

## **Informed Consent and Privacy Practices**

This document contains important information about my professional services and business practices. It notifies you of your rights and responsibilities and will represent an agreement between us.

### **Risks and Benefits of Psychotherapy**

Psychotherapy has benefits and risks. In working on your life, you may experience a range of emotions and discomfort processing these emotions. Your relationships with others may change. Therapy may lead to better relationships, solutions to specific problems and a significant reduction in feelings of distress. What you experience will be unique to you and the specific results of therapy cannot be guaranteed.

### **Initial Evaluation**

My initial evaluation generally takes 2-3 sessions. During this time, we can both decide if I am the best person to meet your treatment needs. By the end of this period and sometimes sooner, I will offer you my first impressions of what our work will include and a suggested course for treatment. If you have any questions about my procedures, you can discuss them with me as they arise.

### **Session Meetings**

I conduct 30 and 60 minute sessions, depending on what we agree serves your needs. Your fee for shorter sessions will be half of our agreed upon fee. Once psychotherapy has begun, we will meet once per week at a time that we agree upon. As the process progresses, we may decide to meet on a less frequent basis.

### **Confidentiality**

In general, the law protects the privacy of all communications between a patient and psychologist and I can only release information about our work to others with your written permission. However, I can release information about our work to others without your permission in these circumstances:

1. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. However, in some proceedings, a judge may order my testimony if he/she determines that the issues demand it. If you are ever involved in a court proceeding, please consult with a lawyer about the legal implications of the proceeding and with me regarding its clinical implications.

2. If I believe that a minor, elderly person or dependent adult is being abused, I am legally obligated to take action to protect them from harm and must file a report with the appropriate state agency.
3. If a patient threatens to harm him/herself or if I deem a patient gravely disabled, I am required to take protective actions that may include hospitalization for the patient and/or contacting authorities, family members, or others who can help provide protection.
4. If I believe that a patient poses a serious danger of violence to others, I am required by law to take protective actions that may include notifying the potential victim(s), contacting the police, or seeking hospitalization for the patient.

If any of the above situations occur, I will attempt to discuss the situation with you before taking action if possible.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I do not use the identifying information of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have.

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### **Fees**

You are expected to pay our agreed-upon fee by cash, check or credit card at the time of each session unless we have made other arrangements. I charge a \$50 fee for any payment returned because of insufficient funds. I reserve the right to raise my fee and I will discuss this with you at least a month before that change is due to go into effect.

### **Use of Insurance**

I do not accept any insurance plans. However, if you have a PPO plan, most will reimburse some amount for our sessions. I can provide you with a monthly invoice, which you can submit to your insurer for reimbursement. You can contact your insurer for questions related to *out of network* benefits.

During the course of treatment, if I have to speak with anyone on your behalf (consultations with other professionals involved in your care) there will be an additional fee for my services that we will discuss.

Most insurance companies require the release of clinical information, including, but not limited to, dates of service, diagnoses, treatment plans, and outcome. Signing this document gives me permission to release to your insurance company the information needed to obtain payment for my services.

### **Cancellation Policy**

If you fail to come to an appointment or do not provide me with **24 hours notice** for cancellation, you will be expected to pay your regular fee for the session. This policy is in effect unless I determine that you were not able to make your appointment or give sufficient notice due to circumstances beyond your control. Additionally, if we can reschedule the missed session within the same week, you will not be charged for the missed session.

Please sign that you have read and agreed to this billing and cancellation policy:

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### **Professional Records**

The laws and standards of my profession require that I keep treatment records. You are entitled to view your records unless I believe that seeing them would be emotionally damaging, in which case I can provide a summary of the records instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them or the summary I provide with me or with the mental health professional of your choice.

### **Contacting Me**

I am not always immediately available by telephone. I do return calls within 24 hours, though, with the exception of weekends and holidays. Messages left on Friday afternoon will most often be returned the following business day.

If you are unable to reach me and feel that you cannot wait for me to return your call, contact your primary care physician or the nearest emergency room and ask for the psychologist on call. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

Do not use e-mail or texting to communicate any private or urgent clinical information to me. This is

not a secure form of communication and I cannot guarantee that what you disclose will not be intercepted by a third party.

## **HIPAA Privacy Practices**

The following describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### **I have a legal duty to safeguard your protected health information (PHI)**

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice. However, I reserve the right to change the terms of my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this document and inform you of the changes. You can also request a copy of this document from me or obtain it from my website .

### **How I may use and disclose your PHI**

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

- A. Uses and disclosures relating to treatment, payment, or health care operations do not require your prior written consent. I can use and disclose your PHI without your consent for the following reasons:
  1. For treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, or any other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
  2. To obtain payment for treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might

send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For health care operations. I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
4. Other disclosures. I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Other uses and disclosures do not require your consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement. For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. For public health activities. For example, I may have to report information about you to the county coroner.
3. For health oversight activities. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a healthcare provider or organization.
4. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
5. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. For specific government functions. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. For workers' compensation purposes. I may provide PHI in order to comply with

- workers' compensation laws.
8. Appointment reminders and health related benefits or services. I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.
- C. Certain uses and disclosures require you to have the opportunity to object.
1. Disclosures to family, friends, or others. 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.
- D. Other uses and disclosures require your prior written authorization. In any other situation not described in sections A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

## **What rights you have regarding your PHI**

You have the following rights with respect to your PHI:

- A. The right to request limits on uses and disclosures of your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.
  
- B. The right to choose how I send PHI to you. You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as I can easily provide the PHI to you in the format you requested.
  
- C. The right to see and get copies of your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than \$.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
  
- D. The right to get a list of the disclosures I have made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable fee for each additional request.

- E. 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, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.
  
- F. The right to get this notice by e-mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

#### **How to complain about my privacy practices**

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

#### **Who to contact for information about this notice or to complain about my privacy practices**

If you have any questions about this notice or any complaints about my privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

Amalea K. Seelig, PSYD  
26 Court Street, Suite 1510  
Brooklyn, NY 11242

#### **Effective date of privacy practices**

These privacy practices went into effect on December 15, 2014.



## Signature page for Informed Consent and Privacy Practices

Your signature below indicates that you have read the Informed Consent and Privacy Practices, have had an opportunity to discuss the document, and agree to abide by its terms during our professional relationship. Please note that you may request a copy of this document from me or obtain it from my website.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_