



Steven B. Smith, Ph.D.
Licensed Psychologist

Notice of Privacy Practices (HIPPA)

This notice describes how information about you can be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, please speak with Dr. Smith about your concerns.

I understand that information about you is personal. I am committed to protecting your information. I will create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care in this office. I am required by law to:

- Keep information about you private;
- Give you this notice of my legal duties and privacy practices with respect to information about you;
- Follow the terms of the notice that is currently in effect.

How I may use and disclose information about you

I may disclose information about you for the purposes of treatment, to obtain payment for treatment, and for health care operations. In accordance with Kentucky law, I will obtain your written authorization before releasing information about you. I may also disclose information about you by way of contacting you for appointment reminders and telling you about treatment options and alternatives that may be helpful to you.

There are certain circumstances when I may disclose information about you without your written authorization. These situations may happen when you are a danger to yourself or others; when ordered to release information by the court; when there is a reasonable suspicion of child or adult abuse in accordance with Kentucky law; or if ordered to do so in compliance with other federal, state or local laws. If you have given written authorization for use and disclosure of information, you can later revoke that authorization by notifying me in writing of your decision

Your Right to Access and/or Amend Your Records

You have a right to look at or get a copy of information that I use to make decisions about your treatment, when you submit a written request. If you request copies of your information, you will receive the first copy free in accordance with Kentucky law and thereafter, you will be charged a fee for the cost of copying, mailing, or other related supplies. If I deny your request for a copy of your records, then you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that I correct the records by submitting a request in writing that provides your reason for requesting the amendment. I could deny your request to amend a record if the information is not maintained by me; or if I determine that your record is accurate. You may submit a written statement of disagreement with a decision by me not to amend a record.

Your Right to An Accounting

You have a right to request a list accounting for any disclosures of your health information that I have made, except for uses and disclosures for treatment, payment, and health care operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions. To request this list of disclosures, indicate the relevant period, which must be after April 14, 2003, but in no event for more that the last six years. You must submit your request in writing to me.

Your Right to Request Restrictions

You may request, in writing, that I not use or disclose information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. I will consider your request and work to accommodate it when possible, but I am not legally required to accept it. I will inform you of my decision on your request. All written requests or appeals should be submitted to me.

Your Right for Confidential Communications

You have a right to request that information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying me in writing of the specific way or location for me to use to communicate with you.

Your Right to Request a Paper Copy of this Notice

You may receive a paper copy of this Notice upon request, even if you have agreed to receive this notice electronically.

Changes to this Notice

I may change this notice at any time. Changes will apply to information I already hold, as well as new information after the change occurs. I will make you aware of the change before it happens if you are a current client. You can receive a copy of the current notice at any time. You will be asked to acknowledge, in writing, each time you receive a copy of this notice.

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Licensed Psychologist



My signature below indicates that I have received a copy of the following documents from Dr. Smith and that I understand these policies and have agreed to comply with them.

- Notice of Privacy Practices (HIPPA)
- Office Policies and General Information Agreement for Psychological Services.

Date: _____

Signature of Client: _____

If a minor, Signature of Parent or Guardian: _____

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Office Policies and General Information Agreement for Psychological Services

Confidentiality

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Be advised that exceptions to confidentiality include, but are not limited to: *1) Cases of suspected abuse or neglect with children or adults, including domestic violence; 2) Cases where there is a threat of violence to self or others; 3) Cases where a court subpoenas me to testify or subpoenas my records.* Please respect the confidentiality of others if you should recognize clients in the office or waiting area.

Health Insurance & Confidentiality of Records

Disclosure of confidential information may be required by your health insurance carrier or their representative in order to process the claims. If you so instruct Dr. Smith, only the *minimum necessary information* will be communicated to the carrier. Unless authorized explicitly by you, notes will not be disclosed to your insurance carrier. Dr. Smith has no control or knowledge over what insurance companies do with the information he submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future eligibility to obtain health or life insurance.

Confidentiality of E-mail, Cell Phone and Fax Communication

It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify Dr. Smith at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes for emergency communication.

Telephone & Emergency Procedures

If you need to contact Dr. Smith between sessions, please leave a message on the voicemail and your call will be returned as soon as possible. If an emergency situation arises, please call the office number and activate the emergency response procedure by **pressing 40**. The first available therapist in our practice will return your call. If you need immediate assistance, please **call 911** or go to the University of Kentucky Medical Center where a psychiatrist is always on call.

Fees & Insurance Reimbursement

The private pay fee-for-service rate for Dr. Smith is based on a sliding scale from \$75.00-\$130.00 per 55-minute session. If using insurance, the reimbursement schedule is set by the insurance company and the session is 45 minutes in length. Dr. Smith will file the insurance for you. Payments are due at the time of the service and at **the beginning of the session**. They may be made with cash, check or Visa/MasterCard. Your insurance is a contract between you and your carrier. Dr. Smith is not a party to that contract. You are fully responsible for charges not paid by your insurance carrier.

If you will not be able to keep your appointment, you must **cancel at least 24 hours in advance** so that my reserved time can be made available to others. If you miss your appointment without canceling 24 hours in advance, you will be charged a flat fee of **\$75 for that missed session**. The answering service will take messages at any time for emergencies or for cancellations. You may leave a message 24 hours a day, 7 days a week to cancel an appointment with the required notice to avoid being charged.

The Process of Therapy

Participation in therapy can result in a number of benefits to you, including improving relationships and resolution of the specific concerns that led you to seek therapy. However, working toward these benefits requires effort on your part. Psychotherapy requires your active involvement, honesty and openness in order to make the changes that you desire.

Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, Dr. Smith is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his assessment of what will best benefit you. During evaluation or therapy, remembering or talking about unpleasant events, feelings or thoughts can result in your experiencing considerable discomfort or strong feelings. Dr. Smith may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel a variety of emotions.

If you have any questions about any of the approaches used in the course of your therapy, their possible risks, Dr. Smith's expertise in employing them, or about your treatment plan, please ask and your questions will be answered fully.

Termination

If at any point during the psychotherapy, Dr. Smith and you determine that you have reached your therapeutic goals, then the treatment will be deemed complete. You have the right to terminate therapy at any time. If you choose to do so, Dr. Smith will offer to provide you with the names of other qualified professionals whose services you might prefer.

Dr. Smith is under no obligation to accept clients and will not accept or continue with clients who, in his opinion, he cannot help.

STATEMENT OF AGREEMENT

1. SCHEDULED APPOINTMENTS

I understand that my appointment hour is reserved for me and that I should make every effort to keep it.

If I will not be able to keep my appointment, I must CANCEL AT LEAST 24 HOURS IN ADVANCE so that my reserved time can be made available to others. If I miss my appointment without cancelling 24 hours in advance, I AGREE TO PAY \$75 for a missed session.

2. PAYMENTS

The private pay fee-for-service rate for Dr. Smith is based on a sliding scale from \$75.00-\$130.00 per 55-minute session. If using insurance, the reimbursement schedule is set by the insurance company and the session is 45 minutes in length. Dr. Smith does not file the insurance but will provide you with the necessary information so that you may submit a claim form for reimbursement. Payments are due at the time of the service and at **the beginning of the session**. They may be made with cash, check or Visa/MasterCard. Your insurance is a contract between you and your carrier. Dr. Smith is not a party to that contract. You are fully responsible for charges not paid by your insurance carrier.

3. CONFIDENTIALITY

I understand that my treatment is confidential and will not be disclosed to anyone without my written consent. *I understand that the exceptions to confidentiality are: 1) Cases of suspected abuse or neglect with children or adults, including domestic violence; 2) cases where there is a threat of violence to self or others; 3) Cases where a court subpoenas me to testify or subpoenas my records; 4) Cases where an insurance company is helping to pay the fee and requires information about diagnosis and/or reports about treatment.* Should I recognize other clients in the office or waiting area, I will respect their confidentiality as well.

My signature signifies that I have read and understand this agreement and that I have received a copy of this document.

Date _____ Client Signature _____

INTAKE INFORMATION

Client name: _____

Sex: M / F

Client address: _____

Email address: _____

DOB. : _____ Age: _____ Marital status: _____

Client phone: (Home) _____

(Cell) _____

Fax: _____

(Work) _____ May I contact you here? Yes No

Prior treatment? If yes, where? _____

Who referred you? _____

Reason for being seen: _____

INSURANCE INFORMATION

Policy holder name: _____

Policy holder DOB: _____

Relationship to patient: _____

Policy holder address: _____

Insurance company name: _____

Policy ID number: _____ Group number: _____

Provider inquiry number (on back of card): _____

Mental health carrier: _____

SECONDARY INSURANCE

Policy holder name: _____ DOB : _____

Relationship to patient: _____ Mental Health Carrier: _____

Insurance company name: _____ Provider inquiry #: _____

ID#: _____ Group#: _____

AUTHORIZATIONS

Authorization #: _____ Effective date: _____