Harmony Wellness Counseling and Consulting Center, LLC

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Laurel MD 20708-4203
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1. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information (“PHI”) that identifies you is kept private.
• Give you this notice of my legal duties and privacy practices with respect to health information.
• Follow the terms of the notice that is currently in effect.
• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client’s personal health information without the client’s written authorization, to carry out the health care provider’s own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of health care

providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
a. For my use in treating you.
b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. 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.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. 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. 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 cost based fee for each additional request.
6. 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 from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

2. Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:
1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

3. Standard Intake Questionnaire

Complaint

What is your major complaint?:

Have you previously suffered from this complaint?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

Current Symptoms

(check all that apply)

- [ ] Anxiety
- [ ] Appetite Issues
- [ ] Avoidance
- [ ] Crying Spells
- [ ] Depression
- [ ] Excessive Energy
- [ ] Fatigue
- [ ] Guilt
- [ ] Hallucinations
- [ ] Impulsivity
- [ ] Irritability
- [ ] Libido Changes
- [ ] Loss of Interest
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grow up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

Present Situation

Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?

(check all that apply)

- [ ] Alcohol
- [ ] Tobacco
- [ ] Marijuanna
- [ ] Hallucinogens (LSD)
- [ ] Heroin
- [ ] Methamphetamines
- [ ] Cocaine
- [ ] Stimulants (Pills)

- [ ] Ecstasy
- [ ] Methadone
- [ ] Tranquilizers
- [ ] Pain Killers

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

Anything else you want the doctor to know?:

Good Faith Estimate Notice

Notice to Clients and prospective clients:

Under the law, health care providers need to give clients who don’t have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service, or at any time during treatment. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, or how to dispute a bill, see your Estimate, or visit https://www.cms.gov/nosurprises.:

5. Credit/ Credit Card consent form

Client name:

(Card holder) Name on card if different than client:

Card Type & Billing Zipcode:

Credit Card number & CVV # (3 or 4 digit number on the back):

Expiration Date:

I authorize Harmony Wellness Counseling and Consulting Center, LLC to charge my credit/debit/health account card for professional services 24 hours before our scheduled appointment. If I do not cancel before 24 hours, I recognize that Lisa Ford will charge my card as a late cancel or no-show if I do not show up for the appointment. I will be billed for the full session charge of $150.00 for initial appointments or $125.00 for regular counseling sessions).

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials:

Card holder Initials (If different than client):

Date:

Signature:

6. GAD-7 Scale

Generalized Anxiety Disorder 7-item Scale (GAD-7)

Patient Name:

Date of Visit:

Client Questions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious, or on edge:

2. Not being able to stop or control worrying:

3. Worrying too much about different things:

4. Trouble relaxing:

5. Being so restless that it's hard to sit still:

6. Becoming easily annoyed or irritable:

7. Feeling afraid as if something awful might happen:

Questionnaire Score

Add up all the numbers for answers 1-7 above.

Total Score:

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?:

7. PHQ-2 Questionnaire

Patient Health Questionnaire 2 (PHQ-2)

Patient Name:

Date of Visit:

Client Questions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things:

2. Not being able to stop or control worrying:

Questionnaire Score

Add up all the numbers for answers 1-2 above.

Total Score:

8. PHQ-9 Questionnaire

The Patient Health Questionnaire 9 (PHQ-9)

Patient Name:

Date of Visit:

Client Questions

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things:

2. Feeling down, depressed or hopeless:

3. Trouble falling asleep, staying asleep, or sleeping too much:

4. Feeling tired or having little energy:

5. Poor appetite or overeating:

6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down:

7. Trouble concentrating on things, such as reading the newspaper or watching television:

8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual:

9. Thoughts that you would be better off dead or of hurting yourself in some way:

Questionnaire Score

Add up all the numbers for answers 1-9 above.

Total Score:

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?:

9. Telehealth Treatment Consent 1

Information and Informed Consent for Telemental Health Treatment

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding

I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telemental health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.

I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

I understand my therapist will advise me about what telemental health platform to use and she will establish a video conference session.

Client Consent

Client Name:

☐ I hereby give my informed consent for the use of telemental health in my care.

Client Initials:

Date of Birth:

Email:

Phone Number:

Client Signature:

10. Release of Information: HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION 1

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date:

I. The Patient

This form is for use when such authorization is required and complies with the Health Insurance Portability Act of 1996 (HIPPA) Privacy Standards.

Client Full Name:

Client Date Of Birth:

Client ID Number:

SSN:

II. Authorization

I authorize [Agency/Provider Name] to use or disclose the following: (check one)

☐ All of my medical-related information

☐ My medical information ONLY related to a specific diagnosis. (complete sentence below)

My medical information only related to:

☐ My medical-related information in a specified date range. (enter date range below)

Enter date range:

☐ Other (please explain below)

Please explain other:

III. Disclosure

The Authorized Party has my authorization to disclose Medical Records to: (check one)

☐ Any party that is approved by the Authorized Party.

☐ Only the following party (enter details below)

Name:

Address:

Phone Number:

Fax Number:

Email Address:

IV. Purpose

The reason for this authorization is: (check one)

- [ ] General Purpose at my request (general)
- [ ] To receive payment. To allow the authorized party to communicate with me for marketing purposes when they receive payment from a third party.
- [ ] To sell my medical records. To allow the Authorized Party to sell my medical records. I understand that the Authorized Party will receive compensation for the disclosure of my medical records and will stop any future sales if I revoke this authorization.
- [ ] Other (please explain below)

Explain other:

V. Termination

The authorization will terminate: (check one)

- [ ] Upon sending a written revocation to the Authorized Party
- [ ] On the following date: (enter below)

Date:

- [ ] Other (please explain below)

Explain Other:

VI. Additional Consent for Certain Conditions

Sensitive information. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

Check One

- [ ] I consent to have the above information released.
- [ ] I do not consent to have the above information released.

VII. Acknowledgement of Rights

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient (if filling out electronically, type your name, you will have the opportunity to sign at the end):

Client Full Name:

If the patient is unable to sign use the signature area below

The patient is unable to sign due to (check one)

☐ Being a Minor (complete the statement below)

The Patient is _____ years old and considered a minor under state law:

☐ Being Incapacitated (please explain below)

Patient is incapacitated due to:

☐ Other (please explain below)

Signature of Representative (if filling out electronically, type your name, there will be an option to sign at the end):

Date:

Printed Name of Representative:

Relationship to Patient (check one)

☐ Parent

☐ Guardian

- [ ] Spouse
- [ ] Other (please explain below)

Explain other:

0. Release of Information: HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION 2

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date:

I. The Patient

This form is for use when such authorization is required and complies with the Health Insurance Portability Act of 1996 (HIPPA) Privacy Standards.

Client Full Name:

Client Date Of Birth:

Client ID Number:

SSN:

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- ☐ My medical information ONLY related to a specific diagnosis. (complete sentence below)

My medical information only related to:

- ☐ My medical-related information in a specified date range. (enter date range below)

Enter date range:

- ☐ Other (please explain below)

Please explain other:

III. Disclosure

The Authorized Party has my authorization to disclose Medical Records to: (check one)

- ☐ Any party that is approved by the Authorized Party.
- ☐ Only the following party (enter details below)

Name:

Address:

Phone Number:

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IV. Purpose

The reason for this authorization is: (check one)

- [ ] General Purpose at my request (general)
- [ ] To receive payment. To allow the authorized party to communicate with me for marketing purposes when they receive payment from a third party.
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- [ ] Other (please explain below)

Explain other:

V. Termination

The authorization will terminate: (check one)

- [ ] Upon sending a written revocation to the Authorized Party
- [ ] On the following date: (enter below)

Date:

- [ ] Other (please explain below)

Explain Other:

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Check One

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The Patient is _____ years old and considered a minor under state law:

☐ Being Incapacitated (please explain below)

Patient is incapacitated due to:

☐ Other (please explain below)

Signature of Representative (if filling out electronically, type your name, there will be an option to sign at the end):

Date:

Printed Name of Representative:

Relationship to Patient (check one)

☐ Parent

☐ Guardian

- [ ] Spouse
- [ ] Other (please explain below)

Explain other:

0. Telehealth Treatment Consent without no show rate

Information and Informed Consent for Telemental Health Treatment

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

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I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

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I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand my therapist will advise me about what telemental health platform to use and she will establish a video conference session.

Client Consent

Client Name:

☐ I hereby give my informed consent for the use of telemental health in my care.

Client Initials:

Date of Birth:

Email:

Phone Number:

Client Signature: