The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

Dear Applicant:

Thank you for considering our Dialectical Behavior Therapy Program. At the Auburn-Davis Center for DBT (ADCDBT), we strive to use the most effective, scientifically validated approaches to help you achieve your goals. Our team of well-trained clinicians will treat you with the compassion you deserve as you work to build a life worth living. The ADCDBT program consists of both groups and individual therapy. The DBT Skills Training Groups are intended to work together with your individual therapy. Therefore, participants in our program must be receiving both individual therapy with one of our DBT trained clinicians AND attending a weekly DBT Skills Training Group.

There are 25 weeks of Skills Training Groups, thus you will need to commit to attending all 25 weeks of treatment. Dialectical Behavior Therapy has been proven to work, but DBT will not be able to help you if you do not come to your appointments or if you are not committed to using the skills you will learn. DBT skills are taught in three main modules (Emotion Regulation, Distress Tolerance, and Interpersonal Effectiveness) and at the start of each module you will receive skills training in Mindfulness. It is during the start of each module that ADCDBT allows new participants to begin the groups. Thus, if a group is full or in the middle of a module, then you can possibly begin weekly individual therapy and be on a waiting list for the next group opening. ADCDBT also offers limited pretreatment groups that may also be offered to you. This will be assessed by the clinician completing the Intake Assessment and options and recommendations presented to you.

Intake Assessment Information

Since we know that successful outcomes require motivated individuals, you will begin this process with an Intake Assessment. When the Intake Coordinator receives your initial inquiry, they will call you to acknowledge receipt. During this time, they may either schedule a date/time for your Intake Appointment or they may let you know that an assigned clinician will call you back soon to schedule this appointment.

During the Intake appointment, a clinician will gain information about your presenting concerns and history, help you to identify your goals of treatment, as well as assess your level of motivation to engage fully in this program. It will be during this time and, prior to the start of therapy, that you and the ADCDBT staff will be able to determine if this program is an appropriate fit for you.

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

IMPORTANT- Prior to your Intake Appointment, you will need to complete and prepare the following items (Check each box to make sure all items are ready):

- ❑ Signed *Consent To Treatment* Form
- ❑ The *Client Information Form*
- ❑ A copy of the front and back of your *Insurance Card* (Kaiser, SHIPS, Magellan)
- ❑ *CMS 1500 Form* if using insurance
- ❑ The *Mental Health History Form*
- ❑ Signed *Informed Consent Statement & Office Policies Receipt and Acknowledgement of Notice* form
- ❑ Signed *Notice of Privacy Practices Receipt and Acknowledgement of Notice* form
- ❑ Signed *Client Financial Responsibility Agreement* form
- ❑ Signed *Credit Card Authorization* form
- ❑ *Authorization to Release Information* forms for us to exchange information with your current/past treatment providers (a separate form will need to be completed for each. For example, one form for a therapist, one form for a psychiatrist, one form for your primary care physician, etc.). Please note, that we may request that additional Authorization to Release Information forms be signed during the course of treatment.
- ❑ Signed *Telehealth Consent*
- ❑ Your payment/copayment by cash, check or credit card, for the cost of the intake appointment.

NOTE: All completed items are to be turned in prior to OR at the start of the Intake Appointment. You can turn in these items directly to the assessing clinician at the time of the Intake Appointment or you can email (edelgado@auburndavisdbt.com) or Fax (530-888-9805) your completed forms to Attn: Intake Coordinator prior to the Intake Appointment.

Program Costs & Billing Information

Unless other arrangements have been agreed upon, ALL payments are processed weekly on Mondays (last names A-L) and Wednesdays (last names M-Z).. Fees can be paid in cash or by credit card. The ADCDBT is a fee for service program. We have very limited relationships with insurance. If insurance is used, **you are ultimately responsible to pay any co-pays or any services not covered by insurance**. If your insurance company will reimburse you, we can provide evidence of your payment and the appointments you attended (a super bill). Please note that all clients are asked to submit a credit card for billing of outstanding fees and/or missed appointment fees (see the attached *Informed Consent Statement and Office Policies* for more information on Fees & Billing).

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

DBT Program Fees:

ADCDBT service rates are "fee-for-service" as we accept very limited insurance (Kaiser, Magellan, and SHIPS). We offer a sliding fee scale for cash pay and out of network clients which is granted on a financial need basis. If a client wishes to apply for the sliding fee scale, we request families provide documentation of total family income for all parent(s)/stepparent(s)/caregiver(s)/guardian(s) regardless of the clients age and parent(s)/stepparent(s)/caregiver(s)/guardian(s) marital status. We also request the number of legal dependents claimed on the tax return, and current out-of-pocket monthly mental health expenses that are not reimbursed for anyone listed on the tax return. If you are not able to provide a tax return, we require submission of any formal paperwork documenting your financial need. After review of these documents, we will determine if the client qualifies for an adjusted fee, which the client will then review before deciding whether to proceed with ADCDBT.
We provide "insurance-friendly" statements that include many of the service codes and information the client's insurance company may require in order to submit for possible and partial "out-of-network" reimbursement.

The ADCDBT does not guarantee that any portion of the fees will be reimbursed by the client's insurance provider. Clients are financially responsible for all services provided by ADCDBT staff and trainees regardless of the reason for a possible denial or reimbursement. While ADCDBT tries to provide clients with the information needed or requested by many insurance companies, we do not work directly with insurance companies (other than Kaiser, Magellan and SHIPS) nor do we enter into single case agreements. If appeals paperwork or communication is required, the time it takes to complete the paperwork will be billed directly to the patient/ family and will not be covered by the insurance company. Telephone, email, completion of outside paperwork (i.e., paperwork requested for use outside ADCDBT such as: insurance company, school, etc.), and travel are billed at the client's therapy services rate and are not reimbursable by the insurance company.

Payments are processed weekly. Credit card billing is done on Mondays for those whose last name begins with A-L and M-Z is billed on Wednesdays. This schedule might vary slightly. The balance of the client's account can be paid by debit card, credit card (Visa, MasterCard, Discover, Amex), or flex-spending debit card(HSA). ADCDBT requires that all clients provide a credit or debit card on file to be used as a primary method of payment. Financial information is stored and processed using PCI-compliant software. After the payment is processed the person responsible for billing will receive a statement via email (unless another method for receiving statements is specified,) which will serve as the receipt of payment. If the patient or caregiver(s)/guardian(s) would like to request a statement citing services rendered and/or the balance on the account prior to the end of the month, please do so in writing at any time by contacting Wendy Murray at wendy@auburndavisdbt.com. For more information regarding billing you can reach the billing department by phone at

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

Sample of Standard Fees (lowest qualifying rate to full rate):

➢ Initial Clinical Assessment: $15 - $275/session
➢ Ongoing Therapy Appointments for Practice Directors: $15 - $275/session
➢ Ongoing Therapy Appointments for All Other Therapists: $15 - $225/session
➢ Group Therapy Intake: $15 - $275/session
➢ Group Therapy (Parent, Teen, Adult, Multifamily: $15 - $100/session

*Note: Appointments are billed based on the time allotted. If something urgent arises causing the session to run longer than scheduled, you'll receive additional charges prorated in 15 min increments. If the session ends early, you will be billed for the full amount of time originally scheduled unless the early termination was due to a clinician conflict or mistake.

Unless other arrangements have been agreed upon, ALL payments are processed weekly on Mondays (last names A-L) and Wednesdays (last names M-Z). Please note that group fees are payable regardless of attendance. This means that you will be charged a $50.00 fee for missed group sessions regardless of whether or not notice was given. Please also note that you will be charged the full fee for any missed individual therapy sessions, if a 48 hours notice of cancellation is not given by phone, text, email, or in person. ALL FEES ARE NON-REFUNDABLE.

Consent To Treatment

NOTICE: Your signature below represents consent to receive treatment at the Auburn-Davis Center for Dialectical Behavior Therapy.

_____ **Client (Teen/Adult)**

_____ **Intake Staff**

_____ **Date**

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

Program Expectations and Guidelines

1. **Participants who drop out of skills training are not out of skills training.**
    a. The only way out is to miss four scheduled sessions of skills training in a row. Inconsistent attendance will be treated as therapy interfering behavior and may indicate that DBT is not working for you.
2. **Participants who join the skills training group support each other and:**
    a. Keep names of other participants and information obtained during sessions confidential.
    b. Come to each group session on time and stay until the end.
    c. Make every effort to practice skills between sessions.
    d. Validate each other, avoid judging each other, and assume the best about each other.
    e. Give helpful, noncritical feedback when asked.
    f. Are willing to accept help from a person they ask or call for help.
3. **Participants who join the skills training group:**
    a. Call ahead of time if they are going to be late or miss a session.
    b. For virtual sessions (both individual and group), it is expected that every participant be in a private location, with video feed on and visible to the camera. (In cases of technical difficulties, such as power/internet outage, some exceptions may be made on a case by case basis). If the participant cannot show that they are in a confidential area the participant may be moved back to the virtual waiting room, and ultimately considered absent.
4. **Participants do not tempt others to engage in problem behaviors and:**
    a. Do not come to sessions under the influence of drugs or alcohol.
    b. If drugs or alcohol have already been used, come to sessions acting and appearing clean and sober.
    c. Do not discuss, inside or outside sessions, current or past problem behaviors that could be contagious to others.
5. **Participants do not form confidential relationships with each other outside of skills training sessions and:**
    a. Do not start a sexual or a private relationship that cannot be discussed in group.
    b. Are not partners in risky behaviors, crime, or drug use.

Program Expectations and Guidelines

I understand and agree to abide by the above expectations and guidelines for the DBT program.

Signatures:

_____ **Client**

_____ **Intake Staff**

_____ **Date**

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

CLIENT INFORMATION FORM

Client's Legal Name (First, Middle, Last): _____

Preferred Name: _____

Date of Birth: _____ **Social Security Number:** _____

Gender (Please Circle): Male/ Female/ Transgender M/ Transgender F/ Non-Binary/ Other

Race_____ **Ethnicity** _____

Street Address: _____**City, State, Zip:** _____

Client Email: _____

Phone Numbers (If you prefer us NOT to leave our name on a recorded message or with someone who answers the phone, circle NO by each corresponding number):

Client's Cell: _____ NO **Parent's Cell:** _____ NO

Home: _____ NO **Work:** _____ NO

Occupation: _____

School (If Applicable): _____

How were you referred to ADCDBT?

_____

_____

Name of Insurance Company: _____

Name of Insurance Plan: _____

Insurance Identification Number: _____

*****PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD (WE CANNOT BILL INSURANCE CLAIMS WITHOUT THIS)*****

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

Parent Information (If under parent's insurance)

Name of Insured Parent: _____

Date of Birth (Necessary if Billing Insurance): _____

Social Security Number (Necessary if Billing Insurance): _____

Street Address: _____ City, State, Zip: _____

Parent Email: _____

Name of Insurance Company: _____

Name of Insurance Plan: _____

Insurance Identification Number: _____

*****PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD (WE CANNOT BILL INSURANCE CLAIMS WITHOUT THIS)*****

Emergency Contact Information (If Different From Above)

Name: _____ Relationship to Client: _____

Phone Number(s): _____

Street Address: _____ City, State, Zip: _____

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

Mental Health Treatment History & Information

Most Recent Individual Therapist: _____

Street Address: _____ City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Beginning Date:_____ Ending Date: _____

Reason for referral?

_____

_____

Most Recent Psychiatrist: _____

Street Address: _____ City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Beginning Date:_____ Ending Date: _____

Reason for Referral?

_____

_____

List ALL Current Medications (Name of Drug/Dose/Frequency/Reason):

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____
10)_____

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

List ALL Psychiatric Hospitalizations (Reason for Admission/Month & Year/Duration of Stay/Hospital Name/City & State):

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____
10)_____

Please list any known mental health diagnoses given in the past (Specify who provided diagnosis/date given):

1)_____
2)_____
3)_____
4)_____
5)_____

Is there ANY other information you feel is relevant or important for us to know?

_____
_____
_____
_____
_____

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

CLIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing the Auburn-Davis Center for Dialectical Behavior Therapy as your mental health care provider. We are honored by your choice and are committed to providing you with the highest quality mental health care. We ask that you read and sign this form to acknowledge your understanding of our *Client Financial Responsibility Agreement*. The client (or the client's parent/guardian if the client is a minor) is ultimately responsible for the payment for his/her treatment and care.

We are pleased to assist you by billing for insurance companies that we have a relationship with (Kaiser, Magellan, and SHIPS). Clients are required to provide us with the most correct and updated information about their insurance and will be responsible for *ANY* charges incurred if the information provided is not correct or updated.

- Clients (or the client's parent/guardian if client is a minor) are responsible for *ALL* payment of copays, co-insurance, deductibles and all other treatment services not covered or denied by their insurance plan.
- Unless other arrangements have been agreed upon, ALL payments are processed weekly on Mondays (last names A-L) and Wednesdays (last names M-Z).
- All program clients are REQUIRED to give us a credit card on file. This card will be used for past due balances more than 30 days old, for missed appointment fees, and for any balances exceeding $500.00.
- Clients may incur and be responsible for the payment of additional charges. These include:
    1. Charges for returned checks
    2. Charges for missed individual therapy appointments without at least 48 hours notice
    3. Costs associated with collection of client balances
- Reminder: All group fees are payable regardless of attendance or notice given (the only possible exception is a missed group due to client hospitalization)

Signatures:

_____ **Client (Teen/Adult)**

_____ **Intake Staff**

_____ **Date**

CREDIT CARD AUTHORIZATION

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

As stated in the *Informed Consent Statement & Office Policies*, as well as in the *Client Financial Responsibility Agreement*, Unless other arrangements have been agreed upon, ALL payments are processed weekly on Mondays (last names A-L) and Wednesdays (last names M-Z). Clients are required to keep a credit card on file. We will bill your credit card for weekly services rendered. This card *will* be used for missed individual therapy sessions not cancelled with at least 48 hours notice, as well as for any outstanding balances over 30 days old, and/or for balances exceeding $500.00. For questions about billing, the Billing Department can be reached at (530) 888-9800. Charges will show as "The Therapy Center of Susan Landes".

Credit Card Information

Name: _____

Card Number #: _____

Exp:_____/_____ 3 Digit CVV _____ Billing Zip Code_____

Notice: Weekly credit card billing is done on Mondays for those whose last name begins with A-L and M-Z is billed on Wednesdays. This schedule might vary slightly.

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

INFORMED CONSENT STATEMENT AND OFFICE POLICIES

The following information answers some important and frequently asked questions concerning our program. If you have further questions after reading this, or other concerns not covered here, please feel free to ask them during your Intake Appointment or first individual therapy session. Please keep this copy of *The Informed Consent Statement and Office Policies* for your records. A signed and dated Receipt and Acknowledgement of Notice form will be kept in your file. It is very important that you read this entire statement carefully before signing.

General Standards

After completing your Intake Assessment, you will be assigned to a clinician who will schedule and provide your therapy. Clinicians hold one of the following licenses or registrations: Licensed Marriage & Family Therapist, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, Associate Marriage & Family Therapist, Associate Clinical Social Worker, Associate Professional Clinical Counselor, or a Doctoral Intern (Note: All unlicensed clinicians are supervised by a licensed clinician).

When you meet with your individual clinician, they will develop and discuss a treatment plan with you according to your goals and needs. If you have any questions about your mental health diagnosis following the Intake Assessment, you have a right to this information. Please be aware that, occasionally, individuals may go through periods in therapy that may result in increased emotional discomfort or a temporary worsening of their symptoms. These periods should subside as the work progresses. However, it is your responsibility to discuss any worsening symptoms, personal doubts, concerns, and/or discomforts regarding your treatment or the program with your individual therapist or skills group leader as they occur. Please remember that you always retain the right to request changes in treatment, refuse treatment, and/or withdraw consent for treatment. Additionally, you have the right to file a grievance or request a hearing at any time.

Complaints and Grievances

Any client who has a grievance arising from their treatment at the Auburn-Davis Center for DBT (ADCDBT) may present their grievance, in writing, to their therapist within two weeks of its occurrence. The therapist will then investigate the nature of the grievance and seek to reach an acceptable and reasonable resolution in a timely manner. If a client who has submitted a written grievance is dissatisfied with the resolution suggested by their therapist then they may submit the grievance, along with the suggested resolution, to the Executive Director. The Executive Director's resolution shall be final.

Clients are encouraged to take their grievances outside the program (e.g., to a licensing board, a state professional organization, a client rights advocacy group, the state insurance commissioner) if they are not satisfied with the resolution determined by the Executive Director. All grievances will be kept confidential unless the law requires that they be disclosed and, if the disclosure is so required, the Executive Director will disclose pertinent information to as few people as possible. The receipt, investigation, and action taken regarding the grievance shall be documented in the client's chart. Of note, all clients and their parents or guardians where appropriate, will be given a copy of this Complaints and Grievances policy at the time of their first appointment.

Safety Policy

ADCDBT staff and client safety are of utmost importance. As such, any act of aggression to self, others or property while on site shall be reported as a critical incident to a program manager and/or the Executive Director. A corrective action plan will be developed and implemented to address the incident, which may involve compensation for damages, taking legal action, and/or immediate termination of ADCDBT services.

Confidentiality

We abide by the laws and ethical principles that govern privilege and confidentiality (HIPAA). We will not disclose to anyone anything you tell us, not even the fact that you are a client in the program, without your written permission via a signed Authorization to Release Information form. However, there are a few exceptions to these standards:

1. It is legally required of us that we act to prevent physical harm to yourself or others when there is "clear and imminent" danger of that happening.
2. We are legally required to report cases of child abuse, elder abuse, and dependent adult abuse.
3. We may have to release clinical information regarding you to insurance carriers as required for payment or review of your claim.
4. We may have to release your records when ordered to do so by a court subpoena. However, if we judge it to be in your best interest, we will discuss the details of privilege with you beforehand and request a signed Authorization to Release Information form from you.
5. We may use a fax machine to send treatment plans, reports, or evaluations to your insurance company, specific agencies, or other providers.
6. The ADCDBT email is HIPPA compliant and confidential to the best of our abilities; However, we cannot guarantee that all recipients of email correspondence maintain the same standards of confidentiality.
7. Phone correspondence (including texting) is not guaranteed confidential.

8. DBT Program Staff consult together weekly about your treatment progress. Occasionally, we need to consult outside of our program; however, if your case were to ever be discussed, we would obtain your permission first and be careful to conceal your name and other identifying information.

Purpose For Authorization To Release Information Forms

In most cases, it is beneficial for you as the client to have your ADCDBT clinician be able to speak with and/or coordinate care with your other treatment providers. Treatment providers may include your psychiatrist, previous therapist(s), primary care physician, etc. In order to communicate/collaborate we must have signed Authorization to Release Information Form(s) signed by you. Your other treatment provider, etc. will also need a copy of this form in order for us to speak. You can give them a copy or we will send/fax them a copy.

Appointments & Cancellations

Individual therapy appointments are arranged by appointment only. We will meet with you at the exact time agreed upon. If we are late, we will make up the missed time or prorate your bill. If you are late, we will charge the full fee and you will lose that portion of time from your session.

Cancellation of sessions should be avoided. If you need to cancel an individual therapy appointment, you will not be charged for the appointment if you notify your individual therapist at least 48 hours in advance of the scheduled appointment time. However, if you no-show/no-call or cancel under 48 hours in advance, you will still be charged the full fee. Group fees are charged regardless of attendance. A missed appointment fee of $50.00 is charged for all missed groups. Fees charged for missed sessions are not reimbursable by insurance companies. Cancellations can be phoned into the Auburn Office Main Line (580-888-9858) and can also be made by text or email to your individual therapist at any time, day or night.

If you miss **FOUR** consecutive sessions (no show or cancellation of scheduled individual or group sessions, regardless of the reason or notice given), you will be considered withdrawn from the program. Inconsistent attendance will also be addressed as therapy interfering behavior and may indicate that DBT is not working for you. Readmission will be decided on a case by case basis through clinical consultation.

Telephone Calls & Emergencies

Non-Urgent: Our voicemail service enables you to call our Auburn Office Main Line (580-888-9858) at any time, day or night, and leave a message for a return call. The Auburn Office Main

Line is checked at least twice a day on business days (M-F) and we will do our best to return your call as soon as possible.

Phone Consultation: If you are calling for the purpose of a "Coaching Call"/Phone Consultation, you will follow the plan that you have discussed and identified with your therapist in individual therapy. Please note that there is variation among therapists' availability for phone consultation, as well as direct contact information, so it is important that you clearly discuss the details of "Coaching Calls" with your individual therapist *prior* to you needing to utilize phone consultation.

Additional Hotline Numbers:

- Sutter Center for Psychiatry, Sacramento (916) 386-3000
- National Suicide Prevention Hotline (800) 273-8255
- 24 Hour Suicide Prevention Crisis Line (916) 368-3111

Emergency or Crisis: If you have already engaged in life-threatening behavior and/or need immediate medical or psychiatric attention, then you should call 911 or go to your nearest emergency hospital immediately.

PLEASE CAREFULLY NOTE THE FOLLOWING INFORMATION:

1. **As previously written, Unless other arrangements have been agreed upon, ALL payments are processed weekly on Mondays (last names A-L) and Wednesdays (last names M-Z). Please remember that group fees are payable regardless of attendance. This means that you will be charged a $50.00 fee for missed group sessions regardless of whether or not notice was given. Please also note that you will be charged the full fee for any missed individual therapy sessions, if a 48 hours notice of cancellation is not given by phone, text, email, or in person. ALL FEES ARE NON-REFUNDABLE.**

   NOTICE: *The only exception to a missed group fee of $50.00 is if the client is missing DBT Skills Training Group due to hospitalization. Parents are still expected to attend their DBT Skills Training Group and will be charged for group sessions even if their child is hospitalized. On rare occasions, a therapist may use their discretion to determine if a parent is not charged for missing the Parent DBT Skills Training Group due to a child's hospitalization.*

2. **All clients are required to keep a credit card on file. For your convenience, we can bill your credit card for weekly services rendered. This card WILL be used for**

missed individual therapy sessions not cancelled with at least 48 hours notice given, as well as for any outstanding balances over 30 days old.

3. **Client accounts are not to exceed a balance of $500.00. When client account balances total $500.00, the ADCDBT Billing Department will then contact the client to discuss payment. If the balance cannot be resolved, then further consideration around the client's treatment and services will need to be discussed.**

4. **Insurance company billings are not to exceed a balance of $2,000.00. When the insurance billing totals $2,000.00, the client is made aware of this and will then be required to follow up on their own with their insurance provider regarding timely payments.**

INFORMED CONSENT STATEMENT & OFFICE POLICIES RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Client Name: _____

Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Auburn-Davis Center for Dialectical Behavior Therapy's Informed Consent Statement & Office Policies. I understand that if I have any questions, regarding the Informed Consent Statement & Office Policies, that I can contact Dr. Susan Landes, PsyD, MFT.

Signatures:

❑ *Please check the box if the client refuses to sign Informed Consent Statement & Office Policies Receipt and Acknowledgment of Notice.*

_____ **Client (Teen/Adult)**

_____ **Intake Staff**

_____ **Date**

The Auburn-Davis Center for Dialectical Behavior Therapy

Adult Program

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *Board of Psychology/CAMFT/ NASW*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker/marriage and family therapist/psychologist licensed in this state and as a member of the National Association of Social Workers/California Association of Marriage and Family Therapists/ Board of Psychology, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *Board of Psychology/CAMFT/NASW* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Clients. We may disclose PHI regarding deceased clients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased clients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in

connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at:

Susan Landes PsyD, MFT
13620 Lincoln Way Suite 380
Auburn, CA 95603

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- **Right to Copy of this Notice.** You have a right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing

with our Privacy Officer at (see above) or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is May 2021

NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Client Name: _____

Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Auburn-Davis Center for Dialectical Behavior Therapy's Notice of Privacy Practices. I understand that if I have any questions, regarding the Notice of Privacy Practices, that I can contact Dr. Susan Landes, PsyD, MFT.

Signatures:

- ❑ *Please check the box if the client refuses to sign Notice of Privacy Practices Receipt and Acknowledgment of Notice.*

_____ **Client (Teen/Adult)**

_____ **Intake Staff**

_____ **Date**