Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

NOTICE OF PRIVACY PRACTICES

Effective August 1, 2018

This Notice of Privacy Practices applies to the care and treatment you receive at Still Waters Therapy facilities that are designated as an "affiliated covered entity" under the federal law known as HIPAA that protects the privacy and security of your medical information. Terms defined in the HIPAA Rules will have the same meaning in this Notice.

This Notice also applies to and will be followed by:

- the health care providers, such as physicians or their staffs, who provide services at Still Waters Therapy PLLC facility, whether or not they are employed by a Still Waters Therapy PLLC facility unless such physicians or their staffs provide a copy of a separate Notice of Privacy Practices that they will follow; and

- other persons who are employed by or work at Still Waters Therapy PLLC facilities.

All of these persons are referred to as "we" in this Notice.

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.

If you would like a list of the Still Waters Therapy PLLC facilities covered by this Notice, or if you have any questions about this Notice or regarding the privacy of your medical information, please contact the Still Waters Therapy PLLC Privacy Office at:

Still Waters Therapy PLLC
PO Box 421
Holly Ridge, NC, 28445
stillwaterspllc@protonmail.com

Still Waters Therapy PLLC

325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

NONDISCRIMINATION NOTICE

Still Waters Therapy PLLC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We are committed to protecting the privacy of health information about you and that can identify you, which we call "protected health information". Protected health information, or PHI, includes information about your past, present or future health, health care we provide you, and payment for your health care contained in the record of care and services provided by Still Waters Therapy PLLC and the entities and medical staffs listed in this Notice (collectively, "Still Waters Therapy PLLC"). This Notice will apply only to records of your care at Still Waters Therapy PLLC facilities. Our privacy practices concerning your PHI are as follows:

- We will safeguard the privacy of PHI about you that we have created or received.
- We will explain how, when and why we use and/or disclose your PHI.
- We will only use and/or disclose your PHI as described in this Notice unless we obtain your written authorization.

We must follow this Notice. We may change this Notice and make the changes apply to PHI we already have if we:

- post the new notice in our locations;
- make copies of the new notice available if someone asks for it (either at our locations or through the Privacy Officer listed in this Notice); and
- post the revised notice on our website

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

FOR TREATMENT: We may use your medical information to provide you with medical treatment or services. We may disclose your medical information to doctors, nurses, technicians, medical students, or other Still Waters Therapy PLLC personnel who are involved in taking care of you.

For example, a clinician treating you for depression may need to know if you have a history of trauma because untreated trauma response may slow the healing process. In addition, the clinician may need to tell the other professional if you have a history of trauma so that we can arrange for appropriate trauma treatment. Different clinicians in Still Waters Therapy PLLC also may share medical information about you in order to coordinate the different things you need, such as further treatment. We also may disclose medical information about you, in electronic or other format, to people outside Still Waters Therapy PLLC who may be involved in your medical care, such as employees or medical staff members of any hospital or skilled nursing facility to which you are transferred or subsequently admitted, or to other health care providers who may be involved in your treatment.

FOR PAYMENT: We may use and disclose medical information about you so that the treatment and services you receive at Still Waters Therapy PLLC may be billed to and payment may be collected from you, an insurance company or a third party (including collection agencies). For example, we may need to give your health plan information about treatment you received so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose information about you to another health care provider, such as a receiving facility, for their payment activities.

FOR HEALTH CARE OPERATIONS: We may use and disclose medical information about you for business activities that we call "health care operations." These uses and disclosures are necessary to run the hospital and clinics and make sure that all of our patients

receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to clinician and students for review and learning purposes. We may also combine the medical information we have with medical information from other health care entities to compare how we are doing and see where we can make improvements in the care and services we offer.

We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who you are. For example, your information may be used for purposes of quality assurance and quality improvement by either the clinics or its clinicians.

We may also disclose information about you to another health care provider for its health care operations purposes if you also have received care from that provider. In addition, we may use and disclose your medical information to comply with this Notice and with applicable laws, or in connection with the sale of all or part of our business.

BUSINESS ASSOCIATES: There are some services provided in our organization through contracts with business associates. When we hire companies to perform these services, we may disclose your health information to these companies so that they can perform the job we've asked them to do. For example, we may use a copy service to make copies of your medical record. To protect your health information, we require the business associates to appropriately safeguard it. They are also required to do so by law.

APPOINTMENT REMINDERS: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

TREATMENT ALTERNATIVES: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

MARKETING OF HEALTH-RELATED BENEFITS AND SERVICES: We may use and disclose your medical information to tell you about health-related benefits or services that may be of interest to you. However, if we will receive direct or indirect payment in exchange for making such communications to you, we will obtain your written authorization before sending you such communications, unless the communication either describes a treatment you currently are being prescribed and the payment we receive for that communication is reasonable, or the communication is made to you face-to-face.

You may elect not to receive any communications from us that encourages you to purchase or use any particular product or service by notifying Still Waters Therapy PLLC in writing.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE: We may release medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are at one of our facilities. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort. We will comply with additional state law confidentiality protections if you are a minor and receive treatment for pregnancy, drug and/or alcohol abuse, venereal disease or emotional disturbance.

AS REQUIRED BY LAW: We will disclose medical information about you when required to do so by federal, state or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone who appears able to help prevent the threat and will be limited to the information needed.

SPECIAL SITUATIONS

ACTIVE DUTY MILITARY PERSONNEL AND VETERANS: If you are an active duty member of the armed forces or Coast Guard, we may give certain information about you to your commanding officer or other command authority so that your fitness for duty or for a particular mission may be determined. We may also release medical information about foreign military personnel to

the appropriate foreign military authority. We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.

WORKERS' COMPENSATION: In accordance with applicable state law, we may release medical information about your treatment for a work-related injury or illness or for which you claim workers' compensation to your employer, insurer, or care manager paying for that treatment under a workers' compensation program that provides benefits for work-related injuries or illness.

PUBLIC HEALTH RISKS: We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births, deaths, and certain injuries and illnesses;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- to support public health surveillance and combat bioterrorism.

HEALTH OVERSIGHT ACTIVITIES: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

LAWSUITS AND DISPUTES: If you are involved in a lawsuit or a dispute, we must disclose medical information about you in response to a valid court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

LAW ENFORCEMENT: We may release medical information if asked to do so by a law enforcement official:

- in response to a court order or court-ordered subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death or injury we believe may be the result of criminal conduct;
- about suspected criminal conduct at Still Waters Therapy PLLC or on Still Waters Therapy PLLC property;
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

PSYCHOTHERAPY NOTES: We will ask for your written authorization before we use or disclose psychotherapy notes, as defined by HIPAA, made by the individual mental health provider during a counseling session, except for certain limited purposes related to treatment, payment and health care operations, and certain other limited exceptions, including government oversight and safety.

INMATES: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you. For more information about these rights, contact Still Waters Therapy PLLC.

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. Usually, this includes medical and billing records, but does not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Still Waters Therapy PLLC, as applicable, will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

If we have all or any portion of your health information in an electronic format, you may request an electronic copy of those records or request that we send an electronic copy to any person or entity you designate in writing.

RIGHT TO AMEND: If 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 request an amendment for as long as the information is kept by or for us. You must provide a written explanation that supports your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for Still Waters Therapy PLLC;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete
- If we deny your request for an amendment, you may submit in writing a statement of disagreement and ask that it be included in your medical record.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request a list of certain disclosures we made of medical information about you, which we call an "accounting of disclosures." This accounting does not include disclosures that are made to carry out treatment, payment, or health care operations, or information that has already been delivered to you or your health care representative, or information disclosed pursuant to an authorization.Your request must state the time period you wish our accounting of disclosures to cover, which can be no more than six years before the date of your request. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period

will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request that we limit our use and disclosure of PHI about you. We are not required to agree to your requested restrictions, except if you ask us not to disclose to your health plan PHI about services for which you paid out of pocket and in full (the amount we charge for the service, not your insurance copay or deductible). However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures that do not require your authorization. You may request a restriction by writing to or emailing stillwaterspllc@protonmail.com.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you about 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. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

RIGHT TO RECEIVE NOTICE OF A BREACH: We are required by law to notify affected individuals if we determine that there has been a breach of unsecured PHI.

RIGHT TO A 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. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

To obtain a paper copy of this Notice, call (910) 622-3418 or e-mail stillwaterspllc@protonmail.com.

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. The Notice will contain the effective date. In addition, each time you register at or are admitted for treatment or health care services, we will make best efforts to make available a copy of the current Notice in effect.

If you believe your privacy rights have been violated, you may file a complaint with our privacy office, or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the Still Waters Therapy PLLC at (910) 622-3418 or email stillwaterspllc@prontmail.com.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us (for example, treatment, payment, and health care operations) will be made only with your written authorization or as required by law. We will not sell your medical information unless we obtain your written authorization to do so. If you provide us with an authorization to use or disclose medical information about you, you may revoke that authorization in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by that authorization. We are unable to take back disclosures that we already made with your authorization.

PRIVACY NOTICE ADDENDUM

You may have additional rights under North Carolina law and other federal laws.

In the event that North Carolina law or other applicable federal law requires us to give more protection to your health information than stated in this notice or required by HIPAA, we will give that additional protection to your health information.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Because it supervises our services, the North Carolina Department of Health and Human Services may inspect our operations and

may review protected health information. If you get care from one of our services, before we release any health information about you to this agency, we will give you a written notice and a chance to object to the release of your health information.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

There are additional state law confidentiality protections relating to treatment for mental health and substance (alcohol or drug) use disorders.

MENTAL HEALTH: North Carolina law permits us to disclose health information related to your mental health or developmental disabilities to another general health care provider or a business partner of that provider in order to provide, coordinate, or manage your health care and to perform quality assessment and improvement activities, but you have the right to object to these disclosures. If you wish to object, please contact the Still Waters Therapy PLLC at (910) 622-3418 or stillwaterspllc@protonmail,com. Even if you do object to these disclosures, there are a number of other circumstances under which we can disclose these types of health information, including to members of our workforce, our professional advisors, and to agencies or individuals that oversee our operations or that help us carry out our responsibilities in serving you. We also may disclose information to the following people: (1) a health care provider who is providing emergency medical services to you; and (2) to other mental health or developmental disabilities facilities or professionals when necessary to coordinate your care or treatment. If we determine that there is an imminent threat to your health or safety, or the health or safety of someone else, we may disclose information about you to prevent or lessen the threat. We also will release information about you if the law requires us to do so, for example, when a court orders disclosure, when we suspect abuse or neglect of a child or disabled adult, and when one of our clinicians believes that a client has a communicable disease or is infected with HIV and is not following safety measures. If we believe it is in your best interests, we may disclose information about you for a guardianship or involuntary commitment proceeding that involves you. When you are admitted to, or discharged from, a mental health or developmental disabilities facility as defined under North Carolina state law, if you have a next of kin who is substantially involved in your care, upon his or her request we are required to provide this kin with information relating to your admission or discharge from a facility, including the identity of the facility, any decision on your part to leave a facility against medical advice, and referrals and appointment information for treatment after discharge after we notify you that this information was requested.

SUBSTANCE USE DISORDERS: In certain circumstances, federal law protects information regarding substance use disorder diagnosis or services. In those circumstances when it applies to us, federal law generally requires that we obtain your written consent before we may disclose information that would identify you as having or having had a substance use disorder. There are some exceptions to this requirement. We can share this information with our workers to coordinate your care and to agencies or individuals that help us serve you. We may share information with medical workers in an emergency. If we believe that a child is abused or neglected, we must report the suspected abuse or neglect to the Department of Social Services, and we may share substance use disorder treatment information when making the report. We also will disclose substance use disorder information to obey a court order if the order includes special protections for patients who have or have had a substance use disorder.

CRIME

If you commit a crime, or threaten to commit a crime, on our property or against our workers, we may report this to the police.

SPECIAL PROVISIONS FOR MINORS UNDER NORTH CAROLINA LAW:

Under North Carolina law, minors, with or without the consent of a parent or guardian, may consent to services for the prevention, diagnosis, and treatment of certain illnesses, including: sexually transmitted diseases and other diseases that must be reported to the State; pregnancy; abuse of drugs or alcohol; and emotional disturbance. In general, however, a minor cannot terminate a pregnancy unless she has permission from a parent, guardian, or a grandparent with whom she has been living for at least six (6) months, unless a court has determined that the minor alone can consent to the abortion. If you are a minor and you consent to one of these services, you have all the rights stated in this Notice relating to that service. If you are a minor and have been married, are a member of the armed services, or have been “emancipated” by a judge, then you have the right to be treated as an adult for all purposes, and have all rights and authority stated in this Notice for all services.

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

Notice of Privacy Practices Receipt and Acknowledgment of Notice

Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Still Waters Therapy PLLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Still Waters Therapy PLLC.

_____

Signature of Client **Date**

_____

Signature or Parent, Guardian or Personal Representative **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Client Refuses to Acknowledge Receipt:**

_____

Signature of Staff Member **Date**

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

Office Policies and Consent to Treatment

Please read and initial each line, signing at the bottom to note acceptance of these policies.

_____ ***Copays, Deductibles and Self-Pay Balances:*** Fees associated with therapy are due and expected at the time of service. A third party vendor, Square, is used to take credit card and HSA (Health Savings Account) card payments. These fees are the responsibility of the client. Clients that have outstanding balances for longer than 60 days will not be permitted to schedule further appointments until these balances are paid. Balances remaining after 90 days following reasonable efforts to collect will be turned over to a collections agency unless arrangements are made with your provider to pay the balance.

_____ ***Missed Appointments and Late Cancellations:*** Missed appointments without at least 24 business hours' notice will result in a $60 fee billed to the client. If you are late to your appointment, you may see the clinician for the remainder of your appointment time if you so choose, but you are not guaranteed the full appointment time and you are responsible for the full fee. I will attempt to make reminder calls/emails, but ultimately your scheduled appointments are your responsibility. For EAP clients, missed appointments or late cancellations will result in one of your authorized units being deducted per EAP regulations.

_____ ***TherapyNotes:*** I give Still Waters Therapy PLLC permission to use this EHR to store my PHI or my child's PHI including, but not limited to, my intake forms, consents, documentation necessary for treatment, insurance/billing information, and to conduct telemental health sessions.

_____ ***Assignment of Insurance Benefits***: You assign directly to Still Waters Therapy PLLC all insurance and/or EAP benefits, if any, otherwise payable to me for services rendered. You understand you are financially responsible for all charges whether or not paid by your insurance. You authorize the use of your signature on all insurance/EAP submissions; You authorize any Still Waters Therapy PLLC holder of psychotherapy information about you to be released to the health care finance administration, insurance company/EAP, and its agents any information needed to determine these benefits or benefits payable to related services. You agree a photocopy of this form may be used in place of the original.

_____ ***Returned Check Fee:*** A $25 fee will be applied for any returned checks written to Still Waters Therapy PLLC.

_____ ***Document Fees:*** I will do what I can to support my clients and provide you with whatever paperwork you need. For letters and other paperwork that takes longer than 15 minutes, there will be a $25 charge per 15 minutes.

_____ ***Treatment Plan Requests:*** Clients have the right to request a copy of their individualized treatment plan. This can be requested in writing to your therapist and will be provided to you within 2 business days.

_____ ***Termination:*** Following 3 no-shows or late cancellations, a client may be terminated from my practice. In addition, any client who engages in inappropriate behavior in my office will immediately be terminated from my practice. Finally, if there has been no scheduled session with the client in 90 days or more, the client will be terminated from my practice. If a client is terminated, I will supply them with appropriate referrals to other

agencies that can address their mental health needs. There is always a risk that you incur when you choose to terminate from services prematurely. These include, but are not limited to: increase in symptoms, regression in progress, etc. You accept responsibility for these risks should you choose to terminate prematurely or fail to contact the provider.

_____ ***In the event of emergency:*** Should you experience an emergency during regular business hours and require support from a mental health professional, you agree to reach out to your provider by phone (910-622-3418) or email (stillwaterspllc@protonmail.com). Should your provider be unavailable, you agree to contact mental health emergency services (i.e. Mobile Crisis at 1-866-437-1821 or the Crisis Text Line at 741741), 911, or go to your nearest emergency room. Outside of regular business hours, you agree to contact mental health emergency services (i.e. Mobile Crisis at 1-866-437-1821 or the Crisis Text Line at 741741), 911, or go to your local emergency room.

_____ ***Additional Fees:*** Should you require your provider to provide services outside of regularly scheduled sessions or for those services that exceed 45-60 minutes, you agree to pay for these services per half hour that they are provided. These additional fees will be based on current fees for services. You recognize that your provider's time is valuable and that your provider must be compensated for additional time to provide services to yourself, your child, and/or your family.

_____ ***Recording of Sessions/Contact:*** I will not video or audio record any of our sessions or other contact, nor will I take pictures of you or during our sessions as I respect your privacy. By initialing here, you agree to respect this and you agree that you will refrain from recording any of our contact whether by audio or video recording or by taking pictures of me or or taking pictures during our sessions.

_____ ***Disclosure Statement:*** In case I am suddenly unable to continue to provide professional services or to maintain client records due to incapacitation or death, I have designated a colleague, who is a licensed mental health professional as my professional executor. If I become incapacitated or die, my professional executor will be given access to all my client records and may contact you directly to inform you of my incapacity or death, to provide access to your records, to provide psychotherapy if needed, and/or to facilitate continued care with another qualified professional if needed. If you have any questions or concerns about the professional executor arrangements, I will be glad to discuss them with you.

I have read, understand and fully accept the above statements that I have initialed. I agree to services for myself and/or my child at Still Waters Therapy PLLC. I have been informed of my rights to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability.

_____	_____	_____
Client Signature	Printed Name	Date Signed/Accepted
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date Signed/Accepted

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

Authorization for Electronic Communication

As a convenience to me, I hereby request that Still Waters Therapy PLLC communicate with me regarding my treatment by Still Waters Therapy PLLC via electronic communications (e-mail, phone, fax, video, or text message). I understand that this means Still Waters Therapy PLLC and/or my treating provider will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Still Waters Therapy PLLC shall not have any responsibility or liability with respect to any error, omission, claim, or loss arising from or in connection with the electronic communication of information by Still Waters Therapy PLLC to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Still Waters Therapy PLLC to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Still Waters Therapy PLLC, I may revoke this authorization by providing written notice to Still Waters Therapy PLLC at PO Box 421, Holly Ridge, NC, 28445, or fax at (910) 660-0500.

I agree that Still Waters Therapy PLLC may communicate with me electronically unless and until I revoke this authorization by submitting notice to Still Waters Therapy PLLC in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

Client Name _____

Signature of Client _____Date _____

Legally Responsible Person Name _____

Signature of Legally Responsible Person _____ Date _____

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

PERMISSION FOR SERVICES/TREATMENT

I, _____
Client Name/Parent Name/Guardian Name/Legal Custodian Name
(_____) parent
(_____) guardian
(_____) legal custodian
(_____) self

of _____
Client Name

give my consent to _Still Waters Therapy PLLC__ (herein referred to as "provider") to authorize assessment, mental health treatment, and referral services. I understand that unanticipated outcomes of treatment are possible in any treatment setting. While provider makes every effort to ensure client safety and avoid unanticipated outcomes, there are risks involved in mental health treatment. Unanticipated outcomes include serious incidents such as reporting of abuse, neglect, or risk of harm to self or others.

I understand that if it is determined that another agency/service can better meet my needs, I will be given the names of those services following evaluation unless I present legal cause for involuntary involvement in care.

I understand that I may withdraw this permission and stop services with provider at any time. I have a right to refuse treatment without fear of retaliation. I have the right to treatment, including access to medical care and habilitation, regardless of age or degree of MH/IDD/SA disability. I have the right to an individualized written treatment plan and the right to access medical care for treatment of physical ailments. If there is a medical emergency during session, I give permission for provider to contact emergency services including, but not limited to, Mobile Crisis, EMS, and/or the local Emergency Room. I understand that provider does not make court appearances. Provider does not assist clients in divorce or custody litigation, writing court reports, making recommendations to the court, or testifying for or against clients in a court of law. Should the clinician be summoned/subpoenaed on behalf of myself or my affiliations to court, I agree to pay the clinician a fee commiserate with the time required to prepare, travel to, and be present in court based on the clinician's current hourly rate.

I have read and fully understand the forgoing statement and agree to its terms as a condition of counseling services.

_____	_____	_____
Client Signature	Printed Name	Date Signed/Accepted
_____	_____	_____
Legally Responsible Person	Printed Name	Date Signed/Accepted

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

Sliding Fee Scale

Scale based on total household income.
Proof of income needed at time of first session or full fee will be charged

SLIDING FEE SCALE - Effective 7/15/2019

Total Gross Household Income:	REGULAR SESSION:	Intake	Family/Couples Therapy
$50,000 & UP.....……..$90		$125	$90-100
$40,000 - 49,000…….$70		$85	$80
$35,000 - 39,999... .....……...$65		$80	$70
$30,000 - 34,999....…….....$55		$75	$60
$25,000 - 29,999...…….....$50		$65	$50
$20,000 - 24,999……. $45		$55	$45
$15,000 - 19,999....……..…...$35		$45	$40
$0- 14,999 ……..……...…….$30		$40	$35

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

Telemental Health Informed Consent

Telemental Health is healthcare provided by any means other than a face-to-face visit. In telemental health services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telemental health services.

Client's
Initials

_____ I understand that telemental health involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telemental health visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telemental health services can only be provided to clients, including myself, who are residing in the state of North Carolina, Alabama, or Virginia at the time of this service.

_____ I understand that telemental health billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telemental health in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telemental health visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telemental health. This includes my right to access my own medical records (and copies of medical records).

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my healthcare provider my identity and current location at _____ in connection with the telemental health services. I acknowledge that failure to comply with these procedures may terminate the telemental health visit.

_____ I agree that my emergency contact (below) may be contacted in the event of an emergency and/or disruption of service and that details regarding my care may be shared with this individual.

_____ _____

Emergency Contact Name Emergency Contact Phone Number

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telemental health and to confirm that he or she is my healthcare provider.

_____ I understand that electronic communication cannot be used for emergencies or time sensitive matters.

_____ I understand and agree that a medical evaluation via telemental health may limit my healthcare provider's ability to fully diagnose a condition or disease. As the client, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing or an in-office visit.

_____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telemental health visit.

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telemental health visit.

_____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 and/or Mobile Crisis services in my community.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

_____
Client Printed Name

_____ _____
Client Signature Date

_____
Legally Responsible Person Printed Name

_____ _____
Legally Responsible Person Signature Date

I certify that I have explained the nature of this agreement to the client/client's legal representative. I have answered all questions fully, and I believe that the *client/legal representative (circle one)* fully understands what I have explained.

_____ _____
Therapist Signature Date

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

Based on recommendations from the NASW and the CDC, these policies will be added to current office policies as of 5/25/2021. These policies will apply to all visitors of the practice Still Waters Therapy PLLC including clients, client companions, colleagues, and others:

- Clients will be required to take their temperatures prior to visiting Still Waters Therapy PLLC. Clients will be required to call and reschedule their appointment should they have a fever of 100 Degrees Fahrenheit or higher within 24 hours of their scheduled appointment.
- Client companions are requested to wait outside the building for the client to complete their session. If it is necessary for a client to be accompanied by a companion during session, the companion will also be required to adhere to all office policies while in the Still Waters Therapy PLLC office.
- If you have been in contact with someone diagnosed with COVID-19, or believe you have symptoms of this diagnosis, please call Holly Mann and reschedule your appointment. You will not be charged a cancellation fee if you believe that you may have contracted COVID-19 or have these symptoms. The symptoms of COVID-19 are listed below:
  - Fever or chills
  - Cough
  - Shortness of breath or difficulty breathing
  - Fatigue
  - Muscle or body aches
  - Headache
  - New loss of taste or smell
  - Sore throat
  - Congestion or runny nose
  - Nausea or vomiting
  - Diarrhea
- Still Waters Therapy will take the following precautions to help prevent the spread of disease:
  - Holly Mann will maintain safe distancing.
  - Hand sanitizer that contains at least 60% alcohol is available in the office.
  - Credit card pads, pens, and other areas that are commonly touched are thoroughly sanitized after each use.
  - Physical contact is not permitted.
  - Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
  - Common areas are thoroughly disinfected at the end of each day.

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to participate in in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telemental health. If you have concerns about meeting through telemental health, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telemental health for everyone's well-being. If you decide at any time that you would feel safer staying with, or returning to, telemental health services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telemental health services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office and/or bringing your child, you are assuming the risk of exposure to the coronavirus (or other public health risks). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, and other clients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telemental health arrangement. Initial each to indicate that you understand and agree to these actions:

- You/your child will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature and/or your child's temperature before coming to each appointment. If it is elevated (100 Degrees Fahrenheit or more), or if you and/or your child have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telemental health. If you wish to cancel for this reason, I won't charge you my normal cancellation fee. __
- You and/or your child will keep a distance of 6 feet when possible and there will be no physical contact (e.g. no shaking hands) with me. ___
- You and/or your child will try not to touch your face or eyes with your hands. If you do, you and/or your child will immediately wash or sanitize hands. ___
- If you and/or your child are bringing a companion, you will make sure that your companion follows all of these sanitation and distancing protocols. ___
- If a resident of your home tests positive for the infection, you will immediately let me know and we will then begin/resume treatment via telemental health.___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

My Commitment to Minimize Exposure
I have taken steps to reduce the risk of spreading the coronavirus within the office and I have posted my efforts in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you and/or your child show up for an appointment and I believe that you and/or your child have a fever or other symptoms, or believe you and/or your child have been exposed, I will have to require you and/or your child to leave the office immediately. We can follow up with services by telemental health as appropriate. If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you and/or your child have tested positive for the coronavirus, I may be required to notify local health authorities that you and/or your child have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent that we agreed to at the start of our work together. Your signature below shows that you agree to these terms and conditions.

_____ _____
Client Signature Date

_____ _____
Legally Responsible Person Signature Date

I certify that I have explained the nature of this agreement to the client/client's legal representative. I have answered all questions fully, and I believe that the *client/legal representative (circle one)* fully understands what I have explained.

_____ _____
Therapist Signature Date

Still Waters Therapy PLLC
325 Sound Road, Suite 208 • Holly Ridge, NC, 28445
Phone: 910-622-3418 • Fax: 910-660-0500
stillwaterspllc@protonmail.com

*****For state funded insurance plans only*****

NC HIEA Notice of Privacy Practices

Disclosure to Health Information Exchanges

This facility participates in the North Carolina Health Information Exchange Network, called NC HealthConnex, which is operated by the North Carolina Health Information Exchange Authority (NC HIEA). We are required to share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from North Carolina programs like Medicaid and State Health Plan. We may also share other patient data with NC HealthConnex not paid for with State funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC HealthConnex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthConnex are available upon request and online at NCHealthConnex.gov. Again, even if you opt out of NC HealthConnex, we still are required to submit your PHI if your healthcare services are funded by State programs. Your patient data may also be used or exchanged by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit NCHealthConnex.gov/patients

By signing below, I acknowledge that I have read and fully understood the above statement and have had an opportunity to ask any questions I may have.

_____
Client Printed Name

_____ _____
Client Signature **Date**

_____
Legally Responsible Person Printed Name

_____ _____
Legally Responsible Person Signature **Date**