Foxborough Counseling Associates
34 School Street Suite# 207
Foxborough, MA 02035

Date: ______________

STATEMENT REGARDING PRIVATE HEALTH INFORMATION:

Name: ______________________________

It is the intent of this office to be in compliance with the Privacy Standards for Private Health Information (PHI) covered under Health Insurance Portability and Accountability Act (HIPAA).

- I understand that I have the right to request that certain information be excluded from my record unless the information is related to my diagnosis or is related to one of the exceptions listed on page 3 of the Therapist – Client Responsibilities.
- I understand that I have the right to amend information but not expunge ("erase") information from my record.
- I understand that I have the right to inspect and/or receive a copy of my Private Health Information (PHI) i.e. Record unless it is legally determined that it would adversely affect my well-being or I am a minor. My request must be fulfilled by this office within 60 days of my written request. There will be a charge for copies.
- As additional HIPAA regulations are mandated and clarified, this office will be altering its policies and procedures to be in compliance.
- If this office is found to be in violation of the Primary Standards put forth in HIPAA, I am urged to speak with my therapist and if not resolved, I have a right to file a formal compliant with the Office of Civil Liberties.

I have read and received a copy of the above Privacy Standards for Private Health Information covered under HIPAA.

Signed: ______________________ Date: ______________

Karen Robinson, MSW, LICSW
Foxborough Counseling Associates

FEE AGREEMENT FORM

Please initial each statement to verify that you have read, fully understand, and agree to comply with the billing practices of Karen Robinson, MSW, LICSW.

_______ All copays are due at the beginning of each appointment in the form of cash or check made payable to Karen Robinson.

_______ Any copays that are not paid at the time of service will include a processing fee of $5.00 per unpaid copay.

_______ I have been informed that health insurance coverage is the responsibility of the client and I will pay any claims that go unpaid by my health insurance plan. If a claim is denied, I will follow up with my insurance company.

_______ I have been notified that late cancellations of 24 hours or less and no shows for appointments are not billable to insurance and require a $65.00 fee payment to be paid prior to scheduling any further appointments.

_______ I am responsible for paying any deductibles and/or unpaid balances within 30 days of receiving an invoice.

_______ Any clinical contacts via phone longer than 5 minutes require a self-pay fee at the rate of $15 for 15 minutes or less, $25 for 15-30 minutes, and $50 for over 30 minutes.

_______ A fee of $10 is required for the copying and/or mailing of any medical records.

_______ Any contact with outside entities (Attny's, MD's, schools, etc.) requires a self-pay fee of $25 for 15 minutes or less, $50 for 15-30 minutes, and $75 for over 30 minutes.

_______ If I request a clinical letter or case summary to be written I will pay a fee of $25 for 0-15 minutes, $50 for 15-30 minutes, and $75 for over 30 minutes for the time spent writing the letter/summary as health insurance does not cover this service.

I understand and agree to all of the above conditions.

CLIENT SIGNATURE: ______________________________ **DATE:** ___________

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use and disclose as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule. The following is a list of categories of uses and disclosures permitted by HIPAA without an authorization: Abuse and Neglect Law Enforcement, Judicial and Administrative, Proceedings National Security, Deceased Persons Public Health, Emergencies Public Safety (Duty to Warn), Family Involvement in Care Research & Health Oversight.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department).
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. I may use or disclose your information to family members that are directly involved in your treatment your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Karen Robinson.

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I am not required to agree to the amendment.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of you PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe your privacy rights have been violated, please contact Karen Robinson. You have the right to file a written complaint to Office for Civil Rights, U.S. Department of Health and Human Services, J.F. Kennedy Federal Building, Room 1875, Boston, MA 02203. I will not retaliate against you for filing a complaint. This Notice is Effective Beginning June 1, 2011.