QUANTUM COUNSELING, LLC – LILLIE MURRAY, LCSW

NOTICE OF HEALTH INSURANCE PORTABILITY ACCOUNTABLITY ACT (HIPPA)
REVIEW OF CLINICAL POLICIES & DESCRIPTION OF SERVICES

Notice of Health Insurance Portability Accountability Act (HIPAA)

This Notice contains important information about federal law, HIPAA, that provides privacy protections and patient rights with regard to the use and disclosure of you Protected Health Information (PHI), for the purpose of treatment, payments, and healthcare operations.
I am required by the federal law known as the *Health Insurance Portability and Accountability Act* (HIPAA) to give you this notice. This Notice will tell you about the ways in which we may use and disclose health information about you and will inform you of your rights and our obligations regarding the use and disclosure of that information.

How I May Use and Disclose Health Information About You

Treatment - I may use or disclose non-identifying health information about you to other health professionals to facilitate counseling and other health treatment.

Payment - I may use and disclose health information about you so that I can be compensated by you, an insurance company, another party, including present or future ecclesiastical leaders if they are paying any portion of the fee for the services I provide you. For example, I may need to provide your insurance company information about our services to you so that your insurance company will compensate us for these services.

Office Operations – I may use and disclose health information about you in order to operate my office and to ensure that you receive the best care possible. For example, my receptionist may take phone calls, and obtain information from you for scheduling purposes.

Limitations to Confidentiality & Special Situations
I may use or disclose your health information without your permission for any of the following reasons:
•Disclosing your health information when I believe such disclosure is necessary to prevent a serious threat to your health and safety or the health and safety of another person.
•Disclosing your health information as required by federal, state, or local law.
•Disclosing your health information as required by law to prevent, or report suspected injury or suspected abuse or neglect.
•Disclosing your health information in response to a court order, subpoena, warrant, summons or similar process. I will seek your authorization and court order if I receive a subpoena. You should consult an attorney to determine if this would be needed.
•Disclosing in event of complaint or lawsuit. I may disclose relevant information to protect myself.
•Disclosing for worker's compensation claim. I may submit to appropriate insurance carrier, employer, and authorized medical providers.

Other Uses and Disclosures of Health Information
Except where otherwise required or authorized by law, we will not use or disclose your health information for any purpose without your written authorization. If you authorize us to use or disclose health information about you, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your health information for the reasons identified in your written authorization, but we cannot undo any uses or disclosures that have already occurred with your permission.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with my office or with the Secretary of the Utah Department of Health and Human Services. To file a complaint with Quantum Counseling, please contact Lillie Murray, at 801-923-8389. You will not be penalized for filing a complaint.

Your Rights Regarding Your Health Information

•Right to inspect and copy your health information, with certain exceptions.
•Right to request that the information be amended and/or updated, if you believe it is incomplete or incorrect.
•Right to obtain an accounting of our disclosures of your health information. These are disclosures of your health information for purposes other than treatment, payment and health care operations.
•Right to request that we restrict or limit our use or disclosure of your health information to only treatment, payment or health care operations. We are not required to comply with your request.

•Right to request that we communicate with you regarding your health matters in a certain way or at a certain location. For example, you can request that we only contact you at work or by mail.
•Right to receive a paper copy of this Notice.
•Right to revoke your authorization for disclosure. I cannot undue any disclosures that have already occurred with your permission.
•Right to choose someone to act for you. This may be a parent, legal guardian, who can exercise rights for you regarding healthcare.
•Right to choose to receive professional services from me.
•Right to terminate therapeutic services from me at any time without financial obligation, other than those previously accrued. I request that you notify me in session or contact me directly letting me know of completion of services.

Review of Clinical Policies

Insurance

Some insurance companies will cover a portion of the costs associated with therapy. You are encouraged to contact your insurance carrier to determine the limits of your coverage. In most cases, we will bill your primary insurance company and provide the necessary documentation required. Please remember that any charge **not covered** by your insurance will be **your responsibility. Your portion of the payment (co-pay, deductible or co-insurance) is required to be paid at the time of service.**

Late Cancellation of Appointments & No Show Policy

On occasion, a situation may arise which prevents you from keeping a scheduled appointment with your therapist. It is required that you notify Lillie Murray, LCSW ***48 hours*** in advance of an appointment you cannot keep. If an appointment is canceled with less than ***48 hours*** notice you will be expected pay a **Late Cancellation** fee of **$50.00**. If you do not come to a scheduled appointment and fail to give any notice *prior to the appointment* (phone call or email) you will be expected to pay a full session **No Show** fee of **$120.00**. Exceptions may be granted to waive the fee in emergency situations, but must be approved by the clinician. Unless arrangements this fee will need to be paid before future appointments can be scheduled.

The purpose of these fees is to encourage responsibility on the part of the client and to ensure that the clinician's time, which has been reserved for you, is utilized efficiently. Late Cancellations and No Shows prevent the clinician from using the period reserved to assist other clients who may need the appointment time. In addition, **Late Cancellations** and **No Shows** affect the clinician financially. Consequently, these fees are in place to resolve these issues and are not typically waived.

Description of Services

Generally, counseling is valuable tool in helping individuals to improve themselves, their relationships, by changing feelings, thoughts, and behaviors. In the process, you, the client determine your goals, the identified problems, the amount of change and energy you are willing to put into this process. Please make your goals and preferences known to your therapist.

Treatment

I incorporate a variety of evidence based treatment approaches in my practice including: Eye Movement Desensitization and Reprocessing (EMDR), Cognitive Behavioral Therapy with Mindfulness, Dialectical Behavioral Therapy.

Benefits and Risks

Most people experience some resolution to problems and symptoms that bring them to counseling. Some experience adverse emotional reactions, pain and anxiety, when they obtain new awareness. The therapist may discuss these though out the course of treatment. To receive the best care possible, the client should notify/update changes to health, medication, and any current or past abuse.

CRISIS & Emergencies - Please call 911 – Local Crisis Line – 801-773-7060
Quantum Counseling, LLC provides office mental healthcare and does not provide 24 hr emergency care.
I will usually respond to emails by the next business day. Please list as urgent to return call. I, however, discourage use of texting or emailing me personal information to protect your confidentiality.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ THIS AGREEMENT IN ENTIRITY AND AGREE TO IT'S TERMS AND CONDITIONS.

Client/Legal Guardian Signature Date

Printed Name

Therapist Signature Date