Cynthia Pastor, MFT Lic #MFC19888
1280 Boulevard Way Suite 212
Walnut Creek CA 94595
(925) 947-6853

NOTICE OF PRIVACY PRACTICES

A. Introduction

This notice will tell you about how your therapist handles information obtained about you. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires you be informed about how we use information here in this office, how we share it with other professionals and how you can have access to it. Because this law and the laws of this state are very complicated we have simplified some parts. If you have any questions or want to know more, please ask.

B. What is meant by your medical information

Each time you visit this or any other doctor's office, information is collected about your physical or mental health. It may be information about your past and present health conditions, or the treatment you received for them. The information your therapist collects from you is called, (in the law), PHI which stands for Protected Health information. This goes into your healthcare file. It may contain data about your history, presenting concerns, diagnosis, treatment plan, legal information, treatment by other professionals, school records, and/or billing information. Your therapist uses this data to plan for your care, to verify services received for your health insurance company and to aid in consultation with other professionals involved with your situation.

C. Privacy and Laws

The HIPAA law requires your therapist to keep your PHI private and to give you this notice which is called the Notice of Privacy Practices or NPP. Your therapist will obey the rules of this notice as long as it is in effect and you will be notified of any changes.

D. What happens to your protected health information

When your PHI is read by the therapist that compiled it, it is legally called "use". If the information is shared with outside professionals, that is legally called 'disclosure'. In contact with other parties, your therapist will disclose only the minimum information needed for the purpose. The law gives you the right to know about your PHI, understand how it is used and control how it is disclosed. *Your written permission* is required for disclosure of your PHI except in special circumstances.

1. Uses and disclosures of PHI in health care with your consent.

After you read this Notice you will be asked to sign a separate Consent form to allow your therapist to use and share your PHI. In almost all cases your therapist will use your PHI as described above: to provide, plan and coordinate treatment

or to arrange billing. In addition, your therapist may share this information with another therapist who might be on call when she is out of town. This helps to better provide for continuing care in case of absence. Together these routine purposes are called TPO.

This Notice and the consent form allows your therapist to use and disclose your PHI for TPO. Under the regulations of HIPPA your therapist cannot treat you without a signed consent. If your therapist wants to use your information for any other purposes she will require your permission on an Authorization form. Furthermore, you can cancel or withdraw your permission at any time, by doing so in writing. Of course, your therapist cannot take back any information she has already disclosed with your previous consent.

2. Uses and disclosure of PHI NOT requiring consent.

In rare cases, the law requires therapists to disclose some of your PHI without your consent. Your therapist is required to report suspected child and elder abuse. In addition your therapist must disclose portions of your PHI if she believes you are likely to harm yourself or someone else. Finally, if you are involved in a lawsuit or legal proceeding and your therapist has received a subpoena, discovery request, or other lawful process she may have to release some or all of your PHI to comply. This will happen only after you have been told about the request. When information on your PHI has been released without your consent you are entitled to obtain records about what and how that information was conveyed.

E. Access to your PHI:

Although your health record is the physical property of the healthcare practitioner or facility that collected it, the information belongs to you. You are entitled to review it. If you want a copy one can be provided but you may be charged for the costs of reproduction and mailing. In some situations you cannot see all of what is in your records. Your PHI will not contain process notes from individual therapy sessions, but rather a summary of progress and treatment. If you have specific questions about your therapist's treatment plan or diagnostic impression, it is most helpful to speak about that directly.

F. Electronic Information:

Your insurance company may require portions of your PHI to be transmitted electronically thru fax or email.

G. Further Information:

If you need more information or have questions about the privacy practices described above please speak to your therapist (privacy officer). If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, let us know. You have the right to file a complaint with us and with the Secretary of the Federal Department of Health and Human Services. No action will be taken against you if you complain.

Cynthia Pastor, MFT Lic #MFC19888
1280 Boulevard Way Suite 212
Walnut Creek, California 94595
(925) 947-6853

This agreement is made between Cynthia Pastor, M.A. and

_____ (client or responsible party).

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) your therapist cannot treat you unless you sign this consent form regarding your Privacy. These procedures are in effect as of October 2, 2007. If these policies are changed in the future you will be notified.

After you have signed this consent, you have the right to revoke it in writing.

I understand that during the course of my treatment my therapist will be collecting what the law calls Protected Health Information (PHI) about me and/or my spouse. The therapist needs to use this information to decide on the best treatment and to coordinate care. My therapist may also share this information with others who provide my treatment or use it to arrange payment for that treatment. I understand that if there is specific information I want not to be disclosed I can communicate that to my therapist and she will do her best to honor that request.

By signing this form I am agreeing to let my therapist use my information here and send it to others as outlined in the Notice of Privacy Practices. I have read this Notice and understand my rights regarding privacy.

_____ _____
Signature of Client or Responsible Party Date

_____ _____
Signature of Therapist Date

Cynthia Pastor, MFT Lic #MFC19888
1280 Boulevard Way Suite 212
Walnut Creek, CA 94595
(925) 947-6853

Consent For Treatment

Client Name:_____

Date of birth:_____

Therapist:_____

In signing the form below, I give permission to the above named therapist to provide counseling and psychotherapy to me.
I understand that, according to California law, communication between a client and her/his therapist is both privileged and confidential. This means the therapist/counselor cannot identify a client by name while discussing information about the client, orally or in writing, without the client's express written permission.
There are some situations, however in which California law has mandated that confidentiality may or must be broken:

- **If a client is a danger to him/herself or to others, the legal protection of confidentiality is no longer in effect. The therapist is required to warn a potential victim, the police or the family of the client who intends to harm him/herself.**
- **If there is reasonable suspicion of child abuse, the therapist must report this to designated authorities.**
- **Any reasonable suspicion of physical abuse of a dependent or elder must be reported by the therapist.**
- **There are specific legal situations in which privilege is waived. For example, to establish competence, to determine sanity, or when the therapist asserts the privilege, but is ordered by a judge to testify.**

In signing the form below, I acknowledge that I have read the above and understand my therapist's ethical/legal responsibility to make such decisions when necessary, either during the course of my therapy work with the above named therapist or after the termination of my therapy. I understand that I may obtain a copy of this form at my request.

Name (please print):_____

Your Signature:_____**Date:**_____

Therapist/Witness:_____**Date**_____

Cynthia Pastor, MFT Lic. #MFC19888
1280 Boulevard Way Suite 212
Walnut Creek, California 94595
(925) 947-6853

Date:_____

Name:_____ Birthdate:_____

Address:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____

Insurance Company:_____ID#_____

Social Security #_____

Marital Status:_____Have you ever been divorced?_____

Names and ages of any children:_____

Do you use any non-prescription drugs or alcohol?(Please specify)

Please list any medications you are taking currently:_____

Previous therapy? When and for how long?_____

_____
Reason for seeking help at this time?

_____

Who referred you to this office?_____

Cynthia Pastor, MFT
Lic. #MFC19888
1280 Boulevard Way Suite 212
Walnut Creek, CA 94595
(925) 947-6853

Client Information Statement

The following information is provided to support our therapeutic relationship regarding scheduled appointments, fees and insurance billing.

1. Payment: Payment is due for each session on day of treatment. A monthly payment can be negotiated if necessary. I prefer to be paid by check but will accept credit card payment if necessary. All payments should be made directly to me.

2. Insurance billing: I will provide you with a monthly bill to be **submitted by you** to your insurance carrier if you request one. Any payments you receive from your insurance company would be reimbursement of fees you already paid to me, and should be made out to you. If you do not receive reimbursement from your insurance carrier you are still responsible for full payment of your bill.

2. Phone calls: Calls that are more than **10 minutes** will be billed at my hourly rate.

3. Cancellation: Any session that is canceled less than 24 hours in advance will be billed at the full rate. This allows me to schedule another client during your absence. I do not bill for sessions missed due to illness.

4. Scheduling: When there is a need to cancel a session (due to illness, work, medical appointments or vacation), I ask clients to try and **reschedule** (our schedules permitting). This helps support the continuity of the work. Frequent absences can interfere with your progress in therapy. **I ask for as much advance notice as possible to accommodate scheduling changes.**

5. Fee Changes: From time to time I may raise my fees. I will notify you several months in advance to help you in planning for this change.

6. EAP Clients: If you are referred by an insurance company (EAP program) it is up to you to get **prior authorization** and to come to your first session with your authorization information. Please find out how many sessions are being authorized. This will help me to keep my records clear and accurate. I only submit billing for EAP clients.

7. Reports: Any additional services requested of me in regard to your treatment (i.e. reports to be written, forms to be filled out, or phone calls with legal counsel etc.) will be billed at my hourly rate.

8. Professional Consultation: On occasion I might consult with other licensed professionals about your case. Your identity will be kept confidential. I do not inform clients of these consultations unless I feel it is important for our work together.

9. Release of Information Form: I will request a signed **release of information form** from you if I plan to consult with a prior therapist or any current therapist/ psychiatrist or medical practitioner for the benefit of our work together. I will discuss this in advance with you and will not call another provider without your prior **written permission.**

10. Messages: I check for messages frequently during weekdays, and at least daily on the weekends. If I am out of town I always have another therapist on call while I am gone. Always leave your phone number when leaving a message.

11. Vacations: I usually take 4-6 weeks off each year for vacation. I typically take off some time around Thanksgiving, Christmas/New Years, as well as some time during the summer. I always give as much advance notice as possible so that clients can plan accordingly. I will always have someone on call when I am gone.

12. Emergencies: In case of an emergency, if I am not immediately available by phone, please be sure to leave your name and phone number where you can be reached so that I can call you when I am able. If I do not answer your call immediately, please **contact the CRISIS HOTLINE at 1-800-833-2900.** This is the number for Central Contra Costa.

Client Signature _____ Date _____

Therapist Signature _____ Date _____