1802 California Street, Eureka, California 95501 *Phone: (707) 443-7358* *Fax: (707) 443-1092*

NOTICE OF PRIVACY PRACTICES

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

II. WE HAVE A LEGAL DUTY TO SAFEGAURD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your PHI, which includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this Notice about our privacy practices, and such Notice must explain how, when and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply or analyze such information within our practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of our agency. With some exceptions, we may use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, we are legally required to follow the privacy practices in this Notice.

However, we reserve the right to change the terms of this Notice of Privacy policy at any time. Any changes will apply to PHI currently on file. Before making any important changes to our policy, we will promptly change this Notice and post a new copy of it in our office(s) located at 1802 California Street, Eureka, CA 95501 & 292 S. Street, Arcata, CA 95521

III. HOW WE MAY USE AND DISCLOSE YOUR PHI

We will use and disclose your PHI for a variety of reasons. For some of these uses or disclosures, we will need your prior written authorization; others, however, we do not. Listed below are the different categories of uses and disclosures along with some examples of each category.

A. Uses and Disclosures relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. We can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. We can use your PHI within our agency to provide you with mental health treatment, including discussing or sharing your PHI with our trainees and interns. We can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care.
2. To Obtain Payment for Treatment. We can use and disclose your PHI to bill and collect payment for the treatment and services provided by us to you, such as insurance companies. We may also provide your PHI to business associates, such as billing companies, claims processing companies and others that process your claim.
3. For Health Care Operations. We can use and disclose your PHI to operate our practice. For example, we may use your PHI to evaluate the quality of services that you received or to evaluate the performance of the health care professionals who provided services to you. We may also provide PHI to our accountant, attorney, consultants, or others to further health care operations.
4. Patient Incapacitation or Emergency. We may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment and/or are unable to communicate with us (ex: due to severe pain or lack of consciousness) and we believe that you would consent to such treatment if you were able to do so, as long as we try to get your consent after treatment is rendered.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.

We can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state or local laws require disclosure. For example, we may have to make a disclosure to applicable governmental officials when law requires us to report information to the government agencies and law enforcement personnel about victims of abuse or neglect
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or claim for workers' compensation benefits, we may have to disclose your PHI in response to a court or administrative order. We may also have to use your PHI in response to a subpoena.
3. When law enforcement requires disclosure, such as in response to a search warrant.
4. When public health activities require disclosure. For example, we may have to use or disclose your PHI to report to a government official an adverse reaction you may have to a medication.
5. When health oversight activities require disclosure. For example, we may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization
6. To avert a serious threat to health or safety. For example, we may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, we may have to use or disclose your PHI for national security purposes.
8. To remind you about appointments and to inform you of health related benefits or service. For example, we may have to use or disclose your PHI to remind you about your appointment or to give you information about treatment alternatives, other health care services, or other health care benefits that may be of interest to you.

C. Certain Uses and Disclosures You Have the Opportunity to Object to.

Disclosures to Family, Friends or Others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Requiring Your Prior Written Authorization. In any other situation not described in sections III A, B and C above, we will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action in response to such authorization) of your PHI by us.

IV. RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on Our Uses and Disclosures. You have the right to request restrictions or limitations on uses or disclosures of your PHI to carry out treatment, payment, or health care operations. You also have the right to request restrictions or limits on disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests in writing. Your requests will be considered, but we are not legally required to accept them. If we do not accept your requests, we will put them in writing and will abide by them, except in emergency situations. However, be advised that you may not limit the uses and disclosures that we are legally required to make.

B. The Right to Choose How I send PHI to You. You have the right to request that we send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide us with information as to how payment for such alternate communications will be handled. We may not require an explanation from you as to the basis of your request, as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that we have on you, but you must make the request to inspect and receive a copy of such information in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you request within 30 days of receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have our denial reviewed.

If you request copies of your PHI, we will charge you not more than $.25 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures We Have Made. You have the right to receive a list of instance, i.e., an Accounting of Disclosures, in which we have disclosed your PHI. The list will not include disclosures made for our treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or disclosures made before April 14, 2003

We will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date this disclosure was made, to how the HPI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request to correct or update your PHI. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records.

Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done i, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact us at: Humboldt Family Service Center 707-443-7358, 1802 California Street, Eureka, CA 95501.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003

1802 California Street, Eureka, California 95501
Phone: (707) 443-7358 Fax: (707) 443-1092

For Office Use Only
Adjusted Fee: $_____
Intake No.: _____

CONFIDENTIAL INTAKE FORM

DATE: _____

CLIENT'S NAME: _____

HOME PHONE: (_____) _____

STREET ADDRESS: _____CITY: _____ ZIP: _____

BIRTHDATE: _____ AGE: _____

SOC. SEC. NO.: _____ DRIVERS LICENSE: _____

EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

* **Legal Guardians of a child client MUST fill out section 2 of this page**

GAURDIAN or 2nd CLIENT NAME: _____

HOME PHONE: (_____) _____

STREET ADDRESS: _____ CITY: _____ ZIP: _____

BIRTHDATE: _____ AGE: _____

SOC. SEC. NO.: _____ DRIVERS LICENSE _____

EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PLEASE LIST OTHERS IN HOUSEHOLD AND RELATIONSHIP TO APPLICANT:

NAME:_____ REL.: _____ AGE: _____

NAME:_____ REL.: _____ AGE: _____

NAME:_____ REL.: _____ AGE: _____

NAME:_____ REL.: _____ AGE: _____

CONFIDENTIAL INTAKE FORM (Cont'd)

Referred by: _____

Have you ever been to counseling before? YES ( ) NO ( )

When? _____ How long? _____

Are you currently taking any medication? YES ( ) NO ( )

Was your previous counseling a positive or negative experience?_____

_____

CURRENT GOALS: Please check your reasons for counseling at this time.

MARITAL PROBLEMS( ) PERSONAL GROWTH( ) ALCOHOL-DRUGS( ) CONFLICT( )

PARENT-CHILD( ) SPOUSAL ABUSE( ) ANXIETY-DEPRESSION( ) SEXUAL ABUSE ( )

JOB STRESS( ) FINANCIAL STRESS( ) RELATIONSHIP PROBLEMS( ) CHILDREN( )

EATING DISORDERS ( ) COURT ORDERED( ) DIVORCE PROBLEMS( )

OTHER: _____

_____

INSURANCE INFORMATION

MEDI-CAL CLIENTS: Do you have any other insurance coverage?

Do you have coverage? YES ( ) NO ( ) Name of Insured _____

Does it cover dependents? YES ( ) NO ( ) Birth date of Insured _____-_____-_____

Does it cover therapy? YES ( ) NO ( ) Employer of Insured _____

Does it cover a Licensed MFCC? ( ), an MFCC Intern? ( ), a Psychologist? ( ), an MSW Intern

Maximum Payable: $_____

Do you have a deductible? YES ( ) NO ( )

Have you met your deductible this year? YES ( ) NO ( )

Name of Insurance Company: _____

Address: _____

Phone: _____

Group No.: _____ Policy No.: _____

Certificate No.: _____

INFORMED CONSENT AND THERAPEUTIC CONTRACT FORM

CLIENTS' RIGHTS

1. You have the right to a confidential relationship with me.

2. If you ask for it, a summary of your records can be released to reveal information to any agency or person you specify. I will inform you at the time of your request whether or not I think releasing that information to that agency or person might be harmful to you in any way.

3. You have the right or review a summary of your records at any time, except in limited legal emergency circumstances.

4. Under certain legally defined situations, I am required to reveal during the course of therapy to other agencies or persons without your written consent. I am not, however, required to inform you of my actions if this occurs. These situations include:

> **A.** If you reveal information to me about child abuse or neglect or elder adult physical abuse, I am required by law to report this to the appropriate authority.
>
> **B.** If you threaten bodily harm or death to another person, I am required by law to warn the intended victim and notify the appropriate law enforcement agencies.
>
> **C.** If you are in therapy or being tested by order of a court of law, the results of treatment or tests ordered must be revealed to that court.
>
> **D.** If a court of law issues legitimate subpoena, I am required by law to provide the information specifically described in the subpoena.

5. You have the right to ask about any of the procedures used in the course of your therapy. If you ask, I will explain my customary approach and methods to you.

6. You have the right to choose NOT to receive therapy from me. If you choose this, I will provide you with names of other qualified professionals whose services you might prefer.

7. You have the right to terminate therapy with me at any time without any financial, legal or moral obligations other than those you've already incurred. A closure session is often helpful, but it is not required.

CLIENTS CONSENT TO TREATMENT AND SERVICES.

I understand that treatment at **Humboldt Family Service Center** may involve discussing relationship, psychological, and/or emotional issues that may at times be distressing. However, I also understand that this process is intended to help me personally and with relationships. I am aware of alternative treatment facilities available to me.

I understand that at **Humboldt Family Service Center :**

a) All therapists are qualified under the licensing regulations of the California Board of Behavioral Sciences.

b) graduate students in family therapy conduct therapy under the close supervision of their clinical supervisor

c) therapy sessions may be videotaped and/or observed by supervisors and

d) research can be part of the ongoing nature of **Humboldt Family Service Center**.

CONSENT TO TREAT A MINOR **Instructions: Complete items 1-8**

Print clearly.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor: _____ 2. Minor's birth date: _____

3. My name (adult giving authorization):_____

4. My home address: _____

5. [ ] I am a parent, grandparent, aunt, uncle, or other qualified relative of the minor (see below for a definition of "qualified relative").

6.Check one or both {for example, if one parent (including yourself) was advised and the other cannot be located}:
[ ] I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.
[ ] I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.

7. My date of birth: _____

8.My California driver's license or identification card number:_____

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: _____ Signed: _____

Notices:
1. This declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody, and control of the minor and does not mean that the caregiver has legal custody of the minor.

2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.

3. This affidavit is not valid for more than one year after the date on which it is executed.

Additional Information:
TO CAREGIVERS:

1. "Qualified relative," for purposes of item 5, means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great", or the spouse or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

2. The law may require you, if you are not a relative or a currently licensed foster parent, to obtain a foster home license in order to care for a minor. If you have any questions, please contact your local department of social services.

3. If the minor stops living with you, you are required to notify any school, health care provider or health care service plan to which you have given this affidavit.

4. If you do not have the information requested in item 8 (California driver's license or I.D.) provide another form of identification such as your social security number or Medi-Cal number.

CONFIDENTIAL INTAKE FORM (Cont'd)

TO HEALTH CARE PROVIDERS AND HEALTH CARE SERVICE PLANS:

1. No person who acts in good faith reliance upon a caregiver's authorization affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit, is subject to criminal liability or to civil liability to any person, or is subject to professional disciplinary action, for such reliance if the applicable portions of the form are completed.

2. This affidavit does not confer dependency for health care coverage purposes.

AUTHORIZATION OF CONSENT TO TREATMENT OF MINOR(S)

I/We, the parent(s), or legal guardian(s) of _____Name(s) of child(ren) do hereby give consent to any counseling, psychological evaluation or treatment of the afore mentioned minor(s) by Humboldt Family Service Center.

_____ _____
Parent/guardian signature Date

_____ _____
Parent/guardian signature Date

Income information for sliding scale: Average combined family income AFTER taxes = net monthly income.

Please circle appropriate income level that best fits your family's total income.

COMBINED NET MONTHLY INCOME	FAMILY SIZE (including self)					
	1	2	3	4	5	6
	1800	2050	2200	2900	3500	4300
	1650	1900	2050	2700	3250	4000
	1500	1750	1900	2500	3000	3700
	1350	1600	1750	2300	2750	3400
	1200	1450	1600	2100	2500	3100
	1050	1300	1450	1900	2250	2800
	900	1150	1300	1700	2000	2500
	750	1000	1150	1500	1750	2200
	600	800	1000	1300	1500	1900

Payment: All services are cash or checks. Other arrangements may be possible through the book keeper if made in advance.

Changes: Please notify our office of any changes in address, phone number or income.

CONFIDENTIAL INTAKE FORM (Cont'd)

OFFICE POLICIES

PAYMENT FOR SERVICE: Patients are expected to pay for services at the time they are rendered unless other arrangements have been made in advance with the front office staff/secretary. Late fees will be assessed on a monthly basis if your account becomes past due. Please notify us if any problems arise during the course of your therapy regarding your ability to make timely payments. In order to make counseling services affordable, we offer some openings on a sliding-scale fee. If for ANY reason a check does not clear the bank, we do NOT re-deposit. You are responsible for paying the bank charges and the charge of the visit. We will only accept cash, money order or cashiers check. We will NOT accept a check for re-payment. If your account is sent to collections, a collection fee will be added to your balance.

INSURANCE REIMBURSEMENT: Clients who carry insurance should remember that professional services are rendered and charged to the insurance company, as a courtesy. If the insurance company has forms for the therapist to complete, be certain to give them to the office as soon as possible. Instances where extra-ordinary professional time is required, additional fees will incur. Humboldt Family Service Center does not have a billing department. It is the responsibility of each client to ensure bills are paid at the conclusion of each counseling session. Any overpayments will be applied to your next counseling session, or reimbursed after your final therapy session with Humboldt Family Service Center. Reimbursement checks require written requests by the client for the exact amount due.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or cancellation of an appointment. You will be charged for that missed session in full. There is a $20 late cancellation fee. The missed session charges will not be billed to Medi-Cal, private insurance, or to any other agency. No other appointments will be scheduled until the balance has been paid. ***MEDI-CAL client are not charged for late cancellations; however, note that two no-shows or late cancellations will result in the closing of your file and no further appointments will be scheduled.***

CONFIDENTIALITY: All information disclosed within counseling sessions is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Disclosure is required in the following circumstances: (a) where there is a reasonable suspicion of child abuse of elder abuse: (b) where there is a reasonable suspicion that the patient presents a danger of violence to others. When the patient is likely to harm him or herself unless, protective measures are taken. Disclosure is not legally required. However, your therapist may choose to do so. Disclosure may also be required pursuant to a legal proceeding. A Notice of Privacy Guidelines shall also be presented to you, prior to your first counseling session, explaining more of your rights and our responsibilities regarding your rights.

EMERGENCY PROCEDURE: If you need to contact your therapist between sessions, please leave a message with the office or answering service at **443-7358**. Your call will be returned. If an emergency situation arises, inform the service that your call is an emergency. Please do this for true emergencies only. Each situation is unique and it is possible you will be billed for a phone consultation.

I have read and understand these office policies.

_____	_____
Client's Name Printed	Second Client's Name Printed
_____	_____
Client's Signature	Second Client's Signature
_____	_____
Date	Date

1802 California Street, Eureka, California 95501
Phone: (707) 443-7358 Fax: (707) 443-1092

Consent to Use and Disclose Your Health Information

This form is an agreement between you (parent/guardian), _____and Humboldt Family Service Center (HFSC). When we use the word "you" below, it will mean your child, relative, or other person if you have written his/her name here _____.

When we assess, diagnose, treat or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We may need to use this information to decide on what treatment is best to provide to you. We may also share this information with others who provide treatment to you or need it to arrange payment of your treatment from other business or government agencies.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read this before signing this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you may obtain an updated copy from our office, by calling (707) 443-7358.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we will comply with your wish.

After you have signed this consent, you have the right to revoke it in writing, letting us know you no longer consent (submitted to: HFSC at 1802 California Street, Eureka, CA 95501) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

_____ _____
Signature of client or personal representative Date

_____ _____
Printed name of client or personal representative relationship to client

_____ _____
Description of personal representative's authority Date of NPP

[ ] Copy of NPP given to client, parent or personal representative.
[ ] Copy of Consent given to client, parent or personal representative.