin, TX 78714-1369.

## OFFICE POLICIES

**QUALIFICATION OF THERAPIST:** All counselors and therapists at The Nourish Place possess a Master's degree in Counseling or a related field such as Psychology or Social Work. Furthermore, they are licensed in the State of Texas to assess, diagnose, and treat mental health issues for children, adolescents, and adults.

**SCHEDULING AND PROCEDURES FOR APPOINTMENTS:** Appointments can be made by calling or emailing your therapist directly. She will give her business card with her direct contact information. During the course of counseling, you and/or your child will meet with your therapist for approximately 45-60 minute sessions, depending on your individual needs. Generally, clients attend counseling once per week. Arrangements can be made for clients who might need to be seen more than once per week. For parents or caretakers of children, **please remain in the building during the child's therapy session.** If you need to leave the office during your child's appointment time, please let your therapist know. We ask that you escort your child to the bathroom if the need arises during the appointment time.

**PAYMENT AND FEES:** Payments are due at the time services are rendered. Payments can be made with cash, check, or credit card. *Checks returned for any reason will incur a \$25.00 return-check fee. The Nourish Place reserves the right to suspend services if there is an unpaid balance on your account.*

- 45 min sessions \$105
- 60 min sessions \$140
- 90 min sessions \$210
- Phone calls over 15 minutes will be billed at the session rate.

**NO SHOW FEE:** *The Nourish Place reserves the right for charge a NO SHOW FEE of \$75.00 for missed appointments. Our time is valuable and we are committed to showing up for you to help you achieve your goals. We ask that you provide us with notice as soon as you are aware you will be unable to attend your scheduled appointment. We ask that you notify us at least 24 HOURS in advance before your scheduled appointment that you will be unable to attend. All appointments missed without notice will result in a \$75.00 NO SHOW FEE.*

**COUNSELING RELATIONSHIP:** Your relationship with your counselor is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and or business relationships undermine the effectiveness of the therapeutic relationship. The therapists of *The Nourish Place* care about you and are not in a position to have personal or social relationships with you. Out of respect for your

privacy, we will not initiate contact with you in a social setting and will be brief if you initiate the contact with us.

**TREATMENT AND THERAPEUTIC PROCESS:** While it may not be easy to seek help from a mental health professional, it is hoped that through therapy you or your child will change in the following ways: 1) gain greater insight into your situation and feelings, 2) develop expanded understanding of life, relationships, and circumstances, 3) move toward resolving concerns, and 4) construct a life plan that promotes greater realization of human potential, happiness, and success. Therapy is a process that requires that both counselor and client are willing to work together. You will be helped and encouraged to set specific goals for yourself or child. These directives will be addressed as a team. Our role will be to help you reach your goal. *With your written consent by signing the "Consent for Release of Confidential Information" Form, we may disclose your mental health information to other professionals to provide, manage, or coordinate treatment.*

**EFFECTS OF COUNSELING:** You may learn things about yourself that you do not like. Often, growth cannot occur until you experience and confront issues that induce you to feel sorrow, anxiety, or pain. While benefits are expected from counseling, specific results cannot be guaranteed. Counseling is a process of personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

**EMERGENCY/CRISIS:** Please know that *The Nourish Place* does not provide a 24 hour crisis counseling service. Should you experience an emergency necessitating immediate mental health attention, call 9-1-1 or go to the nearest emergency room for assistance. Non-emergency matters can be directed directly to your therapist where clients can leave a voicemail after hours that will be treated within a reasonable amount of time.

**TERMINATION:** As a client, you are in complete control of your counseling, you may end our counseling relationship at any time, and we do ask that you participate in a termination session. You also have the right to discuss modification of any counseling techniques or to make suggestions that you believe might be helpful to your effort.

**RESPECT FOR COUNSELING:** Any recordings (audio or visual) of the counseling session are prohibited, unless written consent is given between all parties.

**REFERRALS:** Should you or your therapist believe that a referral is needed, you will be provided with some alternatives, including programs and or people who may be available to assist you.

**PEER CONSULTATION AND SUPERVISION:** Consultation and Supervision is a standard process within the counseling profession whereby cases are reviewed with professional, objective colleagues to ensure quality counseling. It is understood that this process may be utilized with licensed professionals in order to provide the highest quality services.

**COMMUNICATION:** Adult and minor client records are maintained and destroyed in compliance with Texas and Federal laws.

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our offices and make copies available upon request.

**FOR QUESTIONS ABOUT THIS PRIVACY NOTICE, PLEASE CONTACT:**

Antoinette Martinez, M.Ed., LPC (Group Practice Owner)

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