# Emergency Contact Information

**John Davis, LMHC**
**Licensed Mental Health Counselor**

**Patient's Name:**_____Date___/___/____

**In any emergency regarding your participation here, the person below will be contacted:**

**Emergency Contact's Information**

Name of emergency contact: _____

Relationship to patient : _____

Contact's Cell Phone: _____

**I understand that the person listed above will only be contacted for reasons that are emergencies deemed mandatory by my therapist, especially including failure to appear for a scheduled appointment without notifying John Davis, LMHC 48 hours in advance.**

**We have discussed and I understand emergency contacts are made in regard to my immediate health and/or threat, actual or perceived, to my life. I hereby give John Davis, LMHC permission to contact this person.**

_____ Signature

***Please understand our policy:***

***Non-emergency late cancellations 48 hours or less will be billed***

;

# Financial and Confidentiality Contract

with

**John Davis, LMHC**
**Licensed Mental Health Counselor**

**Name** _____ **email** _____

**Date of Birth**____/_____/____ **Patient Cell phone** _____**text? Yes/No**

**Address** _____

_____

**CONFIDENTIALITY:**
Please be aware that under the provisions of confidentiality between Mental Health Providers and their clients, **JOHN DAVIS, LMHC** and/or personnel will not be able to speak to anyone regarding your case without written consent. You may request a consent form at any time.

There are, however, specific limitations to client confidentiality: in the event of a suspected case of ***abuse/neglect of children or the elderly, or the commission of a felony***, I am required by law to make a report to the authorities. Furthermore, as required by law, when a ***client voices suicidal or homicidal thoughts***, **JOHN DAVIS, LMHC** personnel are required to take necessary steps towards protecting the client or the target of the homicidal ideation's. **JOHN DAVIS, LMHC** personnel are also required by law to respond to subpoenas. Also, should I be required to collect fees from you, you will forfeit all your rights to confidentiality under this agreement.

_____ _____
Signature Date

**FINANCIAL RESPONSIBILITY:**
I accept complete financial responsibility for any and all fees incurred by myself or my family members for services provided by **JOHN DAVIS, LMHC**. Unless otherwise discussed, payment of fees will be made at the start of each visit. Should payments made not fully cover the cost of contracted services, I agree to guarantee payment in full.

_____ _____
Signature Date

# Fee Disclosure

**John Davis, LMHC**
**Licensed Mental Health Counselor**

**** Sorry, but we don't accept insurance****

***Regular 45-50 min individual counseling sessions are $150.00 each***

_____

**Payment is due at each session. We do not carry unpaid balances. We prefer cash and local checks. Credit cards are welcome when necessary.**

**Therapy sessions are approximately 45-50 minutes including scheduling and payment.**

***We prefer to protect the confidentiality of our clients, and direct their course of treatment without interference. We do not accept insurance as a direct form of payment. Please request a coded receipt if needed at the time of your appointment.***

Patient's Signature_____ _____ _____ _____ **Date**

***Please understand our firm policy:***

***Non-emergency late cancellations 48 hours or less will be billed***

HIPPA DISCLOSURES
Notice of Privacy Practices
in regard to the
# Health Insurance Portability and Accountability Act

I understand and agree that the HIPAA document regarding the privacy of my personal health information is prominently displayed for me to read at any time in this office. I am aware that I can control how my personal health information is distributed at any time. I understand that personal health information means my name, address, phone number, health history from this office, symptoms, diagnosis, treatment, progress in treatment, prognosis, and any specifically pertinent information. I understand that I can make adjustments or complaints to John Davis at any time regarding these HIPAA policies and my restrictions.

I agree and understand that this office will not disclose any of my personal health information without first getting specific written consent from me, unless there is an emergency, that is a threat to my life or, if I threaten the lives and well being of others, or other specifically listed reasons. In such an emergency my PHI will be disclosed immediately to protect my life or that of others, or for stated reasons listed in the extensive HIPAA document.

*John Davis, LMHC does not:*
use my personal health information for directory purposes, for research without specific prior consent from me nor transmit my personal health information electronically.

I understand and agree that John Davis' consultation with other specialists regarding my care is an important part of receiving the best treatment and that personally identifying information will not be divulged during consultation. By signing below I give permission for my case to be part of consultation case review, when needed, at John Davis' discretion.

Notice of Privacy Practices
in regard to the
Health Insurance Portability and Accountability Act

This office is required by law to provide you with a notice that explains privacy practices with regard to your protected health information,

How it may be used and/or disclosed for your treatment, Payments, Other health related procedures, as well as, Purposes that are permitted and/or required by law. You have certain rights regarding the privacy of your protected health information.

Listed here are examples of how this office may divulge your protected health information.

All of the ways your health information might be divulged by this office fall within one of these categories but the example given may not be exhaustively specific to your particular case.

These are Examples:

Treatment:

This office will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. Your health information will also be disclosed to other physicians who may be treating you. Additionally your health information may also be disclosed to a physician whom you have been referred to by this office, or who has been requested to be involved in your care by this office. For example, your protected health information will be disclosed to any specialist to whom you have been referred for a diagnosis or care to help with our treatment.

Payment;

This office will use and disclose your protected health information, and other information you give, to obtain payment for the services we provide to you. Regardless of your objections, for example, information may be included with a bill to any third party payer, that identifies you, your diagnosis, procedures performed, and supplies used. Your information will be divulged to any legal entity required to obtain payment for service given for which you do not pay. Your information will be divulged to others, to obtain payment you owe, if you default on any payments accidentally or purposefully.

Health Care Operations;

Your protected health information will be used and disclosed to help support the business activities of this office. For example, this office could use your information to evaluate and review the services and treatment performance given while caring for you. In addition, your information may be disclosed to third party business associates who perform billing, consulting, and or transcription services for this office.

Appointment Reminder;

This office will use and disclose your protected health information to contact you as a reminder about appointments. Example: A message will be left on your answering machine or voice mail system regarding appointments, especially if an appointment is missed by you. The message will state that you

have an appointment or missed an appointment, and if one has been missed, that there is concern for your well-being. A reminder may be sent to you by mail.

Treatment or Therapy alternatives:

Notices will be mailed to you from this office letting you know when a new group or therapy that may interest you is available. Example: This office will use your information to mail announcements and other information to you regarding therapy alternatives.

Others Involved in Your Care:

This office will use and disclose your personal health information to a family member, a relative, a close friend, or any person whom you have identified as involved in your care or payment for care. Example: if you have a spouse or parent, or a partner who is involved in your care this office will contact that person for payments you do not make or if situations deemed as emergencies arise involving your care.

Research:

This office will not use your personal health information for research without your express permission in writing.

As Required By Law:

This office will use and disclose your personal health information as required by federal, state, or local laws. You will be notified of any such disclosure.

To Avert A Serious Threat to Public Health:

This office will use and disclose your personal health information to public health authorities that are permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed to by that authority this office will also disclose your personal health information to a foreign agency that is collaborating with the public health authority.

Workers Compensation:

This office will use and disclose your personal health information for workers compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates:

This office will use and disclose your personal health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement officials. Example: this information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security or the correctional institution.

Your Health Information RIGHTS

Although your health record is the physical property of the health care practitioner, John Davis, or the facility that compiled your record, the information belongs to you. You have the right to:

A Paper Copy of This Notice:

You have the right to this paper copy of this notice to you concerning what we can and will do and your rights regarding your records. Your copy is available upon request.

Inspect and Copy:

You have to right to inspect and copy the protected health information that is kept in your file, maintained by this office about you, for as long as we keep that record. This designated record set includes any medical records you provide for us, any billing records we keep, and any paper copies of material new use to make decisions about you and your care. Psychotherapy notes, kept by this office, other therapists you have seen, or other therapists you are treated by here, are not part of this file, are not kept with your record and are not available for you to inspect or copy as part of your record according to law. This office will charge a fee for any copies requested from your file or record.

If you wish to copy or inspect your record you must make that request in writing to this office prior to your request being granted. This office has 30 days in which to respond to your request for information that is kept on this office site. If the information you request is kept offsite, this office is allowed 60 days to respond to your request by law, but we must inform you of that delay.

Amendment:

You have the right to request that we amend your personal health information kept in our files if you feel that the information is incomplete or inaccurate. You must make this request in writing and must state exactly what is incomplete or inaccurate and the reasoning that supports your request for changes. We can deny your request if those rules are not met or if:

We did not create the information here (it was created by another office), or if the person who originally created the information at this office is not longer available to agree that the change is warranted.

The information is not part of the record, which you are allowed to inspect or copy.

The information is not part of the record kept by this office.

Or if the practitioner, John Davis, or other designated therapists, at this office who cared for you, feel the information is accurate and complete.

Request Restrictions:

You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. For example: you may request that we not disclose information about your prior treatment procedures (hypnosis for example) to a family member or friend who may be responsible for your care or payment for care. Your request must be made in writing.

This office is not required to honor or agree with your request if it is in your best interest to use or disclose the information. However, this office will grant your request if there is agreement with you and there is no emergency involved.

Accounting of Disclosures:

You have the right to request an accounting of all disclosures of your personal health information made by this office, outside of this office that are not for treatment, payment or health care operations. Your request must be made in writing to this office and must state the time and period for which you are requesting information. You may not request any information prior to April 14th , 2003 when the law was instated, nor for periods greater than 6 years from the date of the request letter.

Your first request for a disclosure statement within a 12-month period will be free. Any other request for disclosure during any 12-month period will incur an expense to you. You will be informed of this expense prior to incurring it and have the right to withdraw your request without charges.

Confidential Communication:

You have the right to request that communication with you be confidential to preserve your right to privacy. Example: you may request that you be called only at a designated number, only at a designated address, or POBox. Your request for these must be made in writing. You are given the opportunity to do that in the forms you sign today related to these laws. All reasonable requests will be accommodated whenever possible.

Filing a Complaint:

If you believe we have violated your medical information privacy rights you may file a complaint, within 180 days of the suspected violation, directly to John Davis or the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. John Davis will make every effort to reduce your concerns regarding any activity you find objectionable.

Uses or Disclosures Not Covered:

Uses or disclosures of your personal health information not covered by this notice or the law that apply to us may only be made with your consent, verbally and in writing. You may revoke any verbal and written consent in writing at any time and this office will no longer disclose health information about you for the reasons stated in your previously written authorization. However, disclosure already made in reliance of the original authorization to release information are not affected by your revocation.

***I understand and agree that this provider will use all reasonable efforts to honor the requests made and that there may be instances when my Personal Health Information may be released regardless of these stated restrictions.*

Name_____

Signature_____Date _____