Bethesda
Christian Counseling

Notice of Privacy Practices--Brief Version

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information (PHI) as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This document is a shorter version of the full, legally required Notice of Privacy Practices (NPP) for you to retain for your records. You may request the longer version of the NPP from the front office. However, we can't cover all possible situations that may arise, so please talk to our Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information in accordance with this notice and the law. **If you do not consent and sign the form, we cannot treat you.**

If you or your therapist want to use or disclose (send, share, release) your information for any other purposes other than those described above, we will discuss this with you and ask you to sign an Authorization form to allow this disclosure.

Of course we will keep your PHI private, but there are some times when laws require us to use/ share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share
   information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these, but they don't happen very often. They are described in the longer version of the NPP. We do have the right to use your PHI for our own marketing and fundraising purposes but you may opt out of those by informing us that you would like to opt out in writing.

We also have the responsibility to inform you if a breach of your information occurs. If a breach would occur we will notify you according to the directions set forth in the law for us to do so. If you would like more information regarding what we will do in that situation, it is described in more detail in the longer version of the NPP which can be obtained from our privacy officer.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. You also have the right to ask us not to share information with your insurance company if you pay for the session in full yourself.
3. You have the right to look at the PHI we have about you such as your medical and billing records. You can even get a copy of these records, but we may charge you for these copies. However, because psychotherapy notes are held extremely confidential and prohibited by the law to be released even to you, a special authorization is required for you to access these. This access may or may not be granted and will be determined by your therapist. Contact our Privacy Officer to ask about the process of requesting to see your records.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make certain kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes. **Psychotherapy notes can not be amended as they are interpretations by your therapist regarding what was discussed in the session.**
5. You have the right to a copy of this notice. If we change the NPP we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and/or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our ***Privacy Officer, Stacey Eeten*** in Sioux Falls at (605) 334-3739 or by e-mail at stacey@bethesdachristiancounseling.org or our ***Records Clerk, Denise Salker*** in Orange City at (712) 737-2635 or by e-mail at ocoffice@bethesdachristiancounseling.org.

The original date of this NPP is November 1, 2003. The effective date of this revised notice is February 1, 2013.Also, you may have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. The privacy officer/records clerk will be happy to discuss these situations with you now or as they arise.

Patient Copy

Bethesda
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Consent to use and disclose your health information

This form is an agreement between you, _____, the client or client's personal representative and **Bethesda Christian Counseling**. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his/her name here _____.

[Client Name or Parent Name of Minor Child]

[Spouse or Family Members(s) of Client or Minor Child Name]

When we examine, test, diagnose, treat, or refer you to another therapist or physician, we will be collecting or using what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and with others as described in the Notice of Privacy Practices (NPP). The NPP explains in more detail your rights and how we can use and share your information. Please read the NPP before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we **can not treat you.**

In the future we may change how we use and share your information and therefore may change our Notice of Privacy Practices. If we do change it, you can get a copy from our office by calling our Privacy Officer at (605) 334-3739.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell us about your concerns and what you want us to do about your concerns in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree to the limitations, we promise to do as you have asked.

After you have signed this consent, you have the right to revoke it by writing a letter to our Privacy Officer telling us you no longer consent and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that. If you revoke your consent, we can no longer treat you and we will supply you with appropriate referrals at that time.

_____ _____
Signature of client, client's personal representative or spouse — Date

_____ _____
Printed name of client, client's personal representative or spouse — Relationship to client

_____ _____
Signature of client, client's personal representative or spouse — Date

_____ _____
Printed name of client, client's personal representative or spouse — Relationship to the client

_____
Signature of authorized representative of this office

Date of NPP _____

❑ Copy of NPP given to the client/parent/personal representative

❑ Client/parent/personal representative did not take copy of NPP provided

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OUTPATIENT SERVICES AGREEMENT AND CLIENT INFORMED CONSENT

This document contains important information about the professional services and business policies of Bethesda Christian Counseling Midwest, Inc. Please read it carefully and jot down any questions you might have so that you can discuss them with your therapist or our Privacy Officer. Once you sign this, it will constitute a binding agreement between you and Bethesda Christian Counseling Midwest.

Christian Mental Health Services
Counseling has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Counseling often requires discussing unpleasant aspects of your life. However, it has also been shown to have benefits for people who undertake the risks. Therapy usually leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. But there are no guarantees about what will happen in the case of every individual. Counseling requires a very active effort on your part. In order for you to get the best effect out of counseling, you will have to work on things talked about both during your sessions and at home.

Your first few sessions will involve an evaluation of your present complaints, your needs and your history. By the end of the evaluation, your therapist will, generally, be able to offer you some initial impressions of what your therapy work will include and an initial treatment plan to follow, should you decide to continue. The length of a person's course of therapy is different for each individual because it depends on the nature of the problem, the individual's history, the treatment plan to be followed, the individual's personality and diagnosis, and the client/therapist relationship.

Your therapist agrees to give you a truthful, understandable, and appropriate account of your condition. You will be kept fully informed as to the purpose and nature of any evaluation, treatment, or other procedures, and of your right to freely choose (or to refuse) any services offered.

You should evaluate this information along with your own assessment about whether you feel comfortable working with your therapist. Therapy involves a commitment of time, money, and energy; so you should be very careful about the therapist you select. If you have any questions about your therapist's procedures, you are encouraged to discuss them whenever they arise. If your doubt persists, your therapist will be happy to help you secure an appropriate consultation with another mental health professional.

Meetings
Therapy sessions are normally 55 minutes in duration and vary in frequency. Once you have scheduled an appointment you must provide 24-hour notice of cancellation. If you fail to provide this 24 hour notice you will be billed half the full fee for the missed appointment. After two no shows or late cancellations, you will need to visit with your therapist by phone prior to scheduling another appointment.

Billings and Payments
The fee varies depending on the type of service provided and whether or not you qualify for our reduced fee schedule. You are encouraged to inquire about your fee when you come in for your first appointment. You will be expected to pay the full fee for each session at the time it is held, unless your insurance coverage requires another arrangement. Costs for psychological testing and psychiatric visits are different from your routine counseling fees and do not apply to the reduced fee scale. You will be advised of these additional costs when it is determined that such services might be in your best interest.

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If your portion of the bill (not including anticipated insurance payments) is more than 90 days delinquent and suitable arrangements for payment have not been agreed to, Bethesda Christian Counseling Midwest has the option of using legal means to secure payment, including collection agencies or small claims court. If legal options must be used, you will forfeit your right to confidentiality to the extent necessary to process the legal claim against you. Furthermore, if we must take legal action to collect a delinquent account you will also forfeit the right for your treatment information to be released until the delinquent amount is paid in full.

Insurance Reimbursement
In order for Bethesda to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, **you, and not your insurance company, are responsible for full payment of the fee** to which we have agreed. Therefore, it is very important that ***you*** find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance agreements require you to authorize your particular therapist to provide a clinical diagnosis, and sometime additional clinical information such as a treatment plan or summary; or, in rare cases, a copy of the entire record, although, unless specifically authorized by you, we will not release psychotherapy notes to the insurance company. This information will become part of the insurance company files; and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential; but, once in their hands, your therapist has no control over what your insurance company does with it. If you request it, your therapist will provide you with a copy of any report which will be submitted.

Release of Records
Both law and the standards of our profession require that your therapist keep appropriate treatment records and/or psychotherapy notes. Your record will be confidentially secured in Bethesda's offices.

If you are under eighteen years of age, please be aware that the law may provide your parents with the right to examine your treatment records or discuss your treatment with your therapist. Before giving them any information, your therapist will discuss the matter with you, if possible, and will do his or her best to resolve any objections you may have about what would be discussed.

Records are maintained in a secure location at our offices for a period of ten years following the termination of your treatment (In the case of minors it is ten years or until they reach the age of 20 whichever is longer.) Any and all information contained in your files cannot be shared with anyone unless you complete a proper Release of Information form or it is required for us to share by law. You will be responsible for any cost associated with the release of information.

I understand that I may, upon request, review my records with my therapist at any time during the course of my treatment. This does not include the therapist's psychotherapy notes, which I have no access to. I understand that in order for me to see my psychotherapy notes, a special release will need to be signed, and the therapist still may or may not allow me to see these notes even after the request is submitted. I further understand that I have the right to request a change to my records if I believe they do not accurately reflect my statements or condition, this excludes psychotherapy notes. Such changes must be made in cooperation with my therapist.

Confidentiality
In general, the confidentiality of all communications between a client and a therapist is protected by law. Your therapist can only release information about your treatment to others with your written permission. However, there are a number of exceptions to your guaranteed right to confidentiality. These exceptions are:

1) The client authorizes the release of information with a signature.
2) The therapist is ordered by the court to release information.

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3) The client presents a physical danger to self or others.
4) There is evidence or reasonable suspicion of child/elder abuse and/or neglect.
5) The client fails to pay for services rendered. Only information necessary to proceed with legal measures against such clients will be released to court authorities or collection agencies.
6) For treatment, payment, or other health care operations including (TPO), but limited to, our fundraising and marketing campaigns, which I may opt out of in writing. All of these are described in the full version of our Notice of Privacy Practices.

Should any of these situations occur with the exception of what is listed in #6, your therapist will make every effort to fully discuss it with you before taking any action. Your therapist may also, occasionally, find it beneficial to your treatment to consult about a case with other professionals who work for Bethesda Christian Counseling. Such case consultation with inter agency staff is recommended by our profession and offers you, the client, greater assurance of receiving quality care. All staff personnel are bound by the same rules of confidentiality. Unless you object, your therapist will not tell you about these consultations unless he or she believes it is important to the therapeutic relationship.

Periodically, case reports or other confidential information are used as the basis of teaching, research, or other published reports. In such cases your therapist will either take reasonable care to ensure that the reported material is appropriately disguised to prevent client identification, or else ask for your written permission to use your material.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have with your therapist or the Privacy Officer.

Contacting Your Therapist
Your therapist is often not immediately available by telephone. When your therapist is unavailable, an office support staff member or another therapist will be available to take a message or help you with a crisis. Your therapist will make every effort to return your call in a timely manner. If your therapist goes out of town for a period of time, arrangements will be made for another therapist to assist you in case of emergency. You are generally discouraged from calling your therapist at home unless you fear that the issue is life threatening. In most crises you can go to your nearest emergency room for immediate treatment, contact one of our other therapists, or contact your therapist on the following business day to discuss your concerns.

Client's Informed Consent

"I have chosen to receive treatment services at Bethesda Christian Counseling Midwest, Inc. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no guarantee that I will feel better as a result of therapy.

I understand that counseling is a cooperative effort between me and my therapist, and I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which may be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that, if my health insurance decides not to pay for any part of my treatment, I am responsible for such payment in full.

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I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that I may be contacted by Bethesda Christian Counseling Midwest, Inc. after my treatment is concluded to assess the outcome of treatment, unless I object to this in writing.

I understand that my therapist may, occasionally, review the contents of my case with other professionals at Bethesda Christian Counseling Midwest, Inc. for the purpose of providing me with the best quality of care possible.

I have read the basic rights of individuals who have come to Bethesda Christian Counseling Midwest for treatment. These rights include:

1. **The right to be informed of the various steps and activities involved in receiving services.**
2. **The right to confidentiality under federal and state laws relating to the receipt of services.**
3. **The right to humane care and protection from harm, abuse, or neglect.**
4. **The right to make an informed decision whether to accept or refuse treatment.**
5. **The right to contact and consult with legal counsel at my expense.**
6. **The right to select practitioners of my choice at my expense.**
7. **The right to review my records with my therapist and request any changes to my record which I believe would more accurately reflect my statements or condition, excluding the psychotherapy notes kept by my therapist.**
8. **The right to opt out of any fundraising or marketing lists, but I must do so in writing.**

I understand that my therapist, my health benefits company representatives and my primary care physician may exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, or utilization review purposes (excluding psychotherapy notes). I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that, if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I, further, understand that I have had every opportunity to discuss any and all questions and concerns with my therapist. My signature below indicates that I have read the information in this document and agree to abide by its terms during my professional relationship with the staff at Bethesda Christian Counseling Midwest, Inc. I further understand that if I do not sign this consent, treatment will be denied by the therapists at Bethesda Christian Counseling Midwest, Inc."

_____	_____	_____
Signature of Client or Spouse	Printed Name of Client or Spouse	Date
_____	_____	_____
Signature of Client or Spouse	Printed Name of Client or Spouse	Date
_____	_____	_____
Signature of Parent/Guardian if Required	Printed Name Parent/Guardian	Date

_____
Relationship to Client

_____ _____
Therapist's Signature Date

A copy of this agreement is kept in your record. If you would like a copy of this or the NPP, please ask at the front desk, a copy will be provided to you.

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Date_____

CLIENT INFORMATION FORM

Name _____ Home Phone (____) _____

Address _____ Cell Phone (____) _____

City _____ State _____ Zip Code _____

Email Address_____ Work Phone (_____) _____

How would you like to be contacted in case we need to cancel your appointment?

□ Email □ Home Phone □ Work Phone □ Cell Phone

I grant you permission to *(check all that apply)*: □ Email me □ Leave Voicemail/Message

Social Security # _____ Age _____ Date of Birth _____

Employer of Client _____

Employer of Parent/Spouse _____

Church Affiliation _____

Previous Counseling? Yes No If yes, where? _____

Whom may we thank for referring you to us? _____

Marital Status: S M W D Sep. Years of Education _____

Insurance Subscriber's Name and Date of Birth _____

INSURANCE INFORMATION

Company Name _____

Claims Mailing Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____ Deductible Amount $_____ Is it met? Yes No

Policy Number _____ Group Number _____

Subscriber's Name _____ Subscriber's Soc. Sec. # _____

Subscriber's Date of Birth _____

Office Use Only

FINANCIAL INFORMATION

Client Fee $_____/Hr. Financial Assistance $_____/Hr. Sessions Available with F/A _____

Client # _____ Date _____ Therapist _____

Diagnosis # _____ Description _____

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