NOTICE OF PRIVACY PRACTICES
OF
THE FRASER CENTER

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. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available upon request.

All information revealed by you in a counseling or therapy session and most information placed in your counseling/therapy file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered "Protected Health Information," (PHI). As such, your protected health information ***cannot be distributed to anyone else without your express informed and voluntary written consent or authorization.*** The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in the Fraser Center's "Treatment Consent Form" and "Client Rights and Responsibilities" statement.

How We May Use or Disclose Your Health Information Without Your Written Consent:

1. ***For Treatment.*** We may use your PHI to provide you with mental health or substance abuse services. *For example, it may be shared with another Fraser Center provider, such as the psychiatrist, for consultation purposes and continuity of care. (**Note:** A therapist's session notes are not considered part of the medical record).*
2. ***For Payment.*** We may use and disclose your PHI to others for the purpose of receiving payment for treatment and services that you receive. *For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment plan or course of treatment.*
3. ***Threat to Health/Safety.*** We may use and disclose information if there is *suspected child/elder abuse or neglect, a threat of domestic violence*, or, if there is a *serious threat of harm to yourself or others*.
4. ***Required by Law.*** We may use and disclose PHI as required by law. *For example, we may disclose information if files are subpoenaed by a Judge, or, in a case where you are claiming malpractice or breech of ethics, or, if you were to claim mental health issues as a defense in a civil or criminal case.*
5. **Health and Oversight Activities.** *For example, we may correct records or correct records already disclosed.*
6. **Research and Quality Assurance.** We may use PHI for research or quality assurance. *For example, we may do 'outcome' studies of our clients' treatment to see if therapy is being effective.*
7. **Workers' Compensation**. Your health information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation such as *the basic information obtained in therapy/counseling as a result of your Worker's Compensation claim.*
8. **Appointments.** We may use your PHI to provide appointment reminders or to call if there is a change or cancellation. *(**Note:** Please notify the front office if you **do not** want appointment messages to be left on home answering machines or with others in the household.)*

<u>Your Rights to Privacy</u>:

¬ As a client, you have the right to see your counseling/therapy file. Psychotherapy notes are afforded special privacy protection and are *excluded* from this right.

¬ As a client, you have the right to receive a copy of your counseling/therapy file. Psychotherapy notes are afforded special privacy protection under federal law and are *excluded* from this right.

¬ As a client, you have the right to request amendments to your counseling/therapy file.

¬ As a client, you have the right to receive a history of all disclosures of Protected Health Information (PHI).

¬ As a client, you have the right to restrict the use and disclosure of your PHI for the purposes of treatment, payment, and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.

¬ As a client, you have the right to file a complaint with us or with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated. All complaints must be submitted in writing.

In order to exercise any of your rights as set forth in this Notice, please write to:

Privacy Officer
The Fraser Center
203 Mary Lou Drive
Hinesville, GA 31313

Prior to your counseling or therapy, you will receive:

1) An exact duplicate of these two pages
2) A copy of our *Client Rights and Responsibilities and Consent for Treatment* form

It will be necessary for you to sign a certificate indicating that you have received, read, and understand all documents. This certificate will be placed in your counseling/therapy file. Please do not sign the certificate if you do not understand any part of the *Privacy Statements* or the *Client Rights and Responsibilities and Consent for Treatment* forms. Your counselor or therapist will be happy to explain these documents further.

Name:___________________________________ **Social Security #:**___________________________

FRASER CENTER
Client Rights and Responsibilities

Confidentiality: Everything you say to your therapist is confidential. Exceptions have already been noted. Additional confidentiality and privacy information may be found in your copy of the *Privacy Statements* as required by the **Health Insurance Portability and Accountability Act of 1996**.

Informed Consent: You have the right to an explanation of your condition and treatment in language that you can understand. You have the right to consent or agree to treatment, and you also have the right to refuse treatment.

Input into Treatment: You have the right to provide input into the policies of the Fraser Center and into your treatment. You have the right to share in the treatment planning process, determining what options you choose for your treatment. You have the right to file complaints and compliments related to your treatment. You may also have the right to file grievances and appeals related to this treatment.

Promptness: Your counseling sessions will start promptly at the scheduled time, unless your therapist is delayed by a previous emergency. Sessions last 50 minutes, unless previously agreed by the therapist and you.

Respect and Non-Discrimination: You have the right to be treated with respect and dignity by all Fraser Center staff. You have the right to be treated equally regardless of your race, ethnic origin, religion, creed, gender, age, disability status, sexual orientation, or source of payment. Any type of sexual behavior between therapist and client is unethical. It is never appropriate and will not be condoned. You are responsible for treating your therapist, the staff of Fraser Center and others with respect and dignity.

Emergencies: if a mental health emergency occurs after business hours call 911 or the crisis line at 866-713-7763.

Other Information and Options: You have the right to information concerning your provider. You also have the right to know about other treatment options, regardless of their cost or if they are covered by your insurance. You have the right to know what clinical guidelines or standards are used in providing your treatment. You have the right to know about your rights and responsibilities in treatment. You may have other rights and responsibilities as provided by Georgia law. Information about these can be obtained by contacting the Georgia Board Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists, 166 Pryor Street, S.W. Atlanta, Georgia 30303-3465**. Substance Abuse Clients:** you have the right to file a complaint with the *Office of Regulatory Services*, *2 Peachtree St., NW, Suite 33-250, Atlanta, GA 30303-3142* or (404) 657-5728 or (800) 878-6442.

Cancellation Policy: 24-hour notice is required for cancellation, since your therapist reserves time for you when you schedule an appointment. If you do not cancel 24 hours in advance, you will be charged a fee. Note that you may leave a message with the answering service after business hours and on weekends to cancel an appointment.

Fee Payment: You are responsible for paying your fees or co-payments at the time of your appointment, unless you have made other payment arrangements. We will bill your insurance. If in a reasonable time the insurance company has not paid, it is your responsibility to pay for services.

Following Therapeutic Advice: In order for treatment to be effective, you have a responsibility to follow the advice given by your therapist. This may include taking medication as prescribed, completing homework assignments between sessions, or trying new behaviors as suggested by your therapist. If you do not understand your therapist's advice, you have a responsibility to ask questions about it, so that you

can understand. If you do not agree with your therapist's advice, you have a responsibility to inform your therapist so that you can work together to develop an action plan that you are both comfortable with.

Participation in Treatment: In order to benefit fully from treatment, you must participate by giving your provider information needed to guide the treatment process and to deliver the best possible care. This includes telling your provider about any medication you are taking, and informing your provider about any changes in medications prescribed by another doctor. It also includes asking your provider any questions you have about your care, so that you can understand your care and your role in it. You must also inform your provider whenever treatment does not seem to be working for you.

Safety: You are responsible for avoiding any actions that could harm yourself or others. This includes being responsible for telling your therapist if you feel that you might harm yourself or any other person, so that your therapist can take actions to keep you safe.

Court Appearances: Experts employed by attorneys are generally hired as consultants to aid in the preparation of a matter of litigation, or used as an expert witness in a court trial or a deposition. Should this service be necessary, The Fraser Center has a compensation agreement policy regarding consultant/witness fees. Please request a copy of the policy for yourself and your attorney prior to the issuing of a subpoena.

Timely Notification: You are responsible for notifying the receptionist of any change in your address or telephone number so that your therapist can contact you if needed. You are also responsible for notifying the receptionist of any change in your insurance prior to your next scheduled appointment, so that the receptionist can verify your benefits. If you do not notify the receptionist of your new insurance prior to your appointment, you will be required to pay in full for your visit at the time of the appointment.

Discharge Status: If you are not seen by your therapist at least once every 60 days, your chart will be moved to Discharge Status. If you would like to re-activate your case, an appointment must be made with a therapist. Psychiatric services through the Fraser Center are available only to clients whose cases are active.

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CONSENT TO TREATMENT

I, ____, for ____,
(Print your name) *(Print the client's name)*
do hereby voluntarily consent to care and treatment by ____
his/her assistants and /or designees. I am aware that the practice of medicine, psychiatry, clinical psychology, and clinical social work is not an exact science, and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the counseling process and that I share responsibility for treatment. My responsibilities in treatment include informing the therapist of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

____ ___________________________________
(*Sign your name)* *(Date)*

____ ___________________________________
(Witness) *(Date)*

THE FRASER CENTER
203 Mary Lou Drive
Hinesville, GA 31313
(912) 369-7777

Client Rights and Responsibilities Consent to Treatment and Health Insurance and Portability and Accountability Act Certification (*Privacy Statements*)

"*My signature below indicates that I have received, read, and understand* ***The Fraser Center's Client Rights and Responsibilities and Consent to Treatment*** *form and the* ***Privacy Notice and Rights Statements****. I understand that it is my sole responsibility to request clarification or additional information concerning my rights and responsibilities."*

____________________________________ _________________________________
Client Signature Date

If more than one individual (e.g., spouse or family member) is seeking therapy, please have each of the others sign below. Signatures below confirm that each understands and accepts all the information contained in **The Fraser Center's Client Rights and Responsibilities** statement, **Consent to Treatment** and the **Privacy Notice and Rights Statements**.

_______________________________ _____________________________________
Client Signature Date

_______________________________ _____________________________________
Client Signature Date

_______________________________ _____________________________________
Client Signature Date

_______________________________ _____________________________________
Client Signature Date

The signature below certifies that I have explained these rights and responsibilities, using language that is understandable to the client(s). The client has been presented with copies of these forms.

__________________________________ ____________________________________
Provider Signature & Credentials Date