Bhakti Cohen, EDS, NCC, LMFT
Licensed Marriage & Family Therapist (MT 2239)
Florida Supreme Court Certified Family Mediator (24357 F)
Collaborative Divorce Professional / Parenting Coordinator

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Dear Client,

Welcome to my practice. Attached are several documents related to your being treated in my practice. They are:

- A Consent to Treat form
- The Psychotherapist-Patient Services Agreement form
- The Florida Notice form

The latter two forms are required by the recently enacted Health Insurance Portability and Accountability Act (HIPAA).

Please read these forms over, ask me any questions you may have about them, and then, if you agree, sign in the appropriate places. I'm happy to answer all questions you may have about these forms. Please bring the completed forms to our next scheduled meeting. We will not be able to proceed with treatment until these forms are completed.

Thank you for your patience in completing these forms.

Marriage and Family Therapy Services
Bhakti Cohen, EDS, LMFT

Licensed Marriage and Family Therapist
Florida Supreme Court Certified Family Mediator

Consent To Treatment

I, _____(on behalf of)_____ give my permission and consent to receive counseling with Ms Bhakti Cohen. I understand that my therapist will discuss with me her views of my difficulties and explain the risks and benefits of various treatments, including no treatment.

I understand that should my therapist not be available immediately during a crisis, I may contact the 24-hour telephone emergency counseling services that are available through the:

- Alachua County Crisis Center at 352.264.6789

Should I feel that my life is in danger, I can also go/call to the nearest emergency room:

- Shands Hospital: 352.265.0111
- No. Fl. Regional Hospital Emergency Room: 352.333.4900

I understand that counseling sessions and records are confidential. In general, my written authorization is required if I want any information about my counseling provided to another person or agency. However, I have been informed that confidentiality may not be maintained in certain circumstances, including those in which there is a clear and immediate probability of physical harm to any person (including myself) or when release of records and/or information are required by law, as in cases of suspected abuse or neglect of a child, elder, or disabled person. Further, I understand that Ms Bhakti Cohen's fee for each one hour therapy session is $120, and I have agreed to pay: $_____ per session.

I have read the above policies and asked any questions that I needed to ask in order to better understand them. I understand that I can end therapy at any time I wish and that I can refuse any suggestions made by Ms Cohen.

Signed _____ Date _____

Marriage and Family Therapy Services
Bhakti Cohen, EDS, LMFT

Licensed Marriage and Family Therapist
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PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT REGARDING HIPAA

Welcome to my practice. This document contains important information about a new federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.
- There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

  --If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

--If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
--If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
--If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I know, or have reason to suspect, that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited, the law requires that I file a report with the central abuse hotline. Once such a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or seeking hospitalization of the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (other than a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record or a summary thereof, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Furthermore, there may be a copying fee charged per page and for certain other expenses. I may withhold copies of your records until payment of the copying fees has been made. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and

procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with minors [over 13] and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the patient's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

INSURANCE REIMBURSEMENT

I do not accept insurance at this time.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Client Signature Date

FLORIDA NOTICE FORM

Notice of Therapists' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment and Health Care Operations"
  - Treatment is when I provide, coordinate or manage your mental health care and other services related to your mental health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment and health care operations when your appropriate authorization is obtained. An "authorization " is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family therapy session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.
- **Adult and Domestic Abuse:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.
- **Health Oversight:** If a complaint is filed against me with the Florida Department of Health, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization from you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
- *Therapist's Duties*:

  --I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

  --I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

  --If I revise my policies and procedures, I will provide you with a revised notice by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me or the Secretary of the U.S. Department of Health and Human Services.

VI. Cancellation Policy

Appointment cancellations and/or changes must be made within a minimum of 24 hours of the scheduled appointment. Understandably, emergencies happen. While I am willing to forego 2 (two) no shows, I reserve the right to charge the client $50 for all missed appointments after that time.

VII. Electronic Communication

By signing below, I agree to accept and transmit any electronic communication with Ms Bhakti Cohen for the sole purpose of appointment confirmation/change. Although all communication is confidential and Ms Cohen's computer and cell phone are password protected, I understand there are potential limitations to confidential communication (e.g., computer hackers).

VIII. Effective Date and Changes to Privacy Policy

This notice will go into effect on July 6, 2007.
I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised written notice by certified mail.

_____ _____

Client Signature Date