

Patient Information

Date: _____

Name: _____ Social Security # _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Cell Phone: _____

Age: _____ Birth Date: _____ Race: _____ Marital: M S W D

Occupation: _____ Employer: _____

Spouse: _____

How many children? _____ Names and Ages of Children: _____

Name of Nearest Relative: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor (first and last name): _____

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

HISTORY OF PRESENT PROBLEM:

Purpose of this appointment: _____

Have you ever had the same or a similar condition? _____ Yes _____ No If yes, when and describe: _____

PAST HISTORY

Do you ever have: (Place a check mark by conditions that apply to you)

- | | |
|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Relationship Issues |
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Other. List: _____ |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Other. List: _____ |
| <input type="checkbox"/> Drug Addiction | |

Have you had any major illness, hospitalizations or surgeries?

Have you been treated for any health condition by a physician in the last year? _____ Yes _____ No

If yes, describe: _____

What medications or drugs are you taking? (List name and dosage)

Please list any other health problems you have, no matter how insignificant they may be: _____

Patient Name: _____

Date: _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use any tobacco products? _____ Do you smoke? _____ If so, packs per day: _____

Do you take vitamin supplements? _____ If so, please list: _____

Do you consume caffeine? _____ If so, how much per day: _____

Do you exercise? _____ If yes, what is the frequency and type of exercise? _____

Do you sleep well at night? _____ If no, why not? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: _____%

FAMILY HISTORY:

Parents:

Father: living ___ deceased ___ (check one) Current age if still living: _____ Cause of death and age at death if deceased: _____

Mother: living ___ deceased ___ (check one) Current age if still living: _____ Cause of death and age at death if deceased: _____

Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? _____ If so, please list: _____

AUTHORIZATION AND RELEASE: I understand that I am responsible for all costs of therapy and counseling care. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Kim Kares Counseling Informed Consent

CONFIDENTIALITY: Everything you say in these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required by law. _____ **Initial**

WHEN DISCLOSURE IS REQUIRED BY LAW: Disclosure is required or may be required by law when there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, or to property, or is gravely disabled; or when a family member communicates to me that the client presents a danger to others. Disclosure may also be required by the courts. I will not release records to any third party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client. _____ **Initial**

EMERGENCY: If there is an emergency during therapy or after therapy, and 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 or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet. _____ **Initial**

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or other third-party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier. _____ **Initial**

RECORDS AND YOUR RIGHT TO REVIEW THEM: The law requires that I keep treatment records for at least 6 years. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way. Upon your request, I will release information to any agency/person you specify unless I feel that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults involved in the treatment. _____ **Initial**

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call us at 214-325-4844. If we do not answer, we will return your call as soon as possible. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call 911 or go to your nearest emergency room. _____ **Initial**

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for, but it takes effort on your part. I want you to be open and honest. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. I am likely to draw on various psychological approaches. These approaches may include, behavioral, cognitive-behavioral, cognitive, psychodynamic, EMDR, solution focused, system/family, developmental (adult, child, family), humanistic or psycho-educational. I do not prescribe drugs. _____ **Initial**

TREATMENT PLANS: On approximately your second visit, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy or about the treatment plan, please ask and I will explain it to you. You also have the right to ask about other treatments for your condition and their risks and benefits. _____ **Initial**

TERMINATION: After the first meeting, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In that a case, I will give you a number of referrals whom you can contact. If at any point during therapy you are non-compliant, I will terminate treatment. In such a case, I will give you a number of referrals that may be of help to you. Upon your request, I will provide her or him with the essential information needed. You have the right to terminate therapy at any time. _____ **Initial**

DUAL RELATIONSHIPS: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves any dual relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. It is important to realize that in some areas multiple relationships are unavoidable. I will never publicly acknowledge working with you without written permission. I will not accept you as a patient if I feel a significant dual or multiple relationship exists. It is your responsibility to advise me if any dual or multiple relationship becomes uncomfortable for you in any way. I will always listen carefully and respond to your feedback and will discontinue the dual relationship if you find it is or may interfere with the effectiveness of the therapy or your welfare. You may do the same at any time. _____ **Initial**

COURT TESTIMONY: The goal of psychotherapy is the reduction of stress and interpersonal conflict. Additionally, by starting treatment, you are agreeing not to involve me in legal proceeding or attempt to obtain treatment records for legal or court proceedings. In the event that I'm required to provide treatment records or testimony in any legal proceeding, you will be charged \$150 per hour for any preparation time I or other personnel spend getting ready to appear or turn over documents. You are agreeing to pay \$750 per 4-hour block of time that I spend being "on call" to testify, traveling to and from court/deposition, waiting to appear, and/or testifying. The minimum charge will be for 4 hours of time and subsequent time will be billed in 4-hour blocks. The initial \$750 is due in full one week prior to any scheduled court appearance/depositions. _____ **Initial**

SOCIAL NETWORKING AND INTERNET SEARCHES: I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites. _____ **Initial**

I have read the above policies. I understand them and agree to comply with them:

Client's Signature _____ **Date** _____

Therapist's Signature _____ **Date** _____

Kim Kares Counseling

FINANCIAL POLICY AND MISSED APPOINTMENT POLICY

Welcome to **Kim Kares Counseling Office**. Please read over our Financial and Missed Appointment Policy.

FINANCIAL POLICY

Fees. Counseling sessions are 45 minutes long, however, the 1st session is 90 minutes and the fee is **\$145**. The fee for a 45-minute session, either face-to-face, by skype, or by phone, is **\$125**. A first-time patient is charged **50% of Session Fee** by credit card to hold their appointment time. This fee is non-refundable but it is deducted from your first visit. Payment is collected at the first of the session. We also ask you to place a credit card on file for future billing.

Charges. Occasionally there are extra charges or other altered charges, but in your case the fee for a 45-minute session will be \$125.

Self-Pay Patients. Patients without insurance, with high deductibles, or who choose not to use their insurance are responsible for the cost of care. Payment is expected at the time of service.

Methods of Payment. **Kim Kares Counseling** accepts cash, checks, and major credit cards.

Payment in Advance. If your therapist suggests more than 10 visits, you may pay for them in advance and receive a discount of 15%. Payment for multiple visits must be made by the third visit.

MISSED APPOINTMENT POLICY

Twenty-four hour notice is required for the cancellation of an appointment. Appointments canceled with less than 24 hours notice will be charged your full fee of \$125. Appointments missed because of inclement weather will not be charged. The charge will be applied to your credit card on file.

I have read and agree to the above conditions.

Name _____ Date _____

Kim Kares Counseling
Kimberlee Tucker, LPC
15150 Preston Rd, Suite 300, Dallas, TX 75248

**ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgment.
- We weren't able to communicate with the patient.
- Other (please provide specific details) _____

Therapist Signature

Date

Kim Kares Counseling
MANDATORY REPORTING REQUIREMENTS

Patient records are protected by law under federal law. At Kim Kares Counseling we keep our patient records in a locked record storage area. Your records will not be shared without your permission.

However, **therapists are required by law to report to authorities certain activities** that their patients report to them. Those activities include:

1. Any statements, suggestions or innuendoes that **the patient plans to hurt himself or herself.**
2. Any statements, suggestions or innuendoes that **the patient plans to hurt someone else.**
3. Any statements, suggestions or innuendoes that **the patient is being harmed.**
4. Suspected **child abuse or neglect.**
5. Suspected **abuse of the elderly** or other incapacitated adults.
6. The **threat of suicide or homicide.**

**You should be aware any statements you make
regarding any of the above situations
will need to be reported to authorities.**

**These reports could lead to
an investigation of your situation by authorities
and appropriate actions may be taken.**

In addition to these harmful situations, Kim Kares Counseling may also be **required to release your information** if:

1. It is needed by medical personnel in a **medical emergency.**
2. **Crimes** are committed on the Kim Kares Counseling office premises or against Kim Kares Counseling.

I have read and understand the above information.

Patient's Name: _____ Date: _____

Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Kim Kares Counseling, 15150 Preston Rd, Suite 300, Dallas, TX 75248

Kimberlee Tucker, LPC 214-325-4844

Effective Date: September 23, 2013

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. ANY REFERENCES IN THIS DOCUMENT TO MEDICAL PRACTICE, MEDICAL RECORDS, MEDICAL SERVICES, ETC. APPLY ALSO TO PSYCHOTHERAPY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

- 1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts
4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic

violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
17. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]
20. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
21. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
22. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start

receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint by using the form from the website below:

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Kim Kares Counseling Self-Pay Agreement

Most patients/clients who have high deductibles or high co-pays prefer to pay for their care personally instead of filing insurance.

Many other patients/clients also prefer to pay for their care personally so their information remains confidential (not released to insurance companies) and to avoid being labeled as having a mental illness.

For our office to be able to file insurance, I must give you a mental illness diagnosis. This diagnosis will be on your health records for the rest of your life. It can affect employment opportunities and the ability to qualify for life and disability insurance.

We suggest that, if your reimbursement from insurance is low or if your deductible and co-pay are high that you avoid filing insurance if you are concerned about these issues.

I, _____, am signing this agreement to indicate that I am seeking treatment with provider Kimberlee Tucker, LPC.

Treatment will begin on _____.

The cost of treatment will be \$145 for the initial session and \$125 for each additional session.

I am choosing not to use my insurance benefits for this service.

I agree that the provider will collect the full fee-for-service rate. Plan provider discounts and the plan maximum that applies to medically necessary covered services will not apply and will not limit the amount I may become obligated to pay for the proposed services.

I further agree that I will pay for all treatment at the time service is rendered.

Client Name

Date

CREDIT CARD GUARANTEE

[] SELF-PAY PATIENTS

You are responsible for full payment at the time of services. As a convenience to you, we will automatically charge your designated card below on the day of services.

We charge a **missed appointment fee** of **\$125** in the event that you miss an appointment without giving **24-hours' notice**.

I agree to the above terms and authorize you to charge my card.

SIGNATURE

DATE

CREDIT CARD: AMEX VISA MC DISCOVER

CARDHOLDER'S NAME _____

BILLING ADDRESS _____

CARD # _____ EXP. DATE _____

THREE DIGIT CID NUMBER _____