

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“**HIPAA**”).

1. Tell your counselor if you don’t understand this authorization, and the counselor will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):
Salicia Mazero, 140 Prospect Ave, Suite S Kirkwood, MO 63122
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as “Psychotherapy Notes.” All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client’s medical records to maintain a higher standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual’s medical records. Excluded from the “Psychotherapy Notes” definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you, too.

MY RESPONSIBILITIES TO YOU AS YOUR THERAPIST

1. **CONFIDENTIALITY:** As a Licensed Professional Counselor in the State of Missouri, I am bound by the Missouri Administrative Code. In accordance with these rules, information obtained in the counseling session or in written form will **not** be disclosed to any outside person(s) or agency without your written permission except when such disclosure is necessary to “protect *you or someone else* from imminent harm” or is otherwise legally required and/or allowed by law, such as abuse or neglect of a child under 18, elder, or disabled person. This notification may include notifying the victim, notifying the police, or seeking appropriate hospitalization. I may also be required to provide information to the court if provided a court order. If a client files a worker’s compensation claim or disability claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought. If any of the above situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize release to other parties. If I run into you outside of the counseling office, I will protect your confidentiality and wait for you to acknowledge me should you choose to do so.
2. **CONSULTATION:** Information about you may be discussed in confidence, without revealing your identity, with other counseling professionals for the purpose of consultation and providing you the best possible service.
3. **RECORD-KEEPING:** I keep brief records of each session noting the dates we meet, the topics we cover, progress reports from the client’s perspective, interventions and impressions from the therapist and next steps.
4. **DIAGNOSIS:** If a third party such as an insurance company is paying for part of your bill, I am required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you.
5. **RISKS:** In counseling, major life decisions are sometimes made, including decisions involving separation within families, development of other types of relationships, changing employment settings and changing lifestyles. The decisions are a legitimate outcome of the counseling experience as a result of an individual’s calling into question many of their beliefs and values. Furthermore, symptoms may be intensified and the emotional experience may be too intense to deal with at this time. I will be available to discuss any of your assumptions or possible negative side effects in our work together. There is no guarantee of what you will experience in counseling.

6. **OTHER RIGHTS:** You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time, although I recommend finding a way to give me advance notice so that I can help you end treatment well and consolidate gains.
7. **EMERGENCIES:** If an emergency situation for which you feel immediate attention is necessary, please contact emergency services (911) immediately, the 24-hour National Hotline Network , 800-784-2433, or go to your nearest hospital emergency room. If I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can, within the limits of the law, to prevent you from injuring yourself others and to ensure that you receive the proper medical care. Missouri law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of injury to self or others. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if requested. Please do not use e-mail and faxes for emergencies.
8. **FEES:** Individual therapy is \$150 per 50 minute session. You will be asked to pay for each session at the time of the session. Payment can be paid by check, cash, or credit card. A statement of the month's sessions will be furnished to you on the first of each month for the previous month's sessions and payments. You can use the statement for tax purposes or for reimbursement.

NO SHOW or CANCELLATION POLICY: Your visit has been reserved for you. A 24-hours notice is required for cancellation or you will be charged \$92 for that session. You may cancel a session via email, phone call or text.

9. **DISABILITY, CUSTODY CLAIMS, AND SOCIAL SECURITY**
Salicia Mazero provides services solely to the individual issues of the client or clients. Clients receiving these services agree and understand that Salicia Mazero does NOT provide copies of client records or treatment summaries in support of Disability, Social Security, or Custody and/or Legal guardianship claims or disputes. Information regarding services provided is not for secondary use of release.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to the many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc...), *neither you (client's) nor your attorney's, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.* If you do become involved in litigation requiring your therapist's participation, you will be expected to pay for the professional time even if your therapist is compelled to testify by another party.

Interaction with the Legal System: I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after my counseling terminates. This would include any interaction with the Court system, attorneys,

Guardian ad Litem, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record, and I will be responsible for charges in producing that record (including but not limited to postage, travel time, copying charges, etc.) If I believe it necessary to subpoena my therapist to testify at a deposition or a hearing, I would be responsible for her expert witness fees in the amount of \$1,500.00 for four (4) hours to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over four (4) hours will be billed at the rate of \$375.00 per hour including travel time. I understand that if I subpoena my therapist, she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

10. SECURITY OF INFORMATION EXCHANGED VIA ELECTRONIC COMMUNICATIONS

I understand that Salicia Mazero cannot guarantee the privacy/security of information exchanged through electronic communications. (Please initial below).

I agree that information may be exchanged through email or private messagers.

I agree that information may be exchanged with the phone numbers provided via texting.

I agree with the phone numbers provided for confidential or shared information to be left on voicemail.

11. YOUR RESPONSIBILITIES AS A THERAPY CLIENT

You are responsible for coming to your session on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four (24) hours notice within business hours (Monday-Friday), you will be charged for that session.

CLIENT CONSENT TO PSYCHOTHERAPY

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I understand the fee per session and my rights and responsibilities as a client, and my therapist's responsibilities to me. I know I can end therapy at any time I wish.