PlayWorks Counseling
5414 Basswood Blvd #720
Fort Worth, Texas 76134
Tel 817-999-6410
katherine@katherineleath.com
www.playworkscounseling.com

Advisement Form 2017

This advisement form is an additional page of policy updates and reminders of Katherine Leath, LLC, dba PlayWorks Counseling.

1. There is no recording of any kind permitted in the offices of PlayWorks Counseling.

2. Clinical information is not shared over email, unless deemed absolutely necessary by Katherine Leath.

3. Phone calls and emails are billed at the counseling rate that applies to you/your child, in 15-minute increments.

4. In cases of active litigation or post-divorce, anything released from my office in writing, goes to both parties/attorneys.

5. My attorney will be in attendance for any depositions and possibly court hearings, if they are contentious enough that I believe it to be necessary. You are responsible for any and all legal fees incurred as related to your case.

6. There are always serious concerns about releasing clinical notes, which are written by and for the clinician, to parents of minors. I believe it is potentially damaging to the child, the therapeutic relationship, and can often have farther-reaching consequences to the client. I prefer to release a clinical summary, if that is agreeable. That being said, I will of course follow the obligations outlined in the Texas Health and Safety Code regarding the release of records.

7. There is a 24-hour cancellation fee. If you do not cancel by that time, you will be billed for the full amount of the session. I will review specific situations when it is in regards to illness or unpredictable challenges.

8. Please do not come or bring sick children to therapy if they have had a fever or vomiting within the last 24 hours. Please also use best judgment on other illnesses, as well, and notify me as soon as possible, so the session can be offered to those on the waiting list.

9. Payment for sessions are due at the time of service. I accept cash, checks, and credit cards.

10. Any and all information provided to me is part of the clinical file. If I counsel with your child/adolescent, HIPAA does not apply to parents–only the identified patient.

**I, _____ agree to abide by the items listed above in the PlayWorks Counseling Advisement Form.

_____ _____
Printed Client Name Signature of Client

_____ _____
If client is minor, signature of Parent/Guardian Date

Consent for the Release of Confidential Information

Katherine Leath, M.Ed, LPC
200 S. Main St Suit 1
Keller, TX 76248
817-999-6410

I, _____, authorize Katherine Leath, M.Ed, LPC to release and receive information about specific aspects (specified below) of my counseling, beginning on _____/_____/_____ (date) and ending one year after the date of my signature. I understand that, if I so desire, I can terminate this consent at any time, and the termination date will be noted below.

The person to whom the information is to be released is: _____.
Address: _____
Phone: _____
The relationship of this person to me is: _____

The purpose of this release is (check all that apply):
_____ coordination of services/referral _____ legal conditions
_____ family support/involvement _____ consultation
_____ other: _____

The information to be released is (check all that apply):
_____ assessment _____ attendance
_____ progress notes _____ other: _____

In the following manner (check all that apply):
_____ written or verbal dissemination
_____ to request information

I understand that this release gives my counselor permission to provide privileged information, usually kept confidential, to the person above. This form releases my counselor from liability for the release of the above information.

I understand that if I am signing as the parent of a minor or as a guardian, the records release may contain references to myself and my family.

Your relationship to client:

_____Self _____Parent/Guardian _____Other (explain) _____

To the party receiving the information:
This information has been disclosed to you from records whose confidentiality is protected under Federal Law. Federal Regulations (HIPAA, 42 CFR Part 2) prohibit you from making any further disclosure without the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose.

Parent/Guardian Signature (if needed): _____

Client Signature: _____ Date: _____

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Waiver

The following business practices, though not all-inclusive, may constitute a potential risk to your confidentiality, in spite of the security measures that I have in place to protect your privacy. By signing below you understand and acknowledge the possible risk and your consent for such practices to be utilized.

- Use of an electronic calendar
- Use of a paper calendar
- Use of a cell phone for communication with you and other professionals
- Use of a laptop computer
- Use of unencrypted email
- Use of computerized billing
- Use of shared office space with the independent practices of other mental health professionals with potential access to, among other things, common storage and filespace, mailboxes, voicemail, messages, fax machine and faxes.

_____ _____
Printed Client Name Signature of Client

_____ _____
If client is minor, signature of Parent/Guardian Date

HIPPA Notice of Privacy Practices

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of yourelectronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
    - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
    - is not part of your medical or billing records;
    - is not available for inspection as set forth above; or
    - is accurate and complete.

    In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
    - to carry out treatment, payment and health care operations as provided above;
    - to persons involved in your care or for other notification purposes as provided by law;
    - to correctional institutions or law enforcement officials as provided by law;
    - for national security or intelligence purposes;
    - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
    - incidental to other permissible uses or disclosures;
    - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
    - made to patient or their personal representatives;
    - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorizationwith the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) most uses and disclosures of psychotherapy notes (ii) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of your health information; and (iv) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact the Privacy Officer, Katherine Leath, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Katherine Leath, LLC dba PlayWorks Counseling or with the Secretary of the Department of Health and Human Services or Texas Attorney General's office. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services Office of the Secretary 200 Independence Ave, S.W. Washington, D.C. 20201 Tel: (202)619-0257 Toll Free: 877-696-6775 http://www.hhs.gov/contacts	**Office of the Texas Attorney General Consumer Protection Division** PO Box 12548 Austin, TX 78711-2548 Tel: (521) 463-2100 Toll Free: 800-252-8011 https://www.oag.state.tx.us/forms/cpd/form.php	Katherine Leath, LLC dba PlayWorks Counseling Privacy Officer 5421 Basswood Blvd Suite 720 Fort Worth, Texas 76137 817-999-6410

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's web site for downloading.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for this office:

_____ _____

Client Signature/or guardian is client is a minor Date

Consent For Use and Disclosure of Health Informations: I hereby permit and release Katherine Leath, M.Ed, LPC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____ _____

Client Signature/or guardian is client is a minor Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.