S.T.E.P. into Wellness
Striving Towards Endless Possibilities

INSURANCE INFORMATION

Will you be using insurance to pay for your therapy sessions?

_____ YES, I will be using insurance for therapy sessions.

_____ NO, I will be paying the Self-Pay Rate(s).

PLEASE CALL YOUR INSURANCE COMPANY AND COMPLETE THIS FORM PRIOR TO YOUR APPOINTMENT.

Make sure you specify that you need your Outpatient benefits.

Client Name: ____

Date of Birth: ____

Policyholder Name: ____

Policyholder Date of Birth: ____

Policyholder Address and Phone Number: ____

____

Insurance Carrier (If you have more than 1 insurance please indicate which is primary and secondary):

____

Insurance Plan:_________________________ **ID #:** _______________________________________

Insurance Contact #: ______________________________________

Co-Pay Amount: $_______________________________________

Do you have an annual deductible? Yes ____ **No** ____

If yes, what is the amount? $____________ **If yes, have you met your deductible? Yes** ____ **No** ____

If no, how much is remaining? $ _______________

Please initial one of the statements below.

_____ I have another insurance carrier in addition to the one listed above.

This insurance carrier, plan, and ID# are: ____

_____ I do not have any other form on insurance/Medicaid other than the one listed above.

I will notify S.T.E.P. into Wellness, LLC if there are any changes to my insurance. I understand that if an insurance claim is denied at any time then I will be responsible to pay for the services rendered.

____

Signature of client (or guardian, if applicable) Date Relationship to client (if necessary)

FINANCIAL POLICY AGREEMENT

I understand S.T.E.P. into Wellness, LLC is a fee-for-service entity. Meaning, there will be a fee for any service rendered by S.T.E.P. into Wellness, LLC or time spent by S.T.E.P. into Wellness, LLC for client related matters. All policies listed in this agreement apply to clients using insurance as well as those utilizing Self-Pay rates.

Self-Pay Rates

Clinical Intake / First Session $180/hour
Follow Up Psychotherapy Sessions $120/45min session or $160.00/60 min session
Group Psychotherapy $75/45 min session

Other Professional Services (Optional)

Health insurance companies will help pay for psychotherapy session fees however, they often do not pay for optional ancillary services outside of those sessions. I understand that insurance companies do not pay for ancillary services (additional work you request your psychotherapist to complete) and that these ancillary services are completely optional. I agree that my card will be charged the applicable fee for any service I request over and above approved psychotherapy sessions. S.T.E.P. into Wellness, LLC charges the same hourly rate of $160.00 for other professional services you may need, though we will break down the cost in increments of 15 minutes. Other services include: letter writing, consultations with other professionals (with your permission), extended phone calls (over 10 minutes), or any other similar ancillary service. Photocopying records will be $35 per record.

I also understand that legal matters, subpoenas, court appearances, or anything court related do not apply to the above rate and are covered under different rates as listed in the *Legal Policy*.

Cancelations / Missed Appointment Fees

Clients who incur illness or emergencies, which are confirmed by a document from a physician, will not be charged a fee. If you cancel for any other reason with less than a 24 hour notice there will be a $80 fee charged to your card on file. However, if you are able to reschedule your appointment with your therapist during the week of the missed appointment, you will not be charged the cancellation fee. Note that some therapists may have a full schedule with limited or no availability to reschedule.

Additional Policies

Payment is due upon check-in and your card on file will be charged. Credit Card Authorization forms are used once services begin. I will notify S.T.E.P. into Wellness, LLC if my Card on file expires, is lost or stolen, or if I choose to terminate use of this card for payment purposes.
Cash Payments: You are welcome to pay in cash; however, please request a receipt.
S.T.E.P. into Wellness, LLC reserves the right to discontinue services for repeated failure to provide payment for services rendered.

Acknowledgement

I have read and agree to all of the above policies and fee structure. If I am using my insurance, I authorize S.T.E.P. into Wellness LLC to bill my insurance for services rendered.

____

Signature of client (or guardian, if applicable) Date Relationship to client (if necessary)

NOTICE OF LEGAL POLICY FOR TREATMENT (page 1)

Forensic and Litigation Services

Please understand that you are entering into a psychotherapy relationship with S.T.E.P. into Wellness LLC, **NOT** a legal relationship. Our therapists do not participate in lawsuits of any type on a plaintiff's behalf, unless compelled to do so by subpoena or court order. The legal process is typically counterproductive to the psychotherapy process because the psychotherapist cannot maintain confidentiality or a psychotherapy focus once he/she is required to act as a witness. It is difficult to provide a "safe and protected" psychotherapy "space" to address the issues that brought you to treatment if we are required to disclose what is addressed in the sessions to legal system personnel. It is our firm request however, that we NOT be called upon to participate in any legal issues involving you or your family. Please understand that if you or anyone connected to you chooses to disregard our policy, your fees will immediately change to a legal fee structure for any and all contact with legal professionals and you will be expected to pay for these services. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for all of your therapist's professional time, including preparation, deposition, telephone time, transportation costs, court appearance, report writing, consultation and supervision, even if your therapist is called to testify by another party.

Therefore, I (We) ____ agree that neither I (We) nor my (our) attorneys nor anyone else acting on my (our) behalf or in connection to my (our) legal matters will call on or subpoena any psychotherapist employed at or contracted by S.T.E.P. into Wellness, LLC to become a Fact or Expert Witness to testify in court, communicate with child custody evaluators, request a disclosure of psychotherapy records, or any other proceeding. If S.T.E.P. into Wellness, LLC is compelled to become involved in the legal system on my account I further agree that the fees listed below and all other fees associated with servicing my legal matters are NOT paid by insurance companies and that I myself or an organization providing me funding will pay the following fees to S.T.E.P. into Wellness, LLC:

Court Appearance (Paid regardless of Fact or Expert Witness) Includes travel time from place of business **Requires a subpoena**	$1,000 4 hours or less (not prorated) Non-refundable and paid two weeks in advance of the court-date (except in cases when the Commonwealth of Virginia will pay the court costs)
Court Appearance (Paid regardless of Fact or Expert Witness) Includes travel time from place of business **Requires a subpoena**	$2,500 More than 4 hours to a maximum of 8 hours (not prorated) Non-refundable and paid two weeks in advance of the court date (Except in cases when the Commonwealth of Virginia will pay the court costs)
Disposition Includes travel time to and from, wait time, and time it takes for the disposition **Requires a subpoena**	$300 per hour Non-refundable and paid two weeks in advance of the disposition date
Coordination, preparation, consultation (includes reviewing medical records prior to complying with a Subpoena Duces Tecum	$200 per hour Paid in 15-minute increments and a valid credit card must be on file in order to process the fees for payment
Copying Fees for Subpoenaed Records	$0.50 per page

NOTICE OF LEGAL POLICY FOR TREATMENT (page 2)

In addition, I acknowledge that I (we) may be discharged from treatment due to the difficulty of providing effective mental health services when involved in the legal process. I (We) further agree to provide a copy of this document to my legal counsel and/or Guardian Ad Litem (if applicable) immediately when it becomes known that I will be involved in court/legal involvement. I have read this agreement in full and agree to these terms prescribed herein as evidenced by my name and signature below:

____

Printed name of client (or guardian, if applicable)   Date   Relationship to client (if necessary)

____

Signature of client (or guardian, if applicable)   Date   Relationship to client (if necessary)

CREDIT CARD AUTHORIZATION FORM (page 1)

Name on Credit Card:____
Billing Address (please include zip code):

____

____

Primary Phone Number: ________________________________
Credit Card Type (please circle one): Visa Mastercard Discover

Credit/Debit Card Number: ____

Expiration Date: ________________ CV Number on the back of the card: ______________________

By signing this agreement, you are confirming that you understand that it is your responsibility for full payment of our fees. Further you understand that we may submit your claims to your insurance company(ies), if applicable, for direct payment to S.T.E.P. into Wellness and that if your insurance company does not cover 100% of your bills for services provided that it is your responsibility for full payment of our fees, not your insurance company's. Further, you confirm that you understand that it is your responsibility to:

- pay, at the time services are rendered, the agreed upon session fee, co-pay, co-insurance, deductible, or any other fees relating to services rendered that are denied or not fully covered by your insurance company(ies);
- provide current mailing address and phone numbers, as well as notification when there are any changes to this information.
- confirm with your insurance company that the therapist is a participating provider under your specific insurance plan;
- provide appropriate and current insurance information and updates to ensure efficient billing and payment;
- obtain all necessary referrals or authorizations required prior to treatment

ASSIGNMENT OF BENEFITS. By signing this agreement, you authorize payment of all medical insurance benefits, which are payable under the terms of your insurance policy to be paid directly to S.T.E.P. into Wellness, LLC for services rendered. You further authorize the release of any information needed for the purposes of treatment, payment and health care operations, including, but not limited to the processing of these insurance claims. A copy of this authorization may be used in place of the original. **You understand that you are financially responsible for charges not paid by your insurance company.**

DELINQUENT ACCOUNTS AND COLLECTIONS. You are responsible for payment of your therapy fees, regardless of whether or not they are covered by your insurance carrier. **Outstanding balances of more than 60 days will be charged to the credit card on file unless other payment arrangements have been made with the owners of S.T.E.P. into Wellness, LLC.** If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency, and this could affect your credit rating. You agree to the costs of any action necessary to collect your portion of the fee due, including court and attorney fees that might accrue. You will receive appropriate notice of efforts to obtain this debt owed to S.T.E.P. into Wellness, LLC.

CREDIT CARD AUTHORIZATION FORM (page 2)

I, ______________________________________, authorize S.T.E.P. into Wellness, LLC, to charge my credit card for services provided. I understand that a 24-hour notice is required if I am not able to keep my appointment. I understand that I am responsible to pay for cancellations with less than a 24-hour notice as well as missed appointments and outstanding balances.

Upon request, I will receive a copy of the receipt of the fees being charged. I understand that S.T.E.P. into Wellness, LLC, will keep my credit card information on file, but that the utmost caution will be taken in insuring the confidentiality of this information. I understand that I have financial responsibility for this account. I further understand that I must pay at the time that services are received. This agreement will remain in effect and my card will be charged until services are completed or this authorization is revoked in writing.

Clients Authorized to Receive Services Paid for by this Credit Card:

____

____

____

____

____ ______________________

Signature of Responsible Party Authorization Date

INFORMED CONSENT FOR TREATMENT (page 1)

Practice Policies and Procedures
This document contains important information about our professional counseling services and business policies. Please read it carefully and write down any questions you might have so we can discuss them. When you sign this document, it will represent an agreement between us.

Psychotherapy
THE INITIAL CONSULTATION. The initial consultation (intake session) will last approximately 60 minutes. Typically, during the first session, your reasons for seeking treatment and basic background information about you will be discussed. Policies, fees, and scheduling will also be discussed during the intake session. Therapy involves a noteworthy commitment of time and energy. You should be very thoughtful about the therapist you select to determine whether you feel comfortable working with your therapist. If you have questions or doubts about participating in therapy, please talk with your therapist about your concerns. We are more than happy to provide you with referrals for other mental health professionals if you feel your therapist is not a good fit.

COUNSELING SESSIONS. Frequency of counseling sessions will be determined by the severity of your presenting symptoms, your treatment goals, and agreed upon treatment plan. Counseling sessions are generally scheduled once a week and may be reduced in frequency as your progress in treatment. A given hour is considered blocked for a particular client; this hour is comprised of 55 minutes of psychotherapy and 5 minutes of administrative procedures (i.e., collecting co-copay, note-taking, insurance claim submissions). If you are interested in 45-minute sessions, you may discuss this option with your therapist.

24-HOUR CANCELLATION POLICY: Once an appointment is scheduled, you will be expected to attend. Illness and emergencies within reason will not be charged a fee. If you need to cancel for other reasons, please provide at least a 24-hour notice. If you do not cancel before 24 hours you will be charged a cancellation fee. **Note that the cancellation fee/missed appointment fee is $80. Insurance companies will not reimburse for canceled or missed appointments.** If you are able to reschedule your appointment with your therapist for another time the week of the missed appointment, a fee will not be charged.

LATENESS: If you arrive late for a scheduled appointment, only the remainder of the 55-minute session will be available. If your therapist runs late with a prior appointment for some reason, you will still receive the full 55 minutes. It is the office policy, that if you arrive 20 minutes late to your scheduled appointment, without notice, it will be considered a no-show and you will be responsible for the missed appointment fee.

INCLEMENT WEATHER AND CLOSURES: We recognize the possible dangers of inclement weather and therefore the 24-hour cancellation policy is not applied to cancellations due to inclement weather. We ask that clients contact their therapist as early in the day as possible as our office hours are determined by confirmed client appointments. Please contact your therapist directly to confirm or cancel an appointment. Therapists will also contact clients if they are unable to attend the appointment due to inclement weather conditions. Please provide your clinician with your preferred means of communication in those cases in which a clinician needs to cancel or reschedule your appointment. Therapists and clients are encouraged to make the decision based on their location and comfort level. Therapists may decide to open their offices even when schools are closed. If that is the case, your clinician will let you know as early in the day as possible, so you can make an informed decision about keeping or cancelling your appointment.

INFORMED CONSENT FOR TREATMENT (page 2)

EMERGENCIES: In the event of a psychiatric emergency, and you are unable to reach your therapist, please call a local Mental Health Hotline or CALL 911 or go to the nearest Emergency Room of your nearest hospital and ask to be evaluated by the psychologist or psychiatrist on call. Mental Health Hotline numbers include 703-792-7800 (Manassas) and 703-792-4900 (Woodbridge). For less urgent matters or for scheduling issues, please email your therapist or leave a message on your therapist's voicemail. Email is not a secure, confidential form of communication and should not be used for discussion of clinical issues or for urgent communications. Your therapist is often not immediately available by phone but will make every effort to return your call within 24-48 hours, with the exception of weekends and holidays. If your therapist will be unavailable for an extended time, such as for a scheduled vacation, they will provide you with the name of a colleague to contact if necessary.

Professional Records

The laws and standards of the counseling profession require that we keep treatment records. You are entitled to receive a copy of your records unless your therapist believes that you seeing them would be emotionally damaging, in which case your therapist can send them to a mental health professional of your choice or prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, we recommend you review them in your therapist's presence so that they can discuss the contents. Clients will be charged a fee for any professional time spent in responding to information requests.

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request that your therapist will provide parent(s)/legal guardian(s) only with general information about your work together, unless your therapist feels there is a high risk that you will seriously harm yourself or someone else. In this case, your therapist will notify your parent(s)/legal guardian(s) of the concerns. Before giving them any information, your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have about it.

Confidentiality

In general, the law protects the privacy of all communications between a client and a therapist. Your therapist can release information about your work to others only with your written permission (Release of Information form). All aspects of your treatment are confidential, and your therapist will need your written permission if you would like them to discuss your treatment with anyone else. However, there are some situations in which your therapist is legally obligated to take action to protect others from harm, even if the therapist has to reveal some information about a client's treatment. For example, if your therapist believes that a child, elderly, or disabled person is being abused, your therapist is required to file a report with the appropriate state agency. If your therapist believes that a client is threatening serious bodily harm to another, your therapist may be required to take protective actions to include: notifying the potential victim, contacting the police, or seeking hospitalization for the client.

Ending Therapy

You have the right to withdraw from treatment for any reason at any time. We ask that you agree to have a final session after you notify your therapist of your voluntary termination of treatment, so that your therapist may responsibly review and evaluate your reasons and make recommendations related to the termination of treatment.

INFORMED CONSENT FOR TREATMENT (page 3)

INFORMED CONSENT TO TREATMENT:

I have read, understood, and had the opportunity to question, and I agree to the above conditions and policies. I agree and consent to participate in counseling services offered and provided at S.T.E.P. into Wellness, LLC. If the client is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual. I also permit use of a copy of this signed authorization in place of the original.

____

Printed name of client (or guardian, if applicable) Date Relationship to client (if necessary)

____

Signature of client (or guardian, if applicable) Date Relationship to client (if necessary)

____ ____________________

Therapist’s Name Printed Date

____ ____________________

Therapist’s Signature Date

INFORMED CONSENT REGARDING ELECTRONIC COMMUNICATION (page 1)

S.T.E.P. into Wellness therapists offer the option for clients and/or guardians to communicate with their therapist(s) by way of electronic communication. Below provides information regarding our policy, the risks, and general S.T.E.P. into Wellness guidelines for the exchange and storage of electronic communication (i.e., email, e-fax, text messaging, email with document attachments, and/or embedded hyperlinks).

By signing below, the client (or legal guardian of minor client) acknowledges and agrees to the following:

1. The email address indicated below may be used to correspond regarding scheduling, billing, and account balances;
2. Emails regarding billing, invoicing, or account balances should be sent directly to the owner, Barb Stephenson, bstephenson@stepintowellnesspllc.com, for review, or clarification of account as requested;
3. S.T.E.P. into Wellness therapists cannot guarantee the security and confidentiality of email communications as our email service is not encrypted through a secure server, and therefore will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information that is subject to the federal Health Insurance Portability and Accountability Act) that is not caused by intentional misconduct;
4. Emails, text messages, and voicemails will not be maintained as a part of the client's record. However, printing and/or storage of an electronic or voicemail message is at the sole discretion of your therapist.
5. By signing below, you understand and agree to the policy that electronic communication is not subject to a court subpoena if your therapist chooses not to print or store in client record as those communications will no longer exist, per our responsibility and obligation to maintain privacy and confidentiality whenever possible and to the utmost extent;
6. When not printed at the therapist's discretion, electronic messaging will be permanently deleted in order to ensure privacy as much as possible on an unsecure and unencrypted server;
7. S.T.E.P. into Wellness will use reasonable means to protect the security and confidentiality of email information sent and/or received;

S.T.E.P. into Wellness Email Guidelines:

Email is not to be used for urgent or emergent issues, nor the sole means of canceling an appointment unless there is an acknowledgement of receipt of cancelled appointment via email. If you have an urgent/time-sensitive issue, please call your therapist directly and s/he will respond within 24-48 hours (within the timeframe your therapist is scheduled to be in the office). Credit card numbers and social security numbers will NOT be used in email communication.

Email messages will be reviewed but not necessarily responded to within 48 hours. Your therapist retains the right to review and respond or review and not respond depending on the nature of the email. **A face to face appointment should be scheduled to discuss new issues or any sensitive clinical or medical information.** Given email is not secured and may be compromised at any time, it is your responsibility to follow up by way of phone rather than wait for an email response should you not hear back from your therapist regarding an urgent request or scheduling concern.

INFORMED CONSENT REGARDING ELECTRONIC COMMUNICATION (page 2)

I understand electronic communication to and from a S.T.E.P. into Wellness email address carries a number of potential risks, which may include following:

- Backup copies of emails may exist even if the file has been deleted;
- Emailed information may be intercepted, altered, or used without authorization or detection by unintended recipients;
- Email can be used to introduce viruses into computer systems, and;
- S.T.E.P. into Wellness email is neither encrypted nor secure.

Given the above information and understanding of risks associated with electronic communication, I opt to **not** send or receive emails to my therapist.

______________________________ (printed name / signature)

I have read, acknowledge, and understand the risks associated with electronic communication and by signature agree to send and/or receive emails to my therapist.

____

Permitted Email Address(es) of Client

____

Printed name of client (or guardian, if applicable) Date Relationship to client (if necessary)

____

Signature of client (or guardian, if applicable) Date Relationship to client (if necessary)

______________________________ ______________

Printed Name of Therapist Date

______________________________ ______________

Signature of Therapist Date

S.T.E.P. into Wellness
Striving Towards Endless Possibilities

RELEASE OF INFORMATION

Client Name: ____

I authorize S.T.E.P. into Wellness, LLC to ______ **release** and/or to ______ **receive** information pertinent to the clinical treatment of the client listed above to the persons/ agencies indicated below:

____

Agency/Individual Name Phone

____

Agency/Individual Name Phone

____

Agency/Individual Name Phone

____

Agency/Individual Name Phone

Confidential health record information for the purpose of:

____

As the person signing this authorization, I understand that I am giving my permission to S.T.E.P. into Wellness, LLC for disclosure and/or receipt of confidential health records. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization.

This consent is valid until ________________________________. If no date is indicated the consent will expire one year from the signature date.

____

Printed name of client (or guardian, if applicable) Date Relationship to client (if necessary)

____

Signature of client (or guardian, if applicable) Date Relationship to client (if necessary)

____ ____________________

Printed Name of Therapist Date

____ ____________________

Signature of Therapist Date

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

BACKGROUND
The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule grants individuals a fundamental right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a Notice that provides a clear explanation of these rights and practices. The Notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

PURPOSE
This Notice describes how medical and mental health information about you may be used and disclosed and how you can obtain access to this information. Please review the information carefully and provide a signed acknowledgement of your review and receipt of this Notice once you are confident about both your rights as a client or legal guardian of a client, and the legal and ethical responsibilities of your service provider.

Your health record contains personal information about you and your health. Information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how Virginia mental health providers (psychologists, therapists, counselors, and social workers) may use and disclose your PHI in accordance with applicable law, including HIPAA regulations promulgated under HIPAA and including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to, review, and manage your PHI.

We are required by law to maintain the privacy of PHI and to provide you with a Notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We provide a copy of the revised Notice of Privacy Practices by posting a copy on our website, providing a copy with your new client packet, or providing a hard copy version upon request.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU FOR PROFESSIONAL SERVICES
Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other members of a client's treatment team with your written consent. We may also disclose PHI to any other consultant only with your approval and written consent (Release of Information form).

FOR REIMBURSEMENT
If we use and disclose PHI, it would be so that you can receive reimbursement for the treatment services paid for and provided to you. This will only be done upon your request, and the PHI disclosed only following your consent and signature authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you to determine medical necessity or continuation of out-of-network reimbursement, or should provider be asked to participate in a utilization review for the purpose of your reimbursement of fees.

FOR QUALITY ASSURANCE AND COLLABORATION
We may use or disclose your PHI in order to ensure our business (wellness center) policies and procedures are consistently maintained and in accordance with federal and state standards of practice for mental health providers. This includes reviews by supervisors, if applicable to your provider, periodic contractor record reviews by a S.T.E.P. into Wellness Owner, or to comply with licensing activities. Limited PHI may be disclosed for training or teaching purposes (consultation or supervision), or research activities (following notification and your consent). No PHI will be disclosed without notice or your signature authorization.

REQUIRED BY LAW
S.T.E.P. into Wellness must disclose your PHI to you upon your request. To make a request, please submit it in writing, specifying your interest in reviewing medical records. Clinicians strive to protect your family's confidentiality and may prepare a summary of treatment progress in lieu to copying full records at your expense. You are within your rights to request all of your PHI. In addition, your private practice therapist or counselor must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining their compliance with the requirements of the Privacy Rule.

POTENTIAL DISCLOSURES WITHOUT AUTHORIZATION
Below is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit mental health providers to disclose information about you (or a minor client) without your authorization only in a limited number of situations.

Child Abuse or Neglect: We may disclose PHI to a state or local agency that is authorized by law to receive reports of suspected child abuse or neglect.
Judicial and Administrative Proceedings: We may disclose PHI pursuant to a subpoena (with or without your written consent), court order, administrative order or similar process.
Deceased Patients: We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.
Medical Emergencies: We may use or disclose PHI in a medical emergency situation to medical personnel in order to prevent serious harm to yourself or another.
Family Involvement in Care: We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
Health Oversight: If required, we may have to disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent).
Law Enforcement: We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
Specialized Government Functions: We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health: If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
Public Safety: We may disclose your PHI if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
Research: PHI for this purpose may only be disclosed after a special approval process or with your authorization.
Verbal Permission: We may also use or disclose your information to family members or supports you name that are directly involved in your treatment. This occurs with your verbal permission prior to engaging with family members or designated supports.
With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI:
You have the following rights regarding PHI that is collected and maintained at our office. To exercise any of these rights, please submit your request in writing to:

Attn: Your provider
S.T.E.P. into Wellness, LLC
9110 Railroad Drive, Suite 310-A
Manassas Park, VA 20111

Right of Access to Inspect and Copy: You have the right, which may be restricted only in exceptional circumstances, to inspect and copy your PHI. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We will charge the fee outlined in our financial policy. You may also request that a copy of your PHI be provided to another person.
Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask your provider to amend the information although h/she is not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy.
Right to an Accounting of Disclosures: You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable time-based fee if you request more than one accounting in any 12-month period.
Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication: You have the right to request that we communicate with you about health matters in a certain way or at a certain location (in the office, by phone). We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request.
Breach Notification: If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
Right to a Copy of this Notice: You have the right to a copy of this Notice.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

__________ *(Initial)* I HAVE REVIEWED AND BEEN PROVIDED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT THESE POLICIES, AND I UNDERSTAND THAT I MAY ASK QUESTIONS ABOUT THEM AT ANY TIME IN THE FUTURE. I CONSENT TO ACCEPT THESE POLICIES AS A CONDITION OF RECEIVING MENTAL HEALTH SERVICES.

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Printed name of client (or guardian, if applicable) Date Relationship to client (if necessary)

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Signature of client (or guardian, if applicable) Date Relationship to client (if necessary)