Andrea Vargas LMHC
Child & Adolescent Counseling

CHILD INFORMATION FORM

Today's Date: _____

Child/Adolescent First Name: _____ Middle Initial: _____ Last Name:_____

Preferred Name or Nickname: _____ Date of Birth: _____ Age: _____ Sex:_____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Referred by:_____ Reason for Referral: _____

Who is/are the child's Legal Guardian(s): _____

Mother's Name:	Father's Name:
Check if Same as Child: ___ Home Address: _____ City: _____ State:___ Zip Code:_____ May I send correspondence to this address: Y N Mailing Address (if different):_____ City: _____ State:___ Zip Code:____	Check if Same as Child: ___ Home Address: _____ City: _____ State:___ Zip Code:_____ May I send correspondence to this address: Y N Mailing Address (if different): _____ City: _____ State:___ Zip Code:____
Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____ ext: _____ Email: _____ May I reach you at all of the above numbers/email? Y If No please specify:_____	Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____ ext: _____ Email: _____ May I reach you at all of the above numbers/email? Y If No please specify:_____
Mother's Occupation: _____ Place of Employment: _____	Father's Occupation: _____ Place of Employment: _____
Current Marital Status: Married ____ Divorced: _____ Single: _____ Separated:_____ Widowed: _____	Current Marital Status: Married ____ Divorced: _____ Single: _____ Separated:_____ Widowed: _____

***As a courtesy I offer the option of appointment reminders by email, text or landline phone message. These messages are delivered 48 hours in advance. These serve as reminders only. Please also be sure to note your appointments in your own personal schedule and/or calendar.**

Would you like to receive optional courtesy reminders? Y N Requested Method: ___email ____text message or ___landline phone message	Would you like to receive optional courtesy reminders? Y N Requested Method: ___email ____text message or ___landline phone message

EMERGENCY CONTACT

Name: _____ Relation to child: _____Phone ( ) _____

Name: _____ Relation to child: _____Phone ( ) _____

9843 Executive Park Drive, Suite 104, Weston, Florida 33331 Phone (954) 258-5788 Fax (954) 258-5789

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FINANCIAL INFORMATION

FINANCIALLY RESPONSIBLE PERSON INFORMATION

Name: _____ Relation to child: _____

Soc Sec #_____ - ____ - _____ Phone: ( ) _____

Address: _____City: _____ State: _____ Zip Code: _____

Email Address: _____

*Statements will be sent to the above addresses.

INSURANCE INFORMATION

Primary Insurance Company:_____Policy/Member #:_____

Subscriber Name: _____Date of Birth: _____ Relation to Child:_____

Group#: _____Policy Effective Date: _____Co-pay: _____Deductible: _____

Employee Assistance Program (EAP): _____ Phone: _____

Initial Authorization #: _____ Number of Sessions Authorized: _____

Effective Date: _____ Expiration Date: _____

Secondary Insurance Company:_____Policy/Member #:_____

Subscriber Name: _____Date of Birth: _____ Relation to Child:_____

Group#: _____Policy Effective Date: _____Co-pay: _____Deductible: _____

I hereby authorize the release of information necessary to file a claim with the above insurance company, including electronically and assign benefits to Andrea Vargas LMHC PL. If a problem occurs with the insurance company regarding payment for services, I am responsible for payment of the services rendered. (Please refer to SERVICE FOR FEE Agreement). I understand that I am responsible for follow-ups with the insurance company.

Signature: _____ Date: _____

Parent/Guardian Name:_____

Signature: _____ Date: _____

Parent/Guardian Name:_____

Child's Name:_____

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INFORMED CONSENT AND AGREEMENT TO COUNSELING SERVICES

Please read thoroughly, make a note of any questions you may have. Please call me directly to discuss any and all questions you have prior to providing electronic signature to this agreement.
After you sign this agreement electronically you will be able to save/and or print for your records.
A copy of this signed agreement will be stored in a highly confidential, HIPPA compliant encrypted, electronic cloud storage system along with the rest of your child's clinical file.

You may choose to print off this document, fill it out by hand and bring a hardcopy of this to your child's first session instead of submitting electronically.

Andrea Vargas LMHC PL is limited liability company in the state of Florida located at 2863 Executive Park Drive Suite 106 Weston, Florida 33331 providing psychotherapy and professional counseling services for children, adolescents and their families as well as young adults.

Andrea Vargas LMHC is fully licensed in the state of Florida and participates in peer consultation as well as ongoing continuing education.

Benefits of Counseling

Depressed mood can be lifted, managed and alleviated. Anxieties can be managed, mastered and alleviated. Through talk (or for children play) difficult feelings can naturally be resolved. Skills in relationships and communication improve. Develop and maintain a sense of balance in life, a sense of contentment, satisfaction and skills for coping life's challenges. Clarity of direction in and sense of self develops. Experiences of relaxation and relief from mental and physical tension

Risks of Counseling

Occasional uncomfortable levels of sadness, guilt, anxiety, frustration, loneliness, helplessness or other negative feelings as a part of the process of healing and finding balance. Often symptoms worsen before improving. Unpleasant memories may be recalled through the process. Significant others in one's life may have their own objections or negative reactions to a client's positive changes.

Overall, the benefits greatly outweigh the risks. When you and your therapist are both committed to the process of counseling, with understanding therapy is not a ''quick fix'', transformational results are often observed.

Confidentiality

In all but a few situations, your confidentiality and privacy is protected by state law and by the ethical rules of our profession. There are some exceptions as follows:

Limits to Confidentiality:

1. If your child makes a serious threat to harm themselves, the law requires us to try to protect your child by informing appropriate officials
2. If I have reason to believe a child or any adult dependent has been or will be abused or neglected, we are legally required to report this to the proper authorities.
3. If you child is or will be involved in court proceedings and the clinical record is subpoenaed and ordered by a judge.
4. If a guardian ad litem (GAL) is appointed in a custody case involving child clients and she/he is

ordered by the court to have access to mental health practitioners and records therein.
5. The Patriot Act of 2001 requires us in certain circumstances, to provide federal law agents with records, papers and documents upon request and prohibits us from disclosing to my client that the FBI sought or obtained the items under the Act.
6. In professional supervision or consultation with other therapists and/or business associates; shared office space, record storage and voicemail system with a fellow therapist. Professional peers, business associates, fellow therapists are bound by confidentiality as well.
7. As a professional I sometimes need to consult with a professional peer on the services we are providing you in order to ensure your child is receiving the best services possible. This may include details of your child's case and in this age of electronic technology it may mean that this information is shared via cell phone conversations. All professional peers are bound by the same legal and ethical rules of confidentiality. We do not disclose your name or identifying information unless it is a case of imminent emergency and/or involves DCF/CPS.
8. Tele-health including electronic communications include limitations of your confidentiality. Email, texting and cellphone communications cannot be guaranteed confidential. These means of electronic communication are considered "non-secure." (See section on Tele-health)
9. In the case of death or incapacitation, all clients will be contacted and records will be accessed by designated mental health professional who will ensure confidentiality.
10. In the case we need to collect unpaid payments, a collection agency may be utilized.

TELEHEALTH and Your Confidentiality

In this age of electronic communication we are required to be very clear with our clients as to the nature of the risks and benefits of "telehealth." Any time you and we communicate in a way that cannot be guaranteed as secure in maintaining your confidentiality, there is a risk involved. There are limits to your confidentiality when participating in any form of "telehealth."

Tele-health is defined by the U.S. Department of Health and Human Services as:
The use of electronic information and telecommunications technologies to support distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

In order to make every effort to keep secure the confidentiality of your Private Health Information please note the following specific policies:

EMAIL POLICY:
Use of email should be for scheduling payment issues only whenever possible. You may email us about anything you wish but please understand that by doing so you are accepting the risk and limit of your confidentiality by using email.

If you wish to use email as part of your counseling, you may utilize www.hushmail.com as they have an encryption process. Discuss this with your therapist first. There is a charge for time spent reading emails that goes beyond brief exchanges about scheduling and payment issues. Please see fee outlines.

TEXTING POLICY: Texting ideally should be used for brief notification regarding scheduling or notification of running late for appointment. Therapists' phones are protected with passwords but texts may show up when the screen is locked which may be a breach of your confidentiality. If you choose to use texting to communicate sensitive information you do so with full knowledge and acceptance that this is a risk and limit of your confidentiality. I do not participate in therapeutic discussions with clients via text messaging.

PHONE POLICY: Cell phone communications cannot be guaranteed as a confidential form of communication. The only method HIPAA acknowledges as a secure way to have a phone conversation is when both parties are talking on a landline phone that is hard wired from hand- set to wall. In this day and age, we would all be hard pressed to find way to have that kind of phone conversation. We do utilize cell phone technology as most of my clients do as well. I make every effort to ensure our phone conversations are held confidential within our ability to do so. When we have a conversation via cell phone you are acknowledging and accepting the risk and limits of your confidentiality. If you don't wish to take this risk, we advise you only use phone communication to schedule an appointment in person to discuss sensitive information as part of your Private Health Information.

VOICEMAIL POLICY: Per the above policy with regard to cell phone use, please be informed that our voicemail systems are housed on cellular basis and cannot be guaranteed confidential although we take every measure to protect your confidentiality. It is advised that you not leave sensitive information on voicemail, rather utilize voicemail to request a return call and/or to schedule an in-person appointment. Voicemail is password protected and secure to the best of ability. Voicemail is checked throughout the week unless on vacation or out of country for any reason. I am accessible Monday-Friday during normal business hours (9 a.m. to 6 p.m.) and I make every attempt to return all calls within the same business day if possible. When not possible I return all calls within 3 business days maximum. I am not available when in session with other clients. When away from the office for vacation or business travel and unable to access voicemail and/or email I will notify you in advance and will designate a professional counselor colleague to be on call in case of urgent and emergency issues.

SOCIAL MEDIA POLICY: In order to protect your confidentiality and in line with our professional ethics I cannot accept friend or connection requests from clients on any social media platform. You may follow social media accounts that are open to the public but please do not comment or in any way identify yourself or your child as my client. If you do you are accepting the risk of breach of your confidentiality and if we notice you have commented on any public post, your comments will be deleted.

PEER CONSULTATION: As a mental health counselor I sometimes need to consult with a professional peer on the services I am providing you in order to ensure you are receiving the best services possible. This may include details of your case and in this age of electronic technology it may mean that this information is shared via cell phone conversations. All professional peers are bound by the same legal and ethical rules of confidentiality. I do not disclose your name or identifying information unless it is a case of imminent emergency and/or involves Department of Child and Families/Child Protective Services

PUBLIC/SOCIAL INTERACTION POLICY: In the case we cross paths in a public setting, in order to protect the confidentiality of our therapeutic relationship it is my policy not to approach you or initiate contact with you or your child. Your child's right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize this privacy. However, if you or your child, acknowledge me first, I will be more than happy to say a quick hello but keep in mind it is not appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

POLICY on CONFIDENTIALITY FOR CHILD CLIENTS: In working with child clients, though legally the parent(s) or legal guardian(s) of child clients age appropriate privacy is essential relationship and setting for a child's therapy, we do honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians summaries of treatment goals, plan and progress as well as recommendations.

SCHEDULING AND CANCELLATIONS POLICY: (please also refer to Fee for Services Agreement):
I require 24 hours texted or emailed notice of cancellation of any appointment.

If a client does not arrive for a scheduled appointment or cancels inside of 24 hours, there will a charge for the session. (Please see attached Fee for Services Agreement for full explanation). On rare occasion, if there is what is determined to be an unavoidable emergency we made discuss this and I may consider waiving the fee.

Session parameters:
All initial Intake Sessions are 60-90 minutes.
Individual therapy sessions are 50 minutes.
Family counseling sessions are 60 minutes.
Tele-Mental Health Sessions are 50 minutes.
Sessions will start and end on time.

**If you arrive late, the session will be shorter as we do end at the scheduled time. **

VACATION/TRAVEL POLICY: When away from the office for vacation or business travel and unable to access voicemail and/or email I will notify you in advance and will designate a professional counselor colleague to be on call in case of urgent and emergency issues.

AFTERHOURS AND EMERGENCY SUPPORT:
Andrea Vargas LMHC PL is not an emergency service. I do not provide emergency services.

If you have a life threatening emergency you should call 911 or go to the hospital emergency room of your choice. Only contact us in an emergency after you have already obtained emergency assistance from 911 or your choice of medical support.

POLICY on CONFIDENTIALITY WITH MINORS: parents may be legally entitled to some information about your child's therapy. I will discuss with you and your child what information is appropriate for you to receive and which issues are more appropriately kept confidential.

POLICIES ON SEPARATION/DIVORCE AND/OR CUSTODY CASES: I am not a custody evaluator and cannot make any recommendations on custody. I can refer you to a licensed professional who DOES provide custody evaluation if needed.

Due to the sensitive nature of divorce and all potential issues that may arise in such cases, I have very specific policies to which you must agree before we enter a counseling relationship:

1. I require a copy of any most current standing court order demonstrating the custodial rights of each parent and/or the parenting agreement that is signed by both parents and the judge at the first intake session.

2. I may provide an interview with any court-ordered Guardian Ad Litem (GAL) and/or custody evaluator (CE) whom the court has ordered will have access to the child's records and any time spent speaking with the GAL or CE will be billed to and paid by you at my Court-Related-Fee hourly rate.

3. I will be in equal contact with both parents who share in the legal custody of the child being seen for counseling and will offer and encourage opportunities for both parents to participate in parent consultations along the way. In order for your child to have confidence and trust in me, and therapy with me, it is necessary that I have a positive, trusting relationship with both parents. In addition, the great success in therapy exists because I create a safe and neutral space for the child, away from the conflict of divorce or separation. To build this environment, I maintain absolute neutrality with both parents. I will not involve myself in conflicts between parents, and will not engage in negative, unproductive conversation about one parent about the other.

4. Confidentiality exists between, myself, and my client (the child) but not between myself, and the parents. All information given to me by one parent about the child (concerns, questions, input into therapy goals etc.) will be shared openly with the other parent. This is done to promote open and healthy communication, so that all parties know I do not take sides, nor keep secrets for one side or the other. If I believe one parent is engaging in negative, hostile, unproductive communication about the other parent, I will redirect the conversation to promote the healthiest conversation.

5. Family sessions may be recommended and depending on the case, may need to see the child with each parent separately along with siblings and/or other significant family members who live in the homes where the child lives.

6. I require all clients waive right to subpoena me to court. By signing this Agreement you are acknowledging and agreeing NOT to have subpoenaed to court. This policy is put in order to protect the integrity of my relationship with both parents as is necessary to promote the greatest success in therapy with your child. There are exceptions to this and we can discuss further should the issue arise and this policy needs to be waived.

7. In the case the above policy regarding subpoenas and court is waived (or disregarded) and I am subpoenaed to appear in court—even with a waiver of this policy—you will be billed for the full standard fee for Court-Related-Fee rate of $200/hour for all professional time. Any time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the Guardian Ad Litem in connection with the court appearance and any time spent waiting at the courthouse in addition to time on the stand as well as any travel time will be billed at $200 per hour.

FEES, PAYMENT, INSURANCE:

Every effort is made to secure payment or reimbursement for your child's sessions. Please understand that you (responsible party named above) are financially responsible in the event that the health insurance company does not cover all or part of the child's service fees, including co-pays or deductibles. Please keep in mind that I may contact the insurance company to verify benefits however their disclaimer to me is "*verifying benefits does not guarantee payment".* Therefore, you are responsible for understanding coverage and for knowing when the limits of the coverage are being exceeded.

If I am not in-network with your insurance company, I cannot communicate directly with the insurance company. I can however provide a statement for you to file with your insurance company for out of network reimbursement upon request. You are responsible for keeping track of your session statements and filing with your insurance.

You are responsible for keeping track of your session statements and filing with your insurance.

Returned check fee: There is a $25 fee for any returned checks. That fee is due at the time of your next session, along with the payment for that session. If a check is returned for insufficient funds, we will require that you pay using cash or credit card only from that point forward.

Forms of payment: All Major Credit Cards are welcomed. Cash is welcome as well. A receipt is available to you upon request. Checks are made payable to Andrea Vargas LMHC.

Payment is due at the beginning of each session. If a child client is being seen, please be discreet in submitting payment and I ask that you never have the child involved in the payment process.

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Standard Fee Structure is outlined below.

Initial Intake Session (60-90 minutes): $ 200

Family Therapy Sessions (60 minutes long): $ 150

Individual Therapy Sessions (45-50 minutes): $125

Individual Therapy Sessions lasting longer than 50 minutes: $175

Tele-Mental Health Sessions (50 minutes): $100

* TELE-MENTAL HEALTH REQUIRES A SEPARATE CONSENT FORM

Professional Fees:

I charge $175 per hour for any other professional feels you may need. I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations or reading/responding to emails, lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries and time spent performing any other professional service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all my professional time, including preparation and transportation costs, even in I am called to testify by another party. Because of the difficulty of legal involvement, my professional fees for participation in legal proceedings are different:

Court Related Cases: $300/hour of any and all time spent on the case.

YOUR CLINICAL RECORD:
You should be aware that, pursuant to HIPAA, we keep information about all of clients in a collection of professional records. This constitutes your child's Clinical Record. I store your child's clinical record in a HIPAA compliant electronic cloud storage location.

TERMINATION:
Ending relationships can be difficult for children. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with parents and child and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.
Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

COMPLAINTS OR GRIEVANCES: If you feel that there is basis for a formal complaint or grievance about anything related to the professional services I provide I request you to first communicate your concerns to me directly so that I am informed and have an opportunity to respond and resolve any potential misunderstanding. You have a right to file a complain about me and may do so by contacting the Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling at STATE OF FLORIDA DEPARTMENT OF HEALTH Phone: 850-245-4339 http://www.floridahealth.gov/

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FEE FOR SERVICES AGREEMENT:

Please note, your entire record including this form will be stored on HIPAA compliant electronic server

Every time I _____schedule an appointment for my child _____ with his/her therapist I understand that I am entering into a contract with ANDREA VARGAS LMHC PL and for the professional time and services of my therapist.

I recognize that professional services include time and services for preparation for my scheduled session, the actual time in session, time spent outside of session with case review, case notes, confidential consultations with professional colleagues as outlined above.

I understand my therapist's professional fees as outlined in our Agreement to Enter into Counseling Services for scheduled sessions. I understand I have a right to request information about reduced fee options at any time.

I understand that ANDREA VARGAS LMHC PL has a cancellation policy requiring no less than 24 hours advance notice in order to be released from the contract for my therapist's time and services of preparation for my session.

I understand and agree that if I fail to cancel my appointment inside of the 24-hour minimum time period prior to my session I will be charged a full session fee $115 for the appointment. Please note insurance companies will not pay for sessions that you miss and it would fraudulent for me to submit claim for these.

I hereby authorize ANDREA VARGAS LMHC PL to charge my credit card for any missed sessions or unpaid charges per this contract. I understand my credit card will be stored in a triple encrypted merchant services system for my protection.

I understand if there is an emergency situation that prohibits me from canceling within 24 hours I can discuss this with my therapist directly and request a waiver of this policy but I understand that ANDREA VARGAS LMHC is not bound to grant that waiver and may, by this contract, proceed with charging my credit card as agreed herein.

I understand if payment is not made before or during my scheduled session I am hereby authorizing ANDREA VARGAS LMHC PL to charge my afore-listed credit card for services rendered.

I understand this agreement authorizes ANDREA VARGAS LMHC PL to charge my credit card for services requested and rendered outside of the office such as email and phone consultations, preparation of documents requested by me or any court related proceedings.

I, _____, authorize, Andrea Vargas LMHC, to charge my: M/C Visa Discover Amex.

Account #_____ Exp. Date: _____

(Security Number on the back of your card)_____ Zip code: _____

Signature: _____ Date: _____

2863 Executive Park Drive, Suite 106, Weston, Florida 33331 Phone (954) 358-5788 Fax (954) 358-5790

Andrea Vargas LMHC
Child & Adolescent Counseling

HIPAA PRIVACY POLICY

PRIVACY PROTECTION NOTICE

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. THIS POLICY IS POSTED ON MY WEBSITE AT WWW.ANDREAVARGASLMHC.COM A PAPER COPY IS AVAILABLE IN MY OFFICE UPON REQUEST FOR YOUR REVIEW AS WELL.

I. Your Rights to Privacy under HIPAA Preamble: Communications between psychotherapists and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. PHI consists of three components: treatment, payment and health care operations. *Treatment* refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, or talking to your primary care physician about your medication or overall medical condition. *Payment* is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you. *Health care operations* are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary." The use of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks within my office related to your care. Disclosures refer to activities you authorize which occur outside my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might by your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so. There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist -client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate form the overall "designated medical record". "Psychotherapy notes" are my notes "recorded in any medium by

a mental health provider documenting and analyzing the contents of a conversation during a counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes.

Most of the time I will be able to limit reviews of your protected health information to only your "designated record set" which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of you care by managed care companies, and any authorization letters or summaries of care you have authorized me to release on your behalf. You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I ensure that all those performing ancillary administrative service for my practice and refers to these people as "Business Associates" sign and enter into a HIPAA compliant Business Associate Agreement so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out "Duty to Warn" Law, national security threats)

V. Client's Rights and My Duties

You have a right to the following:

- The right to request restrictions on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;
- The right to inspect and receive a copy of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- The right to amend material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;

• The right to an accounting of non-authorized disclosures of your protected health information;
• The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
• The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters.
I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI.
I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s).
My duties as a Licensed Mental Health Counselor on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified.

VI. Complaints

Andrea Vargas is the appointed "Privacy Officer" for Andrea Vargas LMHC PL per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

HIPAA provides client protections related to the electronic transmission of data (the transaction rule), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules").

HIPAA applies to all health care providers, including mental healthcare, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what client protections HIPAA affords all of us.

In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification. By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document.

Andrea Vargas LMHC
Privacy Officer

I understand and may have access to a copy of the Client Notification of Privacy Rights Document upon request, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters.

Andrea Vargas LMHC
Child & Adolescent Counseling

I understand I have the right to review this document before signing this acknowledgment form.

_____

Client Signature or Parent if Minor Date

_____

Client Signature or Parent if Minor Date

Agreement To Enter into Counseling Services and Abide by Fee Agreement and All Policies Herein

I have read or had read to me all the information in New Client Packet.

I have had a chance to review and ask questions about all and any information in this New Client Packet before signing this agreement.

I have had all questions answered to my satisfaction prior.

I agree to abide by all the policies outlined herein including my full agreement not to have Andrea Vargas LMHC subpoenaed by myself, or any attorney I may employ.

By signing this agreement, I am consenting to treatment, understand all the benefits and risks of counseling as outlined herein. I also hereby acknowledge that I have received and reviewed the HIPAA Privacy Policy notice form mentioned herein.

Signature: _____ Date: _____

Parent/Guardian Name:_____

Signature: _____ Date: _____

Parent/Guardian Name:_____

Child's Name:_____

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