CENTER FOR ANXIETY RELIEF AND EDUCATION, PLLC

Confidentiality in Therapy

Before you tell your therapist about yourself, you have the right to know what information can and cannot be kept confidential. Please read this and initial each item only if you understand and agree to the conditions described. If there is anything you do not understand, your therapist will explain it in more detail for you.

General Extent and Limits to Confidentiality

The laws and ethics governing therapy require that therapists keep all information about clients confidential except for certain types of information and situations. Those exceptions are:

Client's request for record release:
If you want your therapist to give information about your treatment to anyone outside this center (including yourself), you must sign a *Release of Information Form* giving permission for this disclosure.

> ***Acknowledgement:*** **I understand that if I want my therapist or this center to release information about my treatment to any outside person or agency, including myself, I must sign a Release of Information consent form.**
> **Initial: _____**

Safety:
Risk of harm to self: If your words or behavior convince your therapist that you are likely to harm yourself, either deliberately or because you are unable to keep yourself safe, your therapist must do whatever he or she can to prevent you from being harmed. This means the therapist must take action up to and including hospitalizing you with or without your consent. If this situation comes up, your therapist will discuss it with you before taking action unless it appears that doing so would be unsafe or immediate action is needed to keep you from being harmed.

Risk of harm to others: If you threaten serious harm to another person (This includes suspicion or actual neglect of a child or physical, emotional and sexual abuse of a child), your therapist must try to protect that person. He or she would report your threat to the police and/or appropriate authorities; warn the threatened person; and try to prevent you from carrying out your threat. If this situation comes up, your therapist will discuss it with you before taking action unless it appears that this would be unsafe or immediate action is needed to keep you from acting on your threat.

> ***Acknowledgment:*** **I understand that if my therapist believes there is a serious risk that I will hurt or kill myself or another person (Including a child), my therapist is legally required to report this, warn the endangered person (if it is someone other than myself) and take whatever action seems needed in his/her professional judgment to prevent harm to myself or others. Initial: _____**

Emergencies: Center for Anxiety Relief and Education, PLLC does not offer emergency services. In the case of emergency, clients should dial 911, contact their family physician, or go to the emergency department. However, in an emergency, when your health or your life is endangered, your therapist must provide medical personnel or other health professionals any information (if requested) about you that is needed to protect your life - but only information that is needed for that purpose. If possible, your therapist would discuss it with you and get your permission first. If not, he/she would talk with you about it afterward.

> ***Acknowledgment*****: I understand that in an emergency when my health or life is in danger, my therapist must give other health professionals any information about me that is needed to protect my life. Initial: _____**

Legal Proceedings: If there is a court order for your therapist to provide information about history of your treatment, the therapist must do so.

> ***Acknowledgment:*** **I understand that if ordered by a judge, my therapist must give the court whatever information about my case the judge rules to be necessary. Initial: _____**

Workers Compensation claims: If you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

> ***Acknowledgment:*** **I understand that if I seek reimbursement under Workers Compensation, all of my care is automatically subject to review by my employer and/or insurer(s). Initial: _____**

Informed Consent: I have read and understand the information presented in this document and consent to Counseling/Psychotherapy services by **Center For Anxiety Relief And Education, PLLC**

Client Name: _____

Client Signature:_____Date_____

CENTER FOR ANXIETY RELIEF AND EDUCATION, PLLC

Privacy Policy Notice

Center for Anxiety Relief and Education, PLLC has a legal duty to observe privacy practices with respect to your mental health information. Therefore, it is the intent of this center to be in compliance with the privacy standards for **Protected Health Information (PHI)** covered under the **Health Insurance Portability and Accountability Act (HIPAA)**. Please read it carefully. It describes how your mental health records may be used and disclosed.

As a result of the legislation, Center for Anxiety Relief and Education, PLLC:

- Documents all types of PHI; for example: progress notes, assessments, emails to clients, billing procedures, referral notes, disposition summaries, reports, etc. Treatment records are created and stored in a HIPAA compliant electronic medical record management software that is encrypted for utmost security.
- Requires your consent to disclose your PHI for treatment and payment. By signing this consent you are authorizing us to provide treatment and to conduct administrative steps associated with your care (e.g. insurance matters).
- Requires your consent to disclose your PHI in the event that we might consult with another health care provider, such as your family physician or another psychotherapist.
- Requires your consent to confirm or deny treatment history to any other source outside of this organization.
- Requires your consent to disclose your PHI in the event that records are needed to obtain reimbursement for your healthcare or to determine coverage and eligibility.
- Requires your consent to disclose your PHI in regards to matters involving licensing board investigations, audits and administrative services, and case management and care coordination.
- Requires your consent to disclose your PHI if you ever want us to send any of your protected health information of any sort to anyone outside our offices (including yourself). You must always first sign a **Release of Information Form** to disclose information to this outside party.

A copy of the **Release of Information Form** is available upon request. The requirement that you sign a specific authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of an instance where you might want your records released is if you request that we speak with your physician about your treatment. Before we talk to any physician, you will first have signed the proper authorization for us to do so. Your authorization must specify if it is limited to speaking to them, releasing records to them, or both. There is no fee to release PHI to your physician; however there is a $35.00 fee to release PHI for your personal use.

Psychotherapy notes

In recognition of the importance of the confidentiality of conversations between the therapist and client in treatment settings, HIPAA permits keeping 'Psychotherapy notes' separate from the overall designated medical record. This means that Psychotherapy notes cannot be secured by insurance companies, nor can they insist upon their release for payment of services. Psychotherapy notes are your therapist's notes and these notes are necessarily more private and contain much more personal information about you; hence, the need for increased security of the notes. **Psychotherapy notes are not the same as progress notes which provide the following information about your care each time you have an appointment at our office: assessment/treatment start and stop times, modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.**

Exceptions in regards to Psychotherapy notes

Most of the time we will be able to limit reviews of your **protected health information (PHI)** to only your designated record set which includes the following: all identifying paperwork you completed at your initial visit, all billing and reimbursement information, a summary of our first appointment, your mental status and progress notes for each session, your treatment plan, discharge summary, reviews by managed care companies, results of psychological testing, and any authorizations you have signed. However certain payers of care, such as Medicare and Workers Compensation, might require the release of both your progress notes and Psychotherapy notes in order to pay for your care. If we are forced to submit your *Psychotherapy notes* in addition to your *Progress notes* for reimbursement for services rendered, we will ask you to sign the specific authorization directing us to release our Psychotherapy notes.

Timeframe for medical storage

The guidelines for record-keeping suggests that records be kept for a minimum of 6 years from the date of last service rendered; at which time your entire records will be completely shredded and disposed of.

Client's Rights

1. I understand that I have the right to decide not to enter therapy, not to participate in any particular type of therapy, and to terminate therapy at anytime.
2. If I wish to terminate therapy here and continue elsewhere, I can be provided with a list of providers with whom I can continue.
3. I understand that I have the right to a safe environment during therapy, free from physical, sexual and emotional abuse.
4. I understand that I have the right to 'complete and accurate' information about my treatment plan, goals, methods, potential risks and benefits, and progress.
5. I understand that I have the right to information about the professional capabilities and limitations of any clinician(s) involved in my therapy, including their certification/licensure, education and training, experience, specialization, and supervision. I have the right to be treated only by persons who are trained and qualified to provide the treatment I receive.
6. I understand that I have the right to written information about fees, payment methods, length and duration of sessions and treatment.
7. I understand that my confidentiality will be protected, and information regarding my treatment will not be disclosed to any person or agency without my signed permission except under circumstances where the law requires such information to be disclosed.
8. I understand that I have the right to know the limits of confidentiality, the situations in which the therapist or agency is legally required to disclose information about my case to outside agencies, and the types of information which must be disclosed.
9. I understand that no portion of my therapy may be recorded in audio or video form without my consent.
10. I understand that I have the right to receive confidential communications by alternative means and at alternative locations.
11. I have the right to inspect and receive a copy of my PHI in the designated mental health record set for as long as PHI is maintained in the record.
12. I have the right to amend material in my PHI, although therapist may deny an improper request and/or respond to any amendment(s) I make to my record of care.
13. I have the right to an accounting of non-authorized disclosures of my PHI.

14. I have the right to revoke any authorization of my PHI except to the extent that action has already been taken.
15. I have the right to request a personal summary of my treatment, including Assessments, progress in treatment, and discharge status, for my personal records (Specific signed consent and $35.00 fee applies).
16. I have the right to request the release of my clinical information to any person or entity I choose (Specific signed consent applies. $35.00 fee applies to any personal representative that is not a treating source. Otherwise, release of information to treatment sources are free!).
17. I understand that if I am no longer an active client at Center for Anxiety Relief and Education, PLLC, the center cannot provide phone consultation to another source on my behalf. However, I have a right to request my past treatment records via written format. (Please note: 1. Specific signed consent applies. 2. Such request to send progress notes to non-treating sources cost a flat rate of $35.00, while such is free for treating sources. 3. A letter request is different from a request for progress notes. Thus, there is a different charge for letter requests that apply to **both** treating or non-treating sources. The cost of a letter request is subject to the ongoing rate at the time of request.
18. If I am not satisfied with the 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 complaint with the Office of Civil Rights and Civil Liberties.

Center for Anxiety Relief and Education, PLLC is required by law to maintain the privacy of your protected health information (PHI) and to provide you with a notice of your Privacy Rights and our duties regarding your PHI. We reserve the right to change our privacy policies and practices as needed, in accordance with law. Current practices are applicable unless you receive a revision of our policies at a future time.

I have read and understand the information presented in the Privacy Policy and Client's rights form and I consent to treatment at Center for Anxiety Relief and Education, PLLC.

Client/Guardian's name: _____

Signature _____

Date: _____

CENTER FOR ANXIETY RELIEF AND EDUCATION, PLLC

Authorization to release information/Release of Information Form

Description of information to be used _____

1. This information is being requested by:

(List whether it is Client OR the personal representative: _____ _____

-Other (list full name) _____

2. The purpose of the disclosure is (please describe)

_____

_____

From: Name, Address, & Title of Person/Organization/Facility/Program disclosing information:

Center For Anxiety Relief And Education, PLLC
146 Wind Chime Court, Suite A
Raleigh, NC 27615 (Business Office)

Therapist Name: Ugochi Babajide, MA, LCMHC

To: Address, & Title of Person/Organization/Facility/Program receiving information:

_____

_____

_____

I hereby permit the use or disclosure of the above information to the Person / Organization / Facility / Program(s) identified above. I understand that:

1. Only this information may be used and /or disclosed as a result of this authorization
2. This information is confidential and cannot legally be disclosed without my permission
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by Center For Anxiety Relief And Education, PLLC
5. I am aware that my revocation will not be effective if the person/s I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization
6. **I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain treatment from Center For Anxiety Relief And Education, PLLC**
7. I have the right to inspect and copy my own protected health information to be used and /or disclosed

Client Name: _____

Client Signature: _____

Date: _____