NOTICE OF PRIVACY PRACTICES, CANCELLATIONS & PAYMENT POLICIES

ELIZABETH J KOWIESKI, LCPC
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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 physical or mental health condition and related health care services is referred to as *PROTECTED HEALTH INFORMATION (PHI*). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the NASW CODE OF ETHICS. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this NPP. We reserve the right to change the terms of our NPP at any time. Any new NPP will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised NPP by giving it to you in session or by sending it to you in the mail upon your request.

HOW WE MAY USE AND DISCLOSE PHI:

Treatment: Your PHI may be used by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services within Selah Healthcare Professionals, LLC (SHP). This includes consultation with Clinical Supervisors, Treatment Team Members at Selah Healthcare Professionals, LLC or your identified medical support. We may disclose PHI to any other outside consultant only with your authorization.

Payment: Your PHI will be used to receive payment for treatment services provided to you. This will be done with your authorization on the Consent Form and this Policy Form you are reading and signing. In order to receive treatment through your insurance plan, the processing of claims, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities, your consent will be required. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI needed for the purpose of collections.

Health Care Operations: We may share your PHI with third parties that perform various business activities (billing) provided we have a written contract with the business that requires it to safeguard the PHI.

Required by Law: We must make PHI disclosures to you upon request. We 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.

Without Authorization: Applied laws and ethical standards permit us to disclose information about you without authorization only in a limited number of situations. The type of use and disclosures that may be made without your authorization are those follow:

- mandatory report of child abuse
- mandatory report of child neglect
- required by Court Order
- to prevent or lessen imminent threat to the health or safety of a person or the public. If PHI 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.
- If a client is expressing a desire to harm oneself or commit suicide.

YOUR RIGHTS REGARDING PHI:

You have the right to access, inspect and copy your PHI. This will require you to submit a written request . There will be a fee for the copying of your records due to the time it requires. Set fee will equal that of one 45-55 minute session. There may also be a denial of such copies if the evidence is clear that receipt of the PHI would cause harm to you or others.

You have the right to amend, request an accounting of disclosures, request restrictions or limitations of your PHI, and you have a right to a copy of this notice. Elizabeth J Kowieski, LCPC is not required to be in agreement with any or all of your requests and will be protected by law should Elizabeth J Kowieski, LCPC refrain from agreeing to your request.

CANCELLATION POLICY: All sessions are 45-55 minutes in length. This time is reserved for you. Should you find yourself unable to keep an appointment at the scheduled time, it is required that you notify this therapist at least 24 hours in advance of the appointment. If you cancel in less than this agreed upon time, you will be charged the full amount for the missed session. Emergencies are always considered, but cancelling a session can penalize other clients who could use that time scheduled. If you consistently change or cancel your appointments, we will discuss in session whether the counseling is of benefit to you and assess your situation together.

PAYMENT AND INSURANCE

Only if Elizabeth J Kowieski, LCPC is contracted with a participating Insurance company as a provider, will you need to pay your copayment or co-insurance, once your deductible has been met. Cash, checks and all Major Credit Cards are Accepted at time of Payment.

Blue Cross Blue Shield PPO and Value Options are the only Insurance Companies accepted by Elizabeth J Kowieski, LCPC at this time. All other insurance companies are considered out of network and you will have to submit your own claim and pay the regular scheduled fee as stated on the Fee Policy Form for Elizabeth J Kowieski, LCPC.

You are responsible for the entire bill whether or not you notified your insurance company that you were coming for therapy. It is your responsibility as the client to understand your mental health insurance coverage as it relates to authorizations, deductibles, copayment, co-insurance, maximum benefits, and submit all receipts/forms to your insurance company for reimbursement when out of network. Elizabeth J Kowieski, LCPC will provide billing services for In Network PPO plans.

Each client will receive a copy of their receipt upon request documenting all the needed information for name, date, diagnosis, next appointment, date and time of appointment and any future payment for the following session.

Please sign below acknowledging you have read and understood the contents of the NPP and have discussed any questions or concerns with Elizabeth J Kowieski, LCPC.

Print Name

Signature and Date

Elizabeth J Koweiski, LCPC

Therapist Signature and Date