Its Time We Talk Therapy LLC
Niti Patel, MS, LMFT
1755 Woodstock Road
Roswell, GA 30075
770-910-2753, EXT. 703

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, LMFT. 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, MS, LMFT 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, MS, LMFT 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 individuals, couples, and families going through life transitions and clients who are struggling with identity issues. Niti is a fully-licensed therapist who is currently the owner of Its Time We Talk Therapy LLC. Niti practices at Cornerstone Family Services location at 1755 Woodstock Rd., Suite 200, Roswell, GA 30075.

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 $115 per hour.

CONSULTATION

Consultation 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. Clinicians often seek consultation with the intent of best practice. I may choose to seek consultation to maintain a higher level of care for my clients. Your case may or may not be discussed in a consultation settling at some point during your work with me. If you have any questions about this process you are encouraged to ask them at any point during your time in therapy.

FEES

Clients seen by Niti Patel, MS, LMFT agree to pay $115.00 per 45-50-minute session. Services will be provided by Niti Patel, MS, LMFT and all payments will be made to Its Time We Talk Therapy 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, MS, LMFT 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 & LATE ATTENDANCE

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 $75.00 for appointments cancelled with less than 24 hours' notice. Its Time We Talk Therapy 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 $75.00 cancellation charge will be charged to your card.

You are expected to arrive at your sessions on time. Sessions will be canceled if clients are any more than 15 minutes late to session. If you are late to your session, regardless of how much time you have left, you will be charged for a full session.

Please note, all sessions must end at the 45-50-minute mark to ensure time for Niti Patel, MS, LMFT has enough time to clean the area to ensure safety for the next client, prepare for the following session, and complete necessary documentation for your session.

Any files that have no activity for a period of 3 months will be considered closed.

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.

METHODS OF COMMUNICATION

The best way to contact me for any reason is by phone at 770-910-2753, EXT. 703. In regard to email, 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. For this reason, I will not accept email correspondence as a means to discuss therapy related matters. Though I will accept rescheduling requests and cancelation requests via email, please consider the security risk.

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, TikTok 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 Cornerstone Family Services' director, 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.

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.

EMERGENCIES

Niti Patel, MS, LMFT 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 call 911 or do one of more of the following:

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

****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 & Late Attendance" section.

Its Time We Talk Therapy LLC
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CREDIT CARD POLICY

I am hereby entering into a contract for Niti Patel, MS, LMFT'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 $75.00. I hereby authorize Its Time We Talk Therapy LLC to charge the following card as payment for sessions or 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, MS, LMFT through Its Time We Talk Therapy. Please have all consenting adults sign below.

_____ _____

Signature Date

_____ _____

Signature Date

Its Time We Talk Therapy LLC
Niti Patel, MS, LMFT
1755 Woodstock Road
Roswell, GA 30075
770-910-2753, EXT. 703

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 Its Time We Talk Therapy 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

Niti Patel, MS, LMFT is the appointed "Privacy Officer" for Its Time We Talk Therapy 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.

<u>CLIENT NOTIFICATION OF PRIVACY RIGHTS</u>

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, MS, LMFT

Its Time We Talk Therapy LLC
Niti Patel, MS, LMFT
1755 Woodstock Road
Roswell, GA 30075
770-910-2753, EXT. 703

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, MS, LMFT
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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.

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TELEMENTAL HEALTH CONSENT

Introduction: "Telemental health involves the use of electronic communications to enable a counselor to evaluate your needs and to provide counseling when you are not able to meet your therapist in person. This may involve a telephone conversation, or a video camera and computer so you can see your counselor. By signing this form, you give your permission to receive telemental health services."

How telemental health services work: Niti Patel, MS, LMFT will be in a private office to ensure privacy and confidentiality on the therapist's end. You will be responsible for creating a safe and confidential space for yourself. You should use a space free of other people. It should be difficult for people outside the space to see you or hear your interactions with your counselor. If you are unsure of how to do this, please ask Niti Patel for assistant. If you choose, you may have a family member with you, or you may be present for counseling with your child. If this is the case, you must notify Niti Patel of the other people in the room or near vicinity. You and Niti Patel will have the required electronic equipment (e.g. phone, iPad, computer) with the necessary HIPAA-compliant links. When the session begins, you will click on the link to begin. When the session is over, you will sign off.

How this is different than an in-office session: There is little difference. Niti Patel, MS, LMFT will meet with you and ensure that documentation is included in your clinical record. You will pay your fee by credit or debit card, which we will keep on file.

Benefits and Risks of telemental health.

Some **benefits** of telemental health, include that you will not spend time driving to and from your appointment. You will also not have the cost of transportation, and you also will be able to talk from the comfort of your own home.

Possible **risks** include: the video connection may not work or may stop working; image resolution may be poor; internet may be spotty of inconsistent; privacy may be compromised if a family member listens in or walks into the room during a session.

By signing this form, I understand and agree to the following:

1. I understand that the laws that protect privacy and confidentiality of personal health information (PHI) also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to anyone without my consent, within the limits of confidentiality. The exceptions to this include threats to harm oneself, another, or suspected abuse of a child or elder.
2. I understand that I have the right to withdraw my consent for the use of telemental health during the course of treatment at any time.
3. I agree to keep a credit or debit card on file to pay for telemental health services if I am responsible for payment. I also understand that my card will be charged for any telemental health visit that I miss or fail to cancel more than 24 hours before the visit. Niti Patel, MS, LMFT's 24-hour cancelation policy stands although services are provided via telemental health.

Client Name: _____

Printed Name (guardian if under 18): _____

Signature: _____ Date: _____