Niti Patel, M.S.
1755 Woodstock Road
Roswell, GA 30075
770-910-2753
www.cornerstonefamilyservices.com

Today's Date _____

Client's Name _____ Date of Birth _____

Parent/Guardian's Name (if applicable) _____ Relationship _____

Home Address _____ City _____ Zip Code _____

May I send information to this address? ❑ Yes ❑ No

If No, please provide an address where information can be mailed: _____

_____

Home Phone Number _____

May I contact you at this number? ❑ Yes ❑ No ❑ Disguised ❑ Safe to Leave Voicemail

Cell Phone Number _____

May I contact you at this number? ❑ Yes ❑ No ❑ Disguised ❑ Safe to Leave Voicemail

Work Phone Number _____

May I contact you at this number? ❑ Yes ❑ No ❑ Disguised ❑ Safe to Leave Voicemail

Education Level Completed _____ Occupation _____

Person to notify in case of emergency _____ Phone _____

***I will only contact this person if I believe it is a life or death emergency.***

Please provide your signature to indicate that I may do so: _____

Referred by

_____

Please briefly describe your presenting concern(s):

_____

_____

_____

_____

How many sessions do you anticipate to address these concerns?

1-5 6-10 11-2 20+ I don't know

FAMILY INFORMATION

Are you currently in a relationship? ❑ Yes ❑ No If yes: ❑ Married ❑ Partnered

Length of current relationship? _____ Any previous significant relationships: ❑ Yes ❑ No

Please list all the people that live in your household and your relationship to them:

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Name _____ Relationship _____ Age _____

Occupation _____ Education Completed _____

Please list any family members who do not live in your house, but are important to you:

Name _____Relationship _____ Age _____ Where they live _____

Occupation _____ Education Completed _____

Name _____Relationship _____ Age _____ Where they live _____

Occupation _____ Education Completed _____

Name _____Relationship _____ Age _____ Where they live _____

Occupation _____ Education Completed _____

Name _____Relationship _____ Age _____ Where they live _____

Occupation _____ Education Completed _____

Has anyone in your family, including parents, siblings, grandparents, aunts and uncles ever suffered from the following:

❑ Depression Who? _____

❑ Anxiety Who? _____

❑ ADHD Who? _____

❑ Bipolar Disorder Who? _____

❑ Schizophrenia Who? _____

❑ Other Who/What? _____

MEDICAL HISTORY

Please explain any significant medical problems, symptoms, or illnesses:

_____

_____

_____

*Current Medications:* Please include over-the-counter medications and vitamins

| Name | Indication | Dosage | Frequency | Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

*Past Medications*

| Name | Date(s) | Indication | Dosage | Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do you smoke or use tobacco? ❑ Yes ❑ No If yes, how much per day? _____

Do you consume caffeine? ❑ Yes ❑ No If yes, how much per day? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how per day/week/month? _____

Do you use any illicit drugs? ❑ Yes ❑ No If yes, which? _____

Do you exercise? ❑ Yes ❑ No If yes, how often? _____

PSYCHIATRIC HISTORY

Have you ever talked with a mental health professional before today? ❑ Yes ❑ No

| If yes: Date(s) | Type of Treatment | Reason | Professional Seen |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Would you like me to contact any of your previous providers? ❑ Yes ❑ No

If yes, please provide their contact information _____

_____

_____

LEGAL ISSUES

Have the concerns you have today resulted in any legal issues? ❑ Yes ❑ No

If yes, please describe briefly: _____

_____

Are you currently involved in any lawsuits, custody battles, or other legal battles? ❑ Yes ❑ No

Is therapy part of any court mandated requirement that you are required to complete? ❑ Yes ❑ No

BEHAVIOR CHECKLIST

Please indicate if you have had difficulty with any of the following currently or in the past:

***Mental Health Symptoms:***

| | | | |
|---|---|---|---|
| Anxiety | ❑ Current | ❑ Past | Time of Onset _____ |
| Depression | ❑ Current | ❑ Past | Time of Onset _____ |
| Mood Changes | ❑ Current | ❑ Past | Time of Onset _____ |
| Anger/Temper | ❑ Current | ❑ Past | Time of Onset _____ |
| Panic | ❑ Current | ❑ Past | Time of Onset _____ |
| Fear | ❑ Current | ❑ Past | Time of Onset _____ |
| Irritability | ❑ Current | ❑ Past | Time of Onset _____ |
| Concentration | ❑ Current | ❑ Past | Time of Onset _____ |
| Loss of Memory | ❑ Current | ❑ Past | Time of Onset _____ |
| Excessive Worry | ❑ Current | ❑ Past | Time of Onset _____ |
| Feeling Manic | ❑ Current | ❑ Past | Time of Onset _____ |
| Trusting Others | ❑ Current | ❑ Past | Time of Onset _____ |
| Drug Use | ❑ Current | ❑ Past | Time of Onset _____ |
| Alcohol Use | ❑ Current | ❑ Past | Time of Onset _____ |
| Frequent Vomiting | ❑ Current | ❑ Past | Time of Onset _____ |
| Issues with Eating | ❑ Current | ❑ Past | Time of Onset _____ |
| Severe Weight Gain | ❑ Current | ❑ Past | Time of Onset _____ |
| Severe Weight Loss | ❑ Current | ❑ Past | Time of Onset _____ |
| Sleeping Too Much | ❑ Current | ❑ Past | Time of Onset _____ |
| Sleeping Too Little | ❑ Current | ❑ Past | Time of Onset _____ |
| Insomnia | ❑ Current | ❑ Past | Time of Onset _____ |
| Head Injury | ❑ Current | ❑ Past | Time of Onset _____ |
| Speaking without Thinking | ❑ Current | ❑ Past | Time of Onset _____ |
| Completing Tasks | ❑ Current | ❑ Past | Time of Onset _____ |

| | | | |
|---|---|---|---|
| Waiting your Turn | ❑ Current | ❑ Past | Time of Onset _____ |
| Paying Attention | ❑ Current | ❑ Past | Time of Onset _____ |
| Easily Distracted | ❑ Current | ❑ Past | Time of Onset _____ |
| Making Careless Mistakes | ❑ Current | ❑ Past | Time of Onset _____ |
| Fidgeting | ❑ Current | ❑ Past | Time of Onset _____ |

***Relationships:***

| | | | |
|---|---|---|---|
| With People in General | ❑ Current | ❑ Past | Time of Onset _____ |
| Parents | ❑ Current | ❑ Past | Time of Onset _____ |
| Children | ❑ Current | ❑ Past | Time of Onset _____ |
| Current Relationship | ❑ Current | ❑ Past | Time of Onset _____ |
| Friends | ❑ Current | ❑ Past | Time of Onset _____ |
| Co-Workers | ❑ Current | ❑ Past | Time of Onset _____ |
| Employer | ❑ Current | ❑ Past | Time of Onset _____ |
| Finances | ❑ Current | ❑ Past | Time of Onset _____ |
| Legal Problems | ❑ Current | ❑ Past | Time of Onset _____ |
| Sexual Problems | ❑ Current | ❑ Past | Time of Onset _____ |
| Domestic Violence | ❑ Current | ❑ Past | Time of Onset _____ |
| Homicidal Thoughts | ❑ Current | ❑ Past | Time of Onset _____ |
| Suicidal Thoughts | ❑ Current | ❑ Past | Time of Onset _____ |
| History of Child Abuse | ❑ Current | ❑ Past | Time of Onset _____ |
| History of Sexual Abuse | ❑ Current | ❑ Past | Time of Onset _____ |
| *Other Types of Trauma* | | *Please Explain:* _____ | |

***Physical Symptoms:***

| | | | |
|---|---|---|---|
| Increased Stress | ❑ Current | ❑ Past | Time of Onset _____ |
| Fainting | ❑ Current | ❑ Past | Time of Onset _____ |
| Dizziness | ❑ Current | ❑ Past | Time of Onset _____ |
| Diarrhea | ❑ Current | ❑ Past | Time of Onset _____ |
| Headaches | ❑ Current | ❑ Past | Time of Onset _____ |
| Shortness of Breath | ❑ Current | ❑ Past | Time of Onset _____ |
| Chest Pain | ❑ Current | ❑ Past | Time of Onset _____ |
| Lump in Through | ❑ Current | ❑ Past | Time of Onset _____ |
| Sweating | ❑ Current | ❑ Past | Time of Onset _____ |
| Heart Palpitations | ❑ Current | ❑ Past | Time of Onset _____ |
| Muscle Tension | ❑ Current | ❑ Past | Time of Onset _____ |

| | | | |
|---|---|---|---|
| Pain in Joints | ❑ Current | ❑ Past | Time of Onset _____ |
| Allergies | ❑ Current | ❑ Past | Time of Onset _____ |
| Chills | ❑ Current | ❑ Past | Time of Onset _____ |
| Hot Flashes | ❑ Current | ❑ Past | Time of Onset _____ |

Any additional information that you would like to include: _____

_____

_____

_____

_____

# INFORMED CONSENT

The following document contains important information about the professional services provided by Niti Patel, MS. It was created with the intention to inform you, the client, with details about what to expect from the therapist with reference to her understanding of therapy, confidentiality, emergencies, and several other components within your treatment. Upon your signing this document, you and Niti Patel enter into an agreement which allows her to provide therapeutic services to you.

Therapy is a cooperative and collaborative operation in which both the therapist and the client carry responsibility. To assure that you are Niti can effectively work together in this experience, please *carefully* read the information and sign below.
Any questions you may have can be addressed with Niti.

## BACKGROUD INFORMATION

A Georgia native, Niti Patel relocated back to her home state to practice therapy following the completion of her graduate program. She attended Nova Southeastern University (NSU) in Florida, where in 2018, she earned her Master of Science in Family Therapy. Prior to obtaining her degree at NSU, Niti she attended the University of South Florida (USF). In 2015, Niti graduated with a Bachelor of Science in Behavioral Healthcare with a double major in Psychology from USF. She has been working with men, women, children, couples, and families since 2015 and continues to do so as seeks licensure. Her professional experience includes working with populations dealing with domestic violence, sexual assault, and substance abuse. Niti has also worked with couples and families going through life transitions and clients who are struggling with identity issues. Niti is a post-masters, pre-licensed therapist who is currently contracted with Cornerstone Family Services (CFS) to provide outpatient mental health counseling services under the direction and supervision of Jennifer D. Vann MS, LMFT, owner of Cornerstone Family Services.

## THEORETICAL VIEWS AND CLIENT PARTICIPATION

I believe that our experiences allow us to create unique narratives that tell the stories of our lives. I work *with* clients to rewrite the stories they feel confined to. By helping you redefine your journey through our collaboration, I hope to empower you in finding the answers you need to reach the goals you set for yourself. The distinct narratives shared by each client should be honored, and I will thrive to help you achieve the success you are in search of by creating a safe space to explore solutions that work for you. In sessions, I practice from a systemic, strength-based approach, believing my clients are the expert of their own lives.

## SERVICES PROVIDED

During your first session, I will speak with you about the reasons that you scheduled your first appointment. If you are seeking therapy for your minor child, I will meet with the parent(s)/guardian(s) *alone* for the first session. Finding the right fit for you and your family's treatment is an important part of the therapeutic alliance. Multiple sessions may be required for you and I to determine if I am the therapist best suited to work with you. I encourage you to interview several therapists to find the best fit for you/your family. Each therapy session typically lasts 45-50 minutes. The duration of the therapeutic process varies for each client. Some clients may feel resolution to their concerns in just a few sessions, while others may take years to complete their process.

Please note that when working with children, the therapeutic process typically takes longer and is slower. Children need to feel comfortable with the therapist with whom they are working with, and processing significant issues require high levels of trust and safety.

If at any point there is need for a referral to be made to a therapist who better fits your or your child's needs, I will provide contact information for at least *three* alternative treatment providers. If at any time you wish to stop receiving services from me, I ask that you schedule one final session in order for us to have appropriate closure and to address any remaining needs that you may have.

WORKING WITH CHILDREN

Due to the importance of trust between client and therapist, when the client is a minor child I will offer parents general information about the therapeutic process and overall themes, but not specific details about what information is exchanged during each session. If, at any time, I feel like your child is engaging in risky/dangerous behavior I will immediately inform you of the situation or have your child do so as part of the therapeutic process. My definition of "risky/dangerous behavior" includes but is not limited to: self-harm or suicidal ideation, homicidal threats, threats of running away, any use of hard drugs, prolonged use of soft drugs, and unprotected sex. I will regularly update you on your child's progress and I encourage you to contact me as frequently as you feel is needed. I will not provide you updates after each session, however if you need to speak with me about your child's behavior please call prior to their weekly session or arrange a time to come in and speak with me. It is important that your child feel that my office is a place where they can trust me enough to share the sensitive things that may be underlying the presenting problem. I am sensitive to a parent's needs to be involved in the process and that is why parenting and family sessions are typically a regular occurrence during the treatment process.

RISKS

Given the work required for personal growth and change to occur, therapy may involve some risks. Since therapy involves discussing difficult aspects of life, you may experience uncomfortable feelings or strong reactions. Making and adapting to changes in your life may have a profound impact on you and your relationships as well as challenge long held assumptions or behaviors. Reasonable efforts will be made to discuss the potential impact, positive and negative, that may result from the changes you make in your life as a result of therapy. Please ask questions if you have any concerns. There are no guarantees for successful therapy due to the overall complexity of the process and the multiple variables brought into it by each individual.

CONFIDENTIALITY

*The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPPA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPPAA applies to all heath care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. An explanation of those rights is attached to this document.*

The information you share with me both written (i.e. intake paperwork) and verbally is part of your Protected Health Information (PHI) and is considered confidential. A detailed description of PHI is included with this intake packet. I will not release your information to anyone, including your family and insurance company if you are a legal adult, without written consent.

If you are a minor, it is the legal right of your parents to have access to the information that we discuss in our sessions. I will discuss with each minor client and their parent/guardian the expectations of exchange of information between parent/child, therapist/child, and therapist/parent for their particular situation. It may be imperative to my therapeutic relationship with a child or adolescent not to reveal the information disclosed to me in session to their parents/guardians. Please note that in couple's therapy, I do not agree to keep secrets. Information disclosed in any context may be discussed with either partner. It is important that all parties involved in the therapeutic process are clear on our communication expectations.

All communication between the client and therapist are confidential and will not be disclosed *unless required by law* such as in, but not limited to, the following situations:

a. If I believe that you are a danger to yourself, I will take action to protect your life and assure your health and safety. This means I may reveal your identity to do so.
b. If you threaten serious bodily harm to someone else, I will take action to protect and the assure the health and safety of all those concerned. This means I may reveal your identity to do so.
c. As a mandated reporter, if I suspect the abuse and/or neglect of a child, elder, or vulnerable adult, I am required to file a report with the appropriate state authorities.
d. If I suspect sexual exploitation has been placed upon you by another therapist, I am required to file a report with the appropriate agency.
e. When a judge orders that information be disclosed. I cannot guarantee that an appeal will be upheld, but I will do everything in my power not to disclose your confidential information.
f. When Homeland Security requests information, according to the Patriot Act.

*WAIVE RIGHT TO SUBPOENA*

In order to protect you and the information you and/or your child(ren) provide to me during our sessions I ask each client to waive their right to call me as a witness to court for any reason. The communication that you/your child(ren) provide during session is considered privileged by O.C.G.A. §24-9-21(7) and covers communication provided by "a licensed...marriage and family therapist... during the psychotherapeutic relationship." If you anticipate the need for a therapist's involvement in court activity I will be happy to refer you to someone who is more suited to meet your needs. If, for any reason, I am required to participate in court proceedings my regular hourly fee will be applied from door to door. In addition, I reserve the right to charge for court preparation including case review, report preparation, and legal and ethical review at $75 per hour.

SUPERVISION

Supervision helps to ensure that you and your family are receiving the best of care and that appropriate measures are being taken to ensure that your needs are being met. I have contracted with a State Board approved supervisor to oversee cases on my current caseload. This supervisor is legally bound to all the confidentiality restrictions listed above. Your case may or may not be discussed with a supervisor at some point during your work with me. During supervision I do not disclose names of clients or specific identifying information. If you have any questions about this process you are encouraged to ask them at any point during your time in therapy. My current director and supervisor is Jennifer D. Vann MS, LMFT.

FEES

Clients seen by Niti Patel, M.S. agree to pay $75.00 per 45-50 minute session. Services will be provided by Niti Patel at Cornerstone Family Services, LLC. Any services beyond the standard 45-50 minute session, such as phone consultation exceeding 20 minutes, excessive paperwork, attending school meetings or court appearances/preparation, will incur additional fees as listed above. Niti Patel reserves the right to announce fee increases, which upon effective date shall become current for all existing clients. I will be happy to provide you with a receipt for payment. Please note that there is a $25 fee for returned checks. Should you miss a payment, for whatever reason, therapy sessions may be postponed until the full payment is rendered. You are responsible for the full payment at the time service is provided.

I also provide a *limited* number of reduced-fee spaces in my case load. If you feel that you qualify for one of these slots, please inform me at the *beginning* of our first session. Because these slots are limited there may be a waiting list. If there are no slots immediately available, I am able to provide you with other low-cost or sliding-scale referrals.

CANCELLATIONS

You are expected to attend all scheduled sessions with your therapist. I understand that "life happens" and that unexpected interruptions occur, but I do expect you to make therapy a priority. If you need to cancel, please call NO LATER THAN 24 HOURS PRIOR to your scheduled appointment. You will be charged $50.00 for appointments cancelled with less than 24 hours' notice. Cornerstone Family Services requires all clients to provide a credit card number to keep on file in the case of missed or cancelled appointments. This information is kept in a confidential file that is locked at all times. If you do not show or cancel your appointment without 24-hour notification the $50.00 cancellation charge will be charged to your card.
*Any files that have no activity for a period of 3 months will be considered closed.*

METHODS OF COMMUNICATION

The best way to contact me for any reason is by phone at 770-910-2753. I am unable to accept email at this time. Because I cannot guarantee the security of incoming and outgoing information, email is not considered a secured form of communication and therefore not protected by HIPAA.

PROTECTING YOUR PRIVACY

To protect your privacy, if we happen to see each other outside of session I will not initiate contact (e.g. say hello, indicate we know one another) unless you choose to do so first. However, depending on your current situation as it relates to the presenting problem in therapy (i.e. dealing with domestic violence, stalking), it may be safer to avoid contact outside of the therapeutic setting.

SOCIAL MEDIA

I am restricted by the Code of Ethics by which I abide from entering into dual relationships with clients except in very limited circumstances where these relationships would be beneficial to you. "Dual relationship" means *any* relationship outside of our therapeutic relationship. To abide by this code, I am not able to accept any requests to friend, like, or otherwise connect via the web or social media sites such as, but not limited to, Facebook, LinkedIn, Instagram, Snapchat, and Twitter.

UPON MY PERMANENT INCAPACITATION OR DEATH

In case of any personal emergency when I am unable to contact my clients, I have designated my director and supervisor Jennifer D. Vann MS, LMFT to have access to my client's first name(s) and contact information only. Your contact information is kept in a secure location on the premises of Cornerstone Family Services and only my designee has access to it. Again, this is only your contact information. No other information is available except as noted in the paragraph below.

In case of my death or permanent incapacitation Jennifer D. Vann MS, LMFT has agreed to abide by my confidentiality statement (listed in this informed consent) and will become the sole owner of all case files held in my possession at that time. Any dissemination of information from those files will then be at the discretion and clinical judgment of Mrs. Vann MS, LMFT. Upon my permanent incapacitation Mrs. Vann MS, LMFT may be contacted at 770-910-2753.

EMERGENCIES

Niti Patel, M.S. does not provide emergency services. I do not carry a pager and I am not available at all times. If this does not feel like it will be sufficient support for you, please inform me and we can discuss additional resources or transfer your case to a therapist or clinic that has 24-hour availability. Generally, I will return phone calls within 24-48 hours. Should I be out of town, I will make every effort to alert you of my absences. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one of more of the following:

1) Call Lakeview Behavioral Health Hospital at (770) 766-7006 or Peachford Hospital at (770)454-5589
2) Call 911
3) Go to the emergency room of your choice
4) Cobb County Mental Health Crisis Line 770.422.0202
5) Fulton County Mental Health Crisis Line 404.730.1600

ETHICAL CONSIDERATIONS

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the American Association for Marriage and Family Therapy. I make it a priority to be familiar with the AAMFT Code of Ethics and to structure my practice to follow those guidelines. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the Georgia Association for Marriage and Family Therapy and the American Association for Marriage and Family Therapy, both which govern my profession.

In order to maintain ethical standards, I find it helpful to occasionally consult with other professionals. In these consultations I do not reveal the identity of my client(s). The consultant is also bound to keep any information about a case confidential by the ethical standards of their own professional association. I do not consult with therapists who are not bound by such ethical standards.

CLINICAL DIAGNOSIS FOR INSURANCE PURPOSES

Many clients decide to seek reimbursement for services through their insurance company. While I do not accept any forms of insurance directly, I am willing to provide you a "superbill" with information that will help you seek reimbursement from your insurance company. Please be advised that most insurance companies require a diagnosis in order for reimbursement to occur. Any diagnosis submitted to an insurance company will become a part of you/your child's permanent medical record. Please check with your insurance provider regarding the details of your insurance plan and network billing requirements.

****Please keep the above information for your record. Return only this page.****

CONSENT TO TREATMENT

By signing below, you agree that you have read (or have had read to you) all of the above sections of the informed consent form and that you understand the risks and benefits associated with the therapeutic process. You understand that you can ask questions about the process at any time. You agree to pay the disclosed fee for services rendered and to provide 24 hours' notice to cancel your appointment.

If Applicable:

_____ _____

Signature (Client/Parent/Guardian) Date Minor's Name

_____

Signature Date

_____

Signature Date

_____

Signature Date

Initial here:

_____ I have read & understand the "Working with Children" section.

_____ I have read & agree to the "Waive Right to Subpoena" section.

_____ I have read & agree to the "No Secrets" policy.

_____ I have read & understand the "Cancelation" section.

Niti Patel, M.S.
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# CREDIT CARD POLICY

I am hereby entering into a contract for Niti Patel, M.S.'s professional time and services when I set an appointment. I understand that by entering this contract for Niti Patel's professional time I am specifically contracting for her services to prepare for my session in advance. I recognize that professional services are not only provided during my appointment time but also during the 24 hours prior to and following my appointment time. I understand that these services involve preparation for my scheduled session, case review, case notes, and consultations with other professionals as agreed in writing by me to assist with my treatment. I understand that Ms. Patel's cancellation policy requires 24 hours advance notice in order to be released from the contract for her time and services of preparation for my session. I agree that if I fail to cancel my appointment before the 24-hour minimum time period prior to my session I will be charged for the missed session and the services provided in preparation of $50.00. I hereby authorize Cornerstone Family Services to charge the following card if I indeed fail to observe this cancellation policy and I understand I am paying for preparation services rendered and time contracted for when I set the appointment.

Visa / Mastercard / Discover (please circle)

Credit Card Number _____ Expiration Date _____

Name on Credit Card _____ Billing Zip Code _____

CVV Code _____


I have read and understand the above credit card policy for services provided by Niti Patel, M.S.

through Cornerstone Family Services. Please have all consenting adults sign below.

_____ _____

Signature Date

_____ _____

Signature Date

Niti Patel, M.S.
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# PRIVACY PROTECTION NOTICE

***Please keep these pages for your records***

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 notice shall go into effect April 15, 2011 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

**I. Preamble**

A recent United State Supreme Court decision held that 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 (3) 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, psychological testing, 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 a client's behalf. (Please note that we do not file insurance for clients at Cornerstone Family Services, LLC.)

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 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. 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 be 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 from the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services. "Psychotherapy notes" are my notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family 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: medication prescriptions and monitoring, 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. Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. 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, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your "designated mental health record."

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 train and monitor the conduct of those performing ancillary administrative service over my therapeutic work and refers to these people as "Business Associates." I do consult with business associates to assist with my administrative matters and these business associates are indeed trained and monitored 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)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

I never release any information of any sort for marketing purposes.

**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 correspondence 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 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 notified so.

**VI. Complaints**

Jennifer D. Vann, MS, LMFT is the appointed "Privacy Officer" for Cornerstone Family Services, LLC 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 contact her immediately about this matter. You will always find her willing to talk to you about preserving the privacy of your protected mental health information. You can reach her by letter at 1755 Woodstock Road, Roswell, GA 30075, or by phone at 770-910- 2753. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to the electronic transmission of data (the transaction rules), 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 health care, 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. You may have already received similar notices such as this one from your other health care providers.

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. Thank you for your thoughtful consideration of these matters.

Niti Patel, M.S.

Niti Patel, M.S.
1755 Woodstock Road
Roswell, GA 30075
770-910-2753
www.cornerstonefamilyservices.com

## RECIEPT OF PRIVACY OF NOTES

I, _____, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____
Client Signature or Parent of Minor or Legal Charge Date

If Legal Charge, describe representative authority: _____

Niti Patel, M.S.
Cornerstone Family Services, LLC
1755 Woodstock Road, Roswell, GA 30075
770-910-2753

## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.
I wish to be contacted in the following manner (check all that apply):

Home Phone Number: _____
___ OK to leave message with detailed information
___ Leave VM with name & call back number only
___ Do not leave messages at home number
___ Do not call me at home

Work Phone Number: _____
___ OK to leave message with detailed information
___ Leave VM with name & call back number only
___ Do not leave messages at home number
___ Do not call me at work

Cell Phone Number: _____
___ OK to leave message with detailed information
___ Leave VM with name & call back number only
___ Do not call me at this number.

Written Communication
___ OK to mail to my home address
___ OK to mail to my work/office address

_____ _____
Parent/Guardian Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: USES AND DISCLOSURES MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.