Official Practice Policies

I. GENERAL PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS: Appointments are 50 minutes. Please remember to cancel or reschedule 48 hours in advance. You will be responsible for the entire fee if cancellation is less than 48 hours. Requests to change the standard session time needs to be discussed with the therapist in order for time to be scheduled in advance***. PLEASE NOTE: 48 hour cancellations can only be made during business hours (Monday-Friday, 8:00 AM-5:00 PM.***

PAYMENT AND BILLING: My fee is $200.00 per 50 minutes session. I do not accept insurance. ***Full payment is expected at the time of each appointment*** unless otherwise arranged. Cash or checks are each acceptable forms of payment. Checks should be payable to "Melinda Rader." Clients are notified of any change in fee 30 days prior to it taking effect. A $50.00 service charge will be charged for any checks returned for any reason for special handling. Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 48 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are more than 20 minutes late for your session, your session will be considered a no-show and the remainder of your session time may be forfeited.

TELEPHONE ACCESSIBILITY: If you need to contact me between sessions, please leave a voicemail message. My voicemail cannot be used as an emergency service. If I am not immediately available, I will attempt to return your call within 24 hours. If a true emergency situation arises, please call 911 or go to any local emergency room. I return text messages between the hours 8:00 AM – 5:00 PM, Monday - Friday.

SOCIAL MEDIA AND TELECOMMUNICATION: Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can discuss further.

ELECTRONIC COMMUNICATION: I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate

via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that: (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. (2) All existing confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.

CLINICAL NOTES: Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the therapist.

MINORS: If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION: Ending relationships can be difficult. Therefore, it is important to have a termination process in place in order to achieve closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

Acknowledgement of Receipt General Practice Policies

By signing below, I certify:

- That I have read or had this form read and/or explained to me.
- That I fully understand its contents including the risks and benefits of telehealth.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature: _____

Print Name: _____

Date: _____

II. PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY.

CONFIDENTIALITY: I understand that health information is personal. I am committed to protecting health information about you. I will create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental

health care practice, and about the ways in which I may use and disclose health information about you. Described in this notice are your rights to the health information I keep about you, and certain obligations I have regarding the use and disclosure of your health information. By law I am required to:

• Make sure that protected health information ("PHI") that identifies you is kept private.
• Give you this notice of my legal duties and privacy practices with respect to health information.
• Follow the terms of the notice that is currently in effect.
• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new notice will be available upon request, in my office, and on my website.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: The following categories describe different ways I use and disclose health information. Not every specific use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories:

• For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.
• Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. Treatment includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.
• Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

WHEN DISCLOSURE REQUIRES YOUR AUTHORIZATION:
• Psychotherapy Notes are made and kept. Any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For my use in defending myself in legal proceedings. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.
• As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
• As a psychotherapist, I will not sell your PHI.

WHEN DISCLOSURE DOES NOT REQUIRE YOUR AUTHORIZATION: Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:
• When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
• For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
• For health oversight activities, including audits and investigations.
• For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
• For law enforcement purposes, including reporting crimes occurring on my premises.
• To coroners or medical examiners, when such individuals are performing duties authorized by law.
• For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
• Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
• For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
• Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose

your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

CERTAIN USES AND DISCLOSURES REQUIRING YOUR OBJECTION: I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

• The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

• The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

• The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way or to send mail to a different address, and I will agree to all reasonable requests.

• The Right to See and Get Copies of Your PHI. Other than psychotherapy notes, you have the right to get an electronic or paper copy of your medical record and other information. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable fee for doing so.

• The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. This list will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable fee for each additional request.

• The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

• The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice and get a copy by e-mail. Even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Policies

By signing below, I certify:

- That I have read or had this form read and/or explained to me.
- That I fully understand its contents including the risks and benefits of telehealth.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature: _____

Print Name: _____

Date _____