SUBURBAN CROSSROADS COUNSELING

For office use

Counselor _____

Notice of Privacy Practices

This Notice describes how personal health information may be used and disclosed, and how you may access your health information. Please review this Notice carefully, and feel free to ask questions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually-identifiable health information used or disclosed in any form — whether electronically, on paper, or orally — is kept confidential. You have the right to understand and control how your health information is used. HIPAA includes penalties for covered entities that misuse personal health information. We have prepared this summary of how we maintain the privacy of your health information and how we may use and disclose this information.

We may use and disclose your medical records for each of the following purposes:

1. Treatment: providing, coordinating, or managing health care and related services by one or more health care providers. For example, documenting a counseling session.
2. Payment: obtaining reimbursement of services, confirming coverage, billing or collecting payment, and utilization review. For example, sending a bill for your session to your insurance company for payment.
3. Health Care Operations: the business aspects of our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. For example, contacting you regarding appointments, about treatment, or concerning payment issues.

The State of Maryland mandates all counselors to report suspected abuse or neglect of a child or vulnerable adult. Also, if a client intends to inflict imminent physical injury upon a specified person or group (including the client him or herself), our counselors have a duty to protect people in harm's way.

Any other uses of your health information will be made only with your written authorization. You may revoke such authorization in writing. We are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

If you would like access to your health information, you may submit a request in writing to your therapist who will provide you with any records you require.

A copy of this Notice is available in each of our offices and online: www.baltimorecounselingservices.org.

If you would like to waive receipt of a printed copy of the privacy practices please initial here: _____

If you would like a printed copy of the privacy practices please initial here: _____

Acknowledgement and Consent By your signature, you acknowledge you have read this Notice, and you consent to the practices outlined regarding the privacy and confidentiality of your health information.

Signature of Client/Guardian _____ Date: _____

SUBURBAN CROSSROADS COUNSELING

BaltimoreCounselingServices.org
Tel. 410-719- 0086
Fax. 443 - 251- 2664
NPI 1588654701

Client Agreement Form

1. I understand it is important for me to be at my appointment on time. My appointment lasts 45 minutes; and therapists are unable to go to over time when I am late **INITIAL HERE** _____

2. I understand that if I do not cancel an appointment with more than 24 hours notice, except in the case of an emergency or weather-related event, I will be charged $60 for the missed appointment. **INITIAL HERE** _____

3. While the staff of Suburban Crossroads Counseling (SCC) will do their best to obtain eligibility and benefits information, I understand that as the client, it is ultimately my responsibility to obtain the following information:

    - Do I have a deductible, has it already met, how much is left, or does it not apply? **INITIAL HERE** _____
    - Do I have a copay or coinsurance? If so, how much is my copay? **INITIAL HERE** _____
    - Do I require pre-certifications or pre-authorizations? If so, this information must be given to the therapist before my first session. **INITIAL HERE** _____
        - If pre-certification or pre-authorization was required but not obtained due to my lack of due diligence, I understand that I will pay the full amount for any sessions not covered by insurance. **INITIAL HERE** _____

4. After SCC receives the EOB from my insurance, and a balance is applied to my account, I understand it is my responsibility to pay such a balance. **INITIAL HERE** _____

5. I understand that for any extra paperwork the therapist or SCC staff is requested to do on my behalf, there is a fee of $25 an hour. **INITIAL HERE** _____

6. I understand that if my therapist is not available and I am in a crisis, I can call 911 or call the office to make an appointment with another therapist, keeping in mind SCC's office phones are available and voicemails are checked Monday to Friday; 9 AM to 5 PM. **INITIAL HERE** _____

Name of Client _____ Date_____