



Client Name: \_\_\_\_\_

## Notice of Privacy Practices and Client Handbook

### Mission Statement:

The mission of ATS is to provide professional services to clients that will enable them to make positive changes in their perceptions, emotions, and behaviors. These changes may be in one's personal life, family life, or professional life. ATS' efforts will be governed by the principles of teamwork, responsibility, accountability, honesty and respect.

### (HIPAA) Health Portability & Accountability Act:

This document contains important information about our professional services and business policies. It also contains summary information about Health Insurance Portability and Accountability Act (HIPAA), a federal law 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 counseling, health care operations, and payments. The law requires that I obtain your signature acknowledging that I have provided you with this information. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. 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.

ATS respects client confidentiality and will only release information about you in accordance with applicable State & Federal Law. If State Law is stricter, these more stringent provisions will always take precedence. This notice describes our policies related to the use of your mental health records.

ATS is required by law to maintain the privacy of protected health information and to provide you with notice of your legal duties and privacy practices. In accordance with state and federal law, we will make reasonable efforts to limit use, disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose.

### LIMITS ON CONFIDENTIALITY:

The law protects the privacy of all counseling communications between a client and a counselor. In most situations, ATS can only release information about your treatment to others if you sign a written authorization form that certain legal requirements imposed by HIPAA. You should be aware that professionals employed at ATS work with other mental health professionals and administrative staff. In most cases, professionals employed at ATS may need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling billing and quality assurance. All mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without ATS' permission.

I will not give counseling information to anyone except when:

- 1) You or your legal guardian ask that counseling information be given to another professional and have signed a release of information with ATS.
- 2) You or your legal guardian automatically releases counseling information by bringing legal charges against your counselor.
- 3) Counseling information is about a criminal act or violation of the law or an indication that you have been a victim or subject of a crime or the possibility of physical harm to the client or someone else.
- 4) A court order exists requiring that the counselor release information.
- 5) Diagnostic and/or treatment planning information are required by your insurance company.
- 6) Information is shared in ATS staff meetings to ensure that diagnosis and treatment decisions are made for each client.

Initial \_\_\_\_\_

### Clinical Record:

You should be aware that, pursuant to HIPAA, ATS keeps protected health information about you in two sets of professional records. One set constitutes your clinical record. It includes information about your reasons for seeking counseling, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for counseling, your progress toward those goals, your medical and social history, your billing records, and any reports that have been sent to anyone, including to your insurance carrier. Although, in unusual circumstances that involve danger to yourself and/or to others, we may review your clinical record. In addition ATS also keeps a set of psychotherapy notes. These notes are for ATS professional use and are designed to assist our staff with treatment. Psychotherapy notes may also contain any particularly sensitive information that you may reveal to ATS that is not required to be included in your clinical record. Your psychotherapy notes are not available to be copied for your records and can not be sent to anyone else, including your insurance carrier, without your signed authorization. If you would like to review your records with your clinician, you may make a request in writing and allow ten days notice. If it is deemed that the review of such records would cause harm to the client, the request may be denied. All mental health and drug or alcohol abuse treatment information, whether recorded or not, and all communications between a physician or psychotherapist and a consumer are both privileged and confidential. In addition, the identity of all consumers who have received or are receiving mental health or drug or alcohol abuse treatment services is both

confidential and privileged. Such information shall only be available to persons or agencies actively engaged in the treatment of the consumer unless an exception under state or federal law applies. The information available to persons or agencies actively engaged in the treatment of the consumer shall be limited to the minimum amount of information necessary for the person or agency to carry out its function or the purpose for the release. I give permission to for all insurance companies/EAP programs payments for ATS services to be paid directly to this agency. Initial \_\_\_\_\_

#### Ethics:

All employees of ATS must maintain an ethical standard. Our employees' job is to be respectful and helpful to our clients. We only help our clients in the ways we are trained and also by informing our clients all about their treatment. Our staff does not meet their personal needs through the counseling relationships with our clients. Our staff respects each of our clients' privacy and rights as human beings. The aforementioned summary of our code of ethics can be requested in its entirety if desired. Ethical problems may be reported to the director of ATS and/or the licensing boards on the professional's *Statement of Professional Disclosure*. Initial \_\_\_\_\_

#### Patient Rights:

Patients under 18 years of age and their parents/guardians should be aware that the law may allow parents to examine their child's clinical records. Due to the importance of privacy in the field of counseling, ATS may request an agreement from the parents that they consent to give up their access to their child's records. If they agree, ATS will provide them only with general information regarding the progress of their child and a summary of the treatment when completed. Any other communication will require the child's authorization, unless ATS professionals feel that the child is in danger or is a danger to someone else, in which case, ATS professionals will notify the parents of such concern. Before giving parents any information, ATS staff will discuss the matter with the child, if possible, and do their best to handle any objections he/she may have. Initial \_\_\_\_\_

#### Client's Rights:

- ✓ Each consumer shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.
- ✓ Each consumer has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.
- ✓ No consumer shall be neglected or sexually, physically, verbally, or otherwise abused.
- ✓ Each consumer shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A consumer shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those consumers adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. If the consumer permits, family shall be involved.
- ✓ Every consumer's record shall be treated in a confidential manner.
- ✓ No consumer shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the consumer.
- ✓ A consumer shall have the right to assert grievances with respect to an alleged infringement on his or her rights.
- ✓ Each consumer has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.
- ✓ No consumer shall be retaliated against or subjected to any adverse change of conditions or treatment because the consumer asserted his or her rights.
- ✓ The full Bill of Rights will be provided upon request.
- ✓ Receive services and/or referrals that meet your needs and have the opportunity to participate in your own treatment plan
- ✓ Have an attorney and/or physician review the records with due notice at ATS with appropriate releases signed
- ✓ Receive an explanation if ATS refuses to provide services
- ✓ Receive written information regarding fees, policies, and clinician training
- ✓ Client has the right for a full copy of client bill of rights (Chapter 15) upon request Initial \_\_\_\_\_

#### Right to accounting of disclosure:

You have a right to receive a list of all times that ATS professionals have shared your information for purposes other than treatment, payment, healthcare operations, and specified exceptions. You should also be aware that your contract with your health insurance company requires that ATS professionals provide it with information relevant to the services that are provided for you. ATS professionals are required to provide clinical diagnosis. Therefore, sometimes ATS is required to provide additional clinical information. In such situations, ATS will make every effort to release only the minimum information about you that is necessary for the purpose request. By signing this agreement, you agree that ATS can provide requested information to your insurance carrier. Initial \_\_\_\_\_

**If you have a complaint:**

Anyone who receives services here, and/or anyone interested in the welfare of a client, may make a formal complaint about rules, policies, actions and/or decisions made or allowed by ATS. **REMEMBER: Such complaints and/or actions will be kept confidential.** You may ask for a complaint form from any ATS staff member. Please complete the form and return it to our office within five business days (when possible) of the incident. The grievance coordinator is Rebecca Livesay. You may request assistance from any professional and/or other person in getting or filling out the form. If anyone attempts to stop you from making a complaint, please contact the director or an ATS staff member. Any complaint filed will **not** result in retaliation and/or refusal of services. You may also contact the Oklahoma Department of Mental Health and Substance Abuse Services **Consumer Advocacy Division:** by email [advocacydivision@odmhsas.org](mailto:advocacydivision@odmhsas.org) or by phone toll free 1-866-699-6605 or Local 405-521-4256 **Initial \_\_\_\_\_**

**Contacting us:**

Our office is generally open from 8:30am -5:30pm Monday – Friday. It should be noted that ATS professionals provide extended service hours in the evenings to ensure that the needs of our clients are met. Occasionally, training, holidays, and/or other activities may alter this schedule. In order to contact us, please call and leave a message. We also have an answering machine that is available after hours. Our staff checks their messages frequently and returns phone calls at their earliest convenience. **If you have an emergency, please contact the nearest emergency room.** **Initial \_\_\_\_\_**

**Appointments:**

Appointments are scheduled to fit your need as much as ATS is able. Please give at least **24 hour** notice if you have to cancel an appointment. You may call and leave a message pertaining to such on our answering machine if calling after regular office hours. Your regular appointment time will not be held for you if you miss a session without canceling. If you and/or your child are sick please cancel your appointment in order to protect the health of all other ATS clients and/ or providers. ATS staff will cancel appointments if they are ill as well. You should also know that it is ATS policy to charge the full session fee if you have not canceled your appointment prior to your scheduled time. Exceptions may be made in unusual circumstances. **Initial \_\_\_\_\_**

**Fees:**

ATS is a for-profit organization, and payment is expected at the time of service is expected, this includes your co-pay (unless other arrangements are made). The fees for services vary depending on the provider and the type of services rendered. Our office is able to accept most insurance and we will help you determine your co-pay and deductible. A late fee of \$25 per month will be charged for all accounts not current. **Initial \_\_\_\_\_**

**HIV/STD/AIDS Education:**

Per Oklahoma Department of Mental Health standards, ATS will provide educational sessions regarding HIV/STD/AIDS to client's and the significant others of the client. Services or referrals for HIV/STD/AIDS testing and counseling will be provided if requested for the client and or significant other. This information will be reviewed at each treatment plan review.

**If you have any questions and/or concerns Please contact:**

Rebecca Kroeker MHR, LPC  
Owner/Program Director 580-242-4673

**I have read and received a copy of ATS Privacy Policy.**

\_\_\_\_\_  
**Client/Guardian Signature** **Date**

**I voluntarily agree to take part in counseling and/or evaluation at ATS/Focus Institute.**

\_\_\_\_\_  
**Client/Guardian Signature** **Date**