December 2018

Jo Ann Kaminsky, MEd, LPC, ATR-BC, RPT-S
2227 N College
Fayetteville, AR. 72701

Office Policy

Appointments

Your therapy time is reserved for you. Any appointment canceled within 24 11hours notification will result in your being charged a $130. Fee. Obviously, unexpected illness and emergencies sometimes do occur.

Payment of Fees

All fees are payable in full at the end of each therapy session. Payment of fees is your responsibility, not the insurance company's. By special arrangement, you may pay your co-pay at the time of treatment and I will file for the remainder. In either case, you are ultimately responsible for payment of all fees.
If you or your family member is a victim of a crime your bill will be submitted to the Arkansas Crime Victims Reparations Board and you will not be required to pay for services unless your claim is not approved. Your counseling services will begin immediately with the assumption that your case will be approved.
There may be occasions when your insurance company or managed care facility refuses to authorize additional treatment. In such situations we will discuss your ability to pay for therapy on your own and explore options for continuing your treatment. These options may include, but are not limited to, decreasing of treatment, utilizing peer support groups, moving you into a group therapy setting or providing referrals to sliding scale facilities.
Please make all payments payable to Jo Ann Kaminsky. A $15.00 Fee will be assessed for any returned checks. Following the return of two checks for insufficient funds, all subsequent fees will be required to be paid in cash.

Office Information

Please park in the back of the building and come around to the front door where the waiting room is. Handicapped parking is available on either side of the front of the building. "Handicapped" includes wheelchair or walking impairment, sick child in the car while someone walks to the waiting room, new baby in car, etc. There is a ramp for wheel chairs in the front of the building. For your child's safety please do not allow your child to play on the playground unattended.

Confidentiality

Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosures of your records or testimony is required by law you will be responsible for and shall pay the costs involved in producing the records and the therapist's fee for the time involved in giving testimony., travel, and reviewing records.
Discussions between a therapist and a client are confidential. No information

will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: Child abuse, abuse of the elderly or disabled, abuse of patients in mental health facilities, sexual exploitation, child custody cases, suits in which the mental health of a party is in issue, situations where the therapist has a duty to warn or disclose, fee disputes between the therapist and the client, and in a negligence suit brought by the client against the therapist. If you have any questions regarding confidentiality, you should bring them to the attention of Jo Ann Kaminsky when you discuss the matter further. By signing this information and consent form you are giving your consent to the undersigned therapist to share confidential information with all persons giving your mental care services and payment for those services and you are also releasing and holding harmless the undersigned therapist from any departures from your right of confidentiality that may result.

By signing this information and consent form you are further giving your consent to the undersigned therapist to contact any person the therapist deems reasonably necessary to protect you or a third party from harm including but not limited to the following person(s).

Name Address Phone Number

Notice of Privacy Policy- As required by the Federal Regulations

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Policy: This information is provided to you in response to federal regulations that took effect April 14, 2003. These regulations were issued by the Department of Health and Human Services of the U.S. Government in response to a law called "HIPAA" which was passed in 1996. I care about your privacy and will always do whatever is necessary to protect it. These regulations are about the privacy of your health and personal information know in the regulations as "Protected Health Information", or PHI. In the process of providing you with proper counseling care and services, I will collect, use, and share certain information you have provided. This policy explains how I collect and how I use your information. It also describes your rights as they relate to your PHI, and states how I protect the security and confidentiality of your information.

Collecting Information: I can disclose PHI without an authorization from you under these circumstances:

- For treatment purposes, such as to your physician, a hospital, or another therapist who may be involved in treatment.
- For payment purposes, such as to your insurance company or other third party-payer.
- For health-care operations, such as to set-up or confirm appointments, or share your PHI with my employees if they are directly involved in your care or if they otherwise have a business need to know about your PHI.
- To communicate with family members or friends who you designate as being allowed to receive this information.

For public health reporting purposes
In cases of suspected abuse, neglect and domestic violence
To avert a serious threat to health or safety
For health oversight activities
For workers compensation purposes
To business associates- there are times I do business with other organizations called business associates such as answering services, collection agencies, etc. These organizations are required to sign agreements with us to safeguard and protect your PHI.

In all other cases, I will disclose your PHI only upon receipt of a proper authorization signed by you or your legal representative.

Your rights regarding your PHI: Although your PHI is the legal property of Jo Ann Kaminsky. You have certain rights regarding PHI. You have the right to:

Obtain a paper copy of this notice of information practices upon request
Inspect and copy your counseling record
Amend your counseling record
Obtain an accounting of disclosures of your counseling information made in the previous six years
Request a restriction on certain uses and disclosures of your information
Authorize individuals, including family and friends, access to your counseling information as it pertains to treatment, payment and/or health care operations
Revoke your authorization to use or disclose counseling information except to the extent that it has already been disclosed

My responsibilities: I have the following responsibilities regarding your PHI:

Maintain the privacy of your counseling information
Provide you with this notice of my legal duties and privacy practices with respect to information I collect and maintain about you
Abide by the terms of this notice
Notify you if I am unable to agree to a requested restriction

I reserve the right to change my practices and to make new provisions effective for all PHI I maintain.

Should my information practices change, I will prominently post the revised notice in my office and make additional copies available upon request.

I will not use or disclose your counseling information without your authorization, except as described in this notice. I will also discontinue to use or disclose your counseling information after I have received a written revocation of the authorization according to the procedure included in the authorization.

For more information or to report a problem: If you have a question, you may contact me at my office.

If you believe your rights have been violated, you can file a complaint with the office of Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Office of Civil Rights
U.S. Department of Health and Human Services

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200 Independence Avenue, S.W.
Room 509F,HHH Building
Washington, D.C. 20201

Emergencies
You may reach me at (479) 587-1387 (message machine available), or my cell at 479-283-2449.. If you have an emergency and cannot reach me call the Crisis Center, adult Hotline 1-888-274-7472. Teen Hotline 1-800-798-8336. If I should be out of town at any time, I will leave the name and number of another therapist who will be available to you in case of emergency.
Fees
One hour of individual therapy is $ 130.
Frequency of sessions:
Initial goals of treatment, purpose, and techniques used:
I have read, understand, and agree to the policies and conditions of treatment listed above. I consent to treatment by Jo Ann Kaminsky. Should I decide to not undertake treatment by Jo Ann Kaminsky I may contact any of the referrals she provides me or give notice that I decide not to participate in any treatment at this time.

Client Signature_____ Date_____

Therapist Signature_____ Date_____

Parent if client is a minor_____Date_____