Dr. Elaina Vasserman-Stokes, PhD, LPC, PLLC

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NPI # 1699122366

Washington DC License # PRC14637

Tax ID# 813-84-3120

**Psychotherapist-Patient Services Agreement and Consent to Treatment**

Welcome to my practice. I appreciate the opportunity to be of help to you. I am providing you with the following information to answer many of the questions people typically have when beginning psychotherapy, and to outline policies and procedures that are specific to my work. Please read it carefully and feel free to share any comments, questions, or concerns you may have.

**Psychotherapy**

As part of our process, I invite you to ask me about my training and therapeutic perspective, as well as voice any concerns or questions you have about therapy. It is my intention to be curious, support you, and refrain from judging you, and I encourage you to share your thoughts and feelings without fear of rejection. Because I only accept clients whom I believe I can help using my professional knowledge and training, I expect to enter our work with optimism and enthusiasm.

Throughout treatment, we will discuss your personal goals, and though they may not always be reached, I will do my best to work with you on reaching them. We will periodically assess our progress, and together decide on further courses of action.

The benefits of therapy have been repeatedly and scientifically demonstrated for most people in most situations. Depending on your concerns and symptoms, possible benefits may include the attainment of your personal goals, a reduction in anxiety and/or depression, an increased sense of well being and self-understanding, and more satisfying relationships. As with any treatment, psychotherapy has both benefits and risks. The possible risks of therapy may include an exacerbation of symptoms, new symptoms, the questioning of beliefs and values, and possible changes in lifestyle, relationships, or employment. Other risks can include recalling unpleasant life events, facing difficult thoughts and beliefs, and the experience of intense and unwanted feelings such as sadness, anger, fear, guilt, or anxiety. These feelings, however, may be a natural, normal, and important part of your therapy. Most people find that any worsening of symptoms is temporary and that the gains made from therapy far outweigh the short-term discomfort they may experience. I encourage you to discuss with me any reactions or adverse effects of therapy during our sessions.

Our work will end once you are satisfied with your progress and we discuss this and how we will end. You may also decide to terminate our work for other reasons, but I encourage that we meet for at least one more session to discuss the ending. In addition, ethical standards dictate that I should terminate therapy when I do not feel it is being helpful, and if I do so, I will be sure to provide you with appropriate referrals.

**Meetings**

My services are by appointment only. I typically conduct an initial evaluation of one to four sessions. During this time, we can both decide if I am the right person to provide the services you need. If we agree to begin psychotherapy, I will usually schedule weekly 50-minute sessions at a time we agree on, though more frequent sessions may be possible or necessary. Effective therapy will require your commitment to the appointments we schedule. Due to the nature of psychotherapeutic work, I must adhere firmly to time guidelines. As such, if you are late for a scheduled session, it will end at its regularly scheduled time. If I am ever unable to start a session on time, I will either make up the lost time or adjust the fee accordingly.

**Cancellation Policy**

Because your scheduled appointment time is reserved for you, **I require a 48 hours notice to cancel a session**. **If you notify me with less than 48 hours, you will be charged the full fee for the session unless we can reschedule within the same week.** If you would like to reschedule a canceled session, I will try to accommodate you, although I cannot guarantee that additional openings will be available. **If you miss an appointment without notifying me in advance, you will be charged the full fee.** Please note that insurance companies typically do not reimburse for canceled or missed sessions, leaving you responsible for the entire fee. If I ever need to cancel our session due to an emergency or illness, I will make every effort to notify you as soon as possible and to reschedule with you in as timely and convenient a way as possible.

**Telephone and Emergency Policy**

If you need to reach me between regularly scheduled appointment times, you can call me at 240-232-6236. The voicemail at this number is confidential. I check these messages once every 24 hours and will return your call at the earliest possible opportunity during business hours. If I will be unavailable for an extended period, I will provide you with the name and contact information of a colleague, if needed. **If you are calling because of an emergency, please leave a message for me; however, if you cannot wait for a return call, proceed to your nearest emergency room or call 911.**

I do not charge for telephone contact shorter than 10 minutes. For conversations longer than 10 minutes, I will charge you for the percentage of time used based on your hourly fee. This also applies to conversations that you authorize me to have with other professionals or relevant outside parties.

**Email**

I offer the option of using email for scheduling or general questions. You may email me for these purposes at drevstokes@gmail.com. Please note that I do not use email to provide psychological services and I will not respond to emails regarding clinical material that should be discussed in session. It is important to be aware that the security, confidentiality, and timely delivery of email cannot be guaranteed. As such, **please do not include any sensitive information over email and never use it to reach me in an emergency**. You may opt into or out of email communication at any time by letting me know in writing.

**Social Media**

To protect your privacy and confidentiality, I do not knowingly establish direct connections with current or former patients through social and professional networking sites. In contrast, some online contact may be difficult to foresee and prevent, such as via listservs or shared connections on social media. Whenever possible, it is important that we discuss any such contact to determine how to protect your confidentiality and to prevent any foreseeable risks to it.

**Fees, Billing, and Insurance**

I charge a rate of $185 for each 50-minute session, subject to annual adjustments. **I require payment at the time of service**. Unless other arrangements are made, I accept cash, checks, or credit cards. **If writing a check, please make it out to Elaina Vasserman-Stokes, PhD, PLLC.** To best utilize session time, it is helpful to make checks out in advance. Please note that returned checks are subject to a $25.00 fee. I will provide you with a statement detailing the services provided and the total amount paid. If this billing arrangement is not feasible, I ask that you discuss this with me to work out an agreeable arrangement. If the bill is two months overdue, I reserve the right to discontinue therapy until you pay the full amount. If you cannot, I will refer you to an inexpensive alternate source of help, if necessary. I also reserve the right to pursue outside options for collection of balances more than two months overdue.

I do not participate with any insurance providers. If you plan to use your insurance’s out-of-network mental health coverage, I will fill out any forms required of me and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled. However, you (and not your insurance provider) are ultimately responsible for full payment of my fees. I encourage you to contact your insurance to find out exactly what mental health services your policy covers.

**Consultation and Professional Development**

As part of my commitment to providing the best services possible, I participate in regular, ongoing consultation and professional development. In order to provide a high quality of care, I may discuss certain clinical material during such activities; however, I will never disclose personally identifying information without your written consent.

**Professional Records**

The laws and standards of my profession require that I keep Protected Health Information about you in your clinical record, which you have access to (upon a written request). However, since they can be confusing, I request that I am present with you to explain them if you want to read them, and you will be required to pay for this time.

**Patient Rights**

HIPAA (Health Insurance Portability and Accountability Act) provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. The attached form entitled “Notice of Policies and Practices to Protect the Privacy of Your Health Information” lists these rights.

**Confidentiality and Privacy of Information**

I will make every effort to safeguard the privacy of information concerning our work together. It is a violation of the District of Columbia Mental Health Information Act of 1978, as well as the Code of Ethics of the National Association of Social Workers, to disclose any information regarding the treatment of clients.

There are several specific exceptions to the rule of confidentiality. The most common are listed below:

* You may authorize me to release records or other information to individuals of your choosing. I may only do this with your expressed written consent.
* Under ethical and legal requirements, I may be required to break confidentiality in the event of a clear and imminent danger to yourself or another person.
* In the event that you disclose information that provides evidence of abuse or neglect of minor children or a vulnerable adult, the law may require that I make a report to the appropriate state agency.
* In certain legal proceedings, confidential information may be disclosed by court order. This is a rare occurrence and would not happen without your knowledge.

**Minors and Parents**

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child’s treatment records. The effectiveness of psychotherapy depends on the patient’s sense of trust and safety in the therapeutic relationship so that the patient is willing to honestly address problems.  While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment.  Therefore, it is usually my policy to request an agreement from any patient between 1-18 and his/her parents allowing me to share general information about the progress of treatment and their child’s attendance at scheduled sessions.  I will also provide parents with a summary of their child’s treatment when it is complete.  Any other communication will require the child’s authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern.  Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

**Acknowledgement and Consent**

**Your signature below indicates that you have read this agreement and agree to its terms, and that you consent to treatment. It also serves as an acknowledgement that you have received the HIPAA notice form “Notice of Policies and Practices to Protect the Privacy of Your Health Information.”**

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:  \_\_\_\_\_\_\_\_\_\_\_

If minor, Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:  \_\_\_\_\_\_\_\_\_\_\_

Signature of Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:  \_\_\_\_\_\_\_\_\_\_\_

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DoB:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OK to leave VM? Circle: **YES/NO**

Email address (only used with your permission):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cultural/Ethnic Background:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have secondary health insurance?   Y    N     GO Card # (GU students): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family:**  Please list all significant family members and any significant others. Please include: Name, Relationship to you, Age, Location, Occupation, and any Mental Illness.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** | **Relationship to you** | **Age** | **Location** | **History of Mental Illness?**  | **Please Describe**  |
|  |  |  |  | Y/N |  |
|  |  |  |  | Y/N |  |
|  |  |  |  | Y/N |  |
|  |  |  |  | Y/N |  |
|  |  |  |  | Y/N |  |
|  |  |  |  | Y/N |  |

\* Please put an asterisk next to your emergency contacts

**Education and Employment**: Please list current and recent **significant** **employment** (position, company, location, and timeframe), and **education** (school, degree, location, and timeframe).

 **Education:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Employment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Health**: Do you have any major medical illnesses (now or in the past)? Circle: **YES/NO**

**If yes, please explain**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Use of Medications:** (include prescribing doctor/psychiatrist’s name):

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Dosage** | **Currently Taking?** | **Prescribing Physician** |
|  |  | **Y/N** |  |
|  |  | **Y/N** |  |
|  |  | **Y/N** |  |
|  |  | **Y/N** |  |
|  |  | **Y/N** |  |

Current psychiatrist:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past psychiatric meds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Issues:**

Are you currently or recently involved in court proceedings? Circle: **YES/NO**

Are you currently or recently involved in a domestically violent situation? Circle: **YES/NO**

**If yes, please explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**History of Abuse/Trauma:**

Have you experienced abuse in your past (emotional, physical, sexual)? Circle: **YES/NO**

**If yes, please explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever thought about (or acted on) harming yourself Circle: **YES/NO**

**If yes, please explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Incidences of harming others? Circle: **YES/NO**

**If yes, please explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health History**

Have you ever received any mental health treatment? Circle: **YES/NO**

If yes, please list any psychiatric hospitalizations, and any therapy/counseling experiences \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Drug/Alcohol Use**

Please describe your **drug and alcohol** use (e.g. # of drinks/week, how frequently):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Mental Health**:  Please check all of the following items that are concerns at this time, and circle those which are most important.

|  |  |  |  |
| --- | --- | --- | --- |
|     Abortion related issues |     Divorce, separation |     Legal problems |     Self-injury, mutilation |
|     Abuse – emotional, physical, verbal, sexual, neglect |     Drug use |     Loneliness |     Self-neglect, poor self-care |
|     Academic issues |     Emptiness |     Mood swings |     Sexual concerns |
|     Advisor/faculty concern |     Family relationships |     Motivation |     Sexual harassment |
|     Aggression/violent behavior |     Fearing failure |     Overly responsible to others |     Sexual orientation/identity |
|     Alcohol use |     Fears, phobias |     Overly sensitive to rejection |     Sexually transmitted disease |
|     Anger, arguing |     Financial problems |     Panic attack |     Shame |
|     Anxiety, nervousness |     Gambling |     Perfectionism |     Shyness, oversensitive |
|     Body image |     Guilt |     Peer relationship concerns |     Smoking, tobacco use |
|     Career concerns, choices | \_\_Eating Issues |  |  |
|     Childhood issues (yours) |     Harassment |     Pregnancy |     Sleep problems |
|     Children/parenting concerns |     Health, medical concerns |     Prejudice/bias concerns |     Stress |
|     Compulsive behaviors |     Hallucinations |     Procrastination/time management |     Suicidal thoughts |
|     Computer excessiveness |     Identity issues |     Racial/ethnic concerns |     Tiredness, fatigue |
|     Concentration |     Impulsive, out of control |     Repeated troubling thoughts |     Violent thoughts |
|     Decision making, indecision |     Independence from parents            |     Relationship concerns |     Withdrawal, isolating |
|     Grief issues |     International student concern |     Relationship violence |     Worthless feeling |
|     Depression, sadness, crying |     Irresponsibility |     Religious/spiritual concerns |     Other |

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Policies and Practices to Protect the Privacy of Your Health Information:**

**HIPAA (The Health Insurance Portability and Accountability Act)**

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  PLEASE REVIEW IT CAREFULLY.

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operation**

I may *use* or *disclose* your *Protected Health Information*  (PHI) for *Treatment*, *Payment*, and *Health Care Operations* purposes with your *written authorization*.  To help clarify these terms, here are some definitions:

* “*PHI*” refers to information in your health record that could identify you.
* “*Treatment, Payment and Health Care Operations*”
	+ *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a psychologist.
	+ *Payment* refers to reimbursement for your health care.  Examples of payment are when PHI is disclosed to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
	+ *Health Care Operations* are activities that relate to the performance or operation of the practice.  Examples are quality assessment and improvement activities, business-related matters (such as audits) and administrative services, case management and care coordination.
* “*Use*” applies only to activities within the office, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
* “*Disclosure*” applies to activities outside of the office, such as releasing, transferring or providing access to information about you to other parties.
* “*Authorization*” is your written permission to disclose confidential mental health information.  All authorizations to disclose must be on a specific legally required form.

**II.  Other Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained.  In those instances when I am asked for information for purposes outside of those outlined above, I will obtain authorization from you before releasing that information.  I will also need to obtain authorization before releasing your *Psychotherapy Notes*.  These are notes I have made about our conversation during a private, group, joint or family counseling session, which I have kept separate from the rest of your record.  These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing.  You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of insurance coverage, the law provides the insurer with the right to contest the claim under the policy.

**III. Uses and Disclosures without Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

* *Child Abuse* – If I know or have reasonable cause to suspect that a child known to me in my professional capacity has been or is in immediate danger of being mentally or physically abused or neglected, I must immediately report such knowledge or suspicion to the appropriate authority.
* *Adult and Domestic Abuse* – If I believe that an adult is in need of protective services because of abuse or neglect by another person, I must immediately report this belief to the appropriate authorities.
* *Health Oversight Activities* – If the D.C. Board of Psychology is investigating me or my practice, I may be required to disclose PHI to the Board.
* *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I have provided you and/or the records thereof, such information is privileged under D.C. law, and I will not release information without the written authorization of you or your legally appointed representative or a court order.  The privilege does not apply when you are being evaluated for a third party or where the evaluation is court offered.  You will be informed in advance if this is the case.
* *Serious Threat to Health or Safety* – If I believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I may disclose the PHI to the appropriate individuals.
* *Worker’s Compensation* – If I am treating you for Worker’s Compensation purposes, I must provide periodic progress reports, treatment records and bills (upon request) to you, the D.C. Office of Hearings and Adjudication, your employer, or your insurer (or their representatives).

**IV. Patient’s Rights and Provider’s Duties**

Patient’s Rights:

* Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information.  However, I am not required to agree to a restriction you request.
* Right to Receive Confidential Information by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are in treatment with me.  Upon your request, I will send bills to another address).
* Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record.  I may deny your access to PHI under certain circumstances, but in some cases you may have the decision reviewed.  You may be denied access to Psychotherapy Notes if I believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury.  I shall notify you or your representative if I do not grant complete access.  Upon your request, I will discuss with you the details of the request and denial process.
* Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record.  I may deny your request.  Upon your request, I will discuss with you the details of the amendment process.
* Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process.
* Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Provider’s Duties:

* I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
* I reserve the right to change privacy policies and practices described in this notice.  Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
* If I intend to revise my policies and procedures, I must describe in the notice to patients how I will provide patients with a revised notice of privacy policies and procedures (e.g. by mail, e-mail).

**V. Questions and Complaints** If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me.I f you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at: 1350 Connecticut Ave. N.W., Suite 403, Washington D.C. 20036.  You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.  I can provide you with the appropriate address upon request.  Please note: you have specific rights under the Privacy Rule.  I will not retaliate against you for exercising your right to file a complaint.

**VI. Effective Date, Restrictions and Changes to Privacy Policy:**This notice went into effect on September 1, 2017.  I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain.  I will provide you with a revised notice by mail or in person.