1215 High Street
Bowling Green, KY 42101

996 Wilkinson Trace Suite A9
Bowling Green, KY 42103

: 270-782-1116
: 270-782-9108

: chestnutparkprofessionals.com

Frederick G Grieve, Ph.D.
Licensed Psychologist

Todd Noffsinger, MAE
LPCC

Heather Dausman
LCSW, BCBA, LBA

HIPAA NOTICE OF PRIVACY PRACTICES (NPP)

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. IT IS OUR LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI) - By law we are required to ensure that your PHI is kept private. The PHI constitutes information created or noted by our practice that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. We are required to provide you with this Notice about our privacy procedures. This Notice must explain when, why, and how we would use and/or disclose your PHI. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice; PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside our practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practices described in this Notice.

Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Before we make any important changes to my policies, we will immediately change this Notice and post a new copy of it in the office and on our website. You may also request a copy of this Notice, or you can view a copy of it in the office or on our website, which is located at https://www.chestnutparkprofessionals.com.

III. HOW WE WILL USE AND DISCLOSE YOUR PHI - We will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

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

1. For treatment. We can use your PHI within our practice to provide you with mental health treatment, including discussing or sharing your PHI with trainees and interns. We may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, we may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. We may disclose your PHI to facilitate the efficient and correct operation of our practice. Examples: Quality control - we might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. We may also provide your PHI to our attorneys, accountants, consultants, and others to make sure that we are in compliance with applicable laws.

3. To obtain payment for treatment. We may use and disclose your PHI to bill and collect payment for the treatment and services provided you. Example: We might send your PHI to your insurance company or health plan in order to get payment for the health care services that we have provided to you. We could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for our office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that we attempt to get your consent after treatment is rendered. In the event that we try to get your consent but you are unable to communicate with your provider (for example, if you are unconscious or in severe pain) but we think that you would consent to such treatment if you could, we may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. We may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: We may make a disclosure to the appropriate officials when a law requires your provider to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to state Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. We may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to medication).
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the state Child Abuse and Neglect Reporting law. For example, if there is a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the state Elder/Dependent Adult Abuse Reporting law. For example, if there is a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell your provider of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, we may need to give the county coroner information about you.
11. For health oversight activities. Example: We may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. Examples: We may disclose PHI of military personnel and veterans under certain circumstances. Also, we may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.
14. For Workers' Compensation purposes. We may provide PHI in order to comply with Workers' Compensation laws.
15. Appointment reminders and health related benefits or services. Examples: We may use PHI to provide appointment reminders. We may use PHI to give you information about alternative treatment options, or other health care services or benefits we offer.
16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess our compliance with HIPAA regulations.
18. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object - 1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, we will request your written authorization before using or disclosing any of your PHI. Even if you

have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that we have not taken any action subsequent to the original authorization) of your PHI by your provider.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI - These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in our possession, or to get copies of it; however, you must request it in writing. If we do not have your PHI, but we know who does, we will advise you how you can get it. You will receive a response from us within 30 days of my receiving your written request. Under certain circumstances, we may feel we must deny your request, but if we do, we will give you, in writing, the reasons for the denial. We will also explain your right to have the denial reviewed.

If you ask for copies of your PHI, we will charge you not more than $.25 per page. We may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. While we will consider your request, we are not legally bound to agree. If we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via e-mail instead of by regular mail). We are obliged to agree to your request providing that we can give you the PHI, in the format you requested, without undue inconvenience. 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.

D. The Right to Get a List of the Disclosures We Have Made. You are entitled to a list of disclosures of your PHI that we have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI 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 cost, unless you make more than one request in the same year, in which case we will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that we correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. We may deny your request, in writing, if we find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of our records, or (d) written by someone other than your provider. Our denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and our denial be attached to any future disclosures of your PHI. If we approve your request, we will make the change(s) to your PHI. Additionally, we will tell you that the changes have been made, and we will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by E-mail. You have the right to get this notice by e-mail. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES - If, in your opinion, we may have violated your privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also 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. If you file a complaint about our privacy practices, we will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY 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: Chestnut Park Professionals, 1215 High St. Bowling Green, KY 42101 (p) 270-782-1116, (e) chestnutparkpros@gmail.com.

VII. NOTIFICATIONS OF BREACHES - In the case of a breach, Chestnut Park Professionals, LLC requires to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, Chestnut Park Professionals, LLC is ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website. Chestnut Park Professionals, LLC bears the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

VIII. PHI AFTER DEATH - Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. Chestnut Park Professionals, LLC may disclose deceased individuals' PHI to non-family members, as well as family members, who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

IX. INDIVIDUALS' RIGHT TO RESTRICT DISCLOSURES; RIGHT OF ACCESS - To implement the 2013 HITECH Act, the Privacy Rule is amended. Chestnut Park Professionals, LLC is required to restrict the disclosure of PHI about you, the patient, to a health plan, upon request, if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. (OCR clarifies that the adopted provisions do not require that covered healthcare providers create separate medical records or otherwise segregate PHI subject to a restrict healthcare item or service; rather, providers need to employ a method to flag or note restrictions of PHI to ensure that such PHI is not inadvertently sent or made accessible to a health plan.)

The 2013 Amendments also adopt the proposal in the interim rule requiring Chestnut Park Professionals, LLC, to provide you, the patient, a copy of PHI if you, the patient, requests it in electronic form. The electronic format must be provided to you if it is readily producible. OCR clarifies that Chestnut Park Professionals, LLC must provide you only with an electronic copy of their PHI, not direct access to their electronic health record systems. The 2013 Amendments also give you the right to direct Chestnut Park Professionals, LLC to transmit an electronic copy of PHI to an entity or person designated by you. Furthermore, the amendments restrict the fees that Chestnut Park Professionals, LLC may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access, from up to 90 days currently permitted to 30 days, with a one-time extension of 30 additional days.

X. NPP - Chestnut Park Professionals, LLC NPP must contain a statement indicating that most uses and disclosures of psychotherapy notes, marketing disclosures and sale of PHI do require prior authorization by you, and you have the right to be notified in case of a breach of unsecured PHI.

XI. EFFECTIVE DATE OF THIS NOTICE - This notice went into effect on Jan. 30, 2013

I acknowledge receipt of this notice

_____

Signature of client or client representative (parent, guardian, or another authorized signatory) Date

_____

Printed name of client

_____

Printed name of client representative Relationship to client Date

INFORMED CONSENT AND POLICIES OF OUR PRACTICE

Welcome to the mental health practice at Chestnut Park Professionals, LLC (CPP). This document (The Agreement) contains important information about our professional services and business policies. If you have questions about it, please discuss them with your professional provider. After you sign it, it will represent an agreement between you, the client, or the client's representative, and CPP.

MENTAL HEALTH SERVICES

Psychotherapy, also described as therapy or counseling, is the process of a professional provider talking with you about your problems to help you solve them and feel better. The provider is called a counselor or a therapist. We have psychologists, clinical social workers, marriage and family therapists, and professional counselors as providers. The methods of psychotherapy vary but the process always focuses on you and what you need. You may ask about your therapist's therapy orientation, experience, and procedures.

For therapy to be successful, you will need to do your part, such as working on things talked about, both during and in between sessions. You may experience some uncomfortable feelings at times because therapy often involves discussing unpleasant aspects of your life. However, research shows that talk therapy has many benefits, such as better relationships, solutions to problems, and feeling better. After your first session, your therapist will tell you if he or she can treat your problem and determine goals for your treatment. We hope that you will benefit and that your needs will be met. You have the right to end therapy at any time. If you decide to stop before the completion of your treatment, you are encouraged to talk with your therapist before making your final decision because sometimes such decisions are the result of misunderstandings or the painfulness of what you may be dealing with.

BENEFITS AND RISKS

Therapy often leads to more satisfying relationships, resolution of specific problems, and reduction of distress. Risks may include experiencing uncomfortable feelings, recalling unpleasant memories, increase in conflict in relationships or even the dissolution of a relationship. It is possible that your problems may worsen immediately after beginning therapy. Most of these risks are to be expected when making important changes. Finally, it is important to note that even with the best effort, therapy may not succeed. For individuals that have chronic problems involving suicidal behavior (e.g. repeated suicide attempts), one of the risks of outpatient psychotherapy is death, although this is infrequent in outpatient care. There are no guarantees about the outcome of therapy, satisfaction will likely increase with your commitment to the process, including a willingness to continue through difficult feeling and fully participate. Please notify us if therapy is not helping or is making things worse.

SESSIONS

Session typically consist of (60 minutes) per week at first, and then less often as you progress in therapy. If it is necessary to bring children with you, please bring another adult with you to supervise them while you are in session. If you must cancel an appointment, please give at least two days' notice. For missed appointments for which you did not give at least one weekdays' notice, you will be charged $60, unless you experienced a documented emergency, or your therapist is able to fill the opening. Insurance companies do not pay for missed appointments.

CONTACT INFORMATION & EMERGENCIES

The CPP telephone is answered by office staff or the answering machine. Your therapist will try to answer your call within 24 hours, except on weekends or holidays. Outside of office hours, the answering machine will direct you to call the number provided by your therapist or to call the Help Line at 270-843-4357. At the Help Line there is a trained person available for you around the clock. For emergencies, call 911 for help and guidance or go to the nearest emergency room. In addition, you also consent to receive text messages from the practice and/or your therapist on your cell phone number that you have provided. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan. You may request a change of this text message policy in writing.

PRIVACY PRACTICES

Information regarding the content of your sessions is confidential and protected by law. We cannot share any information about you without your written permission. However, we are legally and ethically required to disclose information with or without your permission: (1) in the event that of clear and imminent danger to yourself or another person; (2) evidence or suspicion of threats of violence, harm, abuse, or neglect; (3) court issued legitimate subpoena requiring records or

testimony. We may find it helpful to consult with other professionals regarding your treatment or diagnosis; every effort is made to keep identifying information confidential, the consultant is legally bound to keep the information confidential. Unless you object, we will not tell you about these consultations unless we feel it is important to our work together.

REFERRALS

Participation in therapy is voluntary. You have the right to discontinue and/or request a referral at any time. If your therapist does not feel qualified to address your concern, or believes additional help is needed for your treatment, your therapist may refer to another professional or service; you may decline the referral. If it is believed our services are not productive or sufficient for you, we may end counseling with you. If this occurs, we will discuss the reasons and provide a list of referrals for continued treatment.

INSURANCE & FEES

PROFESSIONAL FEES

Our psychotherapy fees are $150 for the first session and $125 for all subsequent ones. Our fee for other mental health services, such as psychological testing, report writing, telephone conversations over 10 minutes, consulting with other professionals, and preparation of records or treatment summaries, is $35 per 15 minutes or $125 per hour. Our fees for legal testimony are higher due to the extra requirements and challenges of legal involvement. In such cases, including child custody evaluations, you will be charged for all professional time spent, including transportation, preparation, and consultations. (A legal fee schedule is available on request.)

BILLING AND PAYMENTS

Payment of fees, copays, or deductibles is due at time of service. In cases of unusual financial hardship, your therapist may be able to negotiate a payment installment plan. Overdue accounts will be charged a monthly rebilling fee of $5. Accounts overdue more than 90 days will be sent to a collection agency, who may secure legal means to secure payment. If your account is not paid when due, and CPP retains an attorney or collection agency for collection, by signing, you agree to reimburse us the collection fess of any collection agency, which shall be based on a percentage at a maximum rate of 33.3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing. In most collection situations, the only information released is the client's name, address, phone number, the nature of the services provided, and the amount due. Most of our clients pay their bills promptly, which the staff at CPP appreciates very much.

INSURANCE REIMBURSEMENT

Health Insurance will usually provide substantial coverage for mental health treatment. Our staff can assist you in obtaining authorizations for receiving the benefits to which you are entitled. Since you are going to be responsible for full payment of fees, it is important to learn about your insurance's coverage of mental health services. If you have trouble getting this information, our office staff can assist you.
It is also important to know that health insurance companies usually ask to know your diagnosis, and sometimes your treatment plan and progress notes. In all cases, CPP will abide by the HIPAA guidelines and your therapist will
release only the minimum information necessary for the purpose requested. By signing this agreement, you agree that your therapist may provide the requested information to your insurance company. Note that you have the right to pay for services yourself to avoid having information released to a third party (unless prohibited by contract).

_____

Policyholder's Name | Employer | Policyholder's Birthdate

_____

Insurance Company | Policyholder's SSN | Policy Number

Responsible Party (if other than client):_____

Address:_____

ASSIGNMENT OF BENEFITS: I request that payment of private insurance and/or government benefits for my treatment be made to Chestnut Park Professionals, LLC.

_____

Signature of client or client representative (parent, guardian, or another authorized signatory) Date

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

When we evaluate, diagnose, treat, or refer you or the person you represent, we will be collecting what the law calls Protected Health Information (*PHI*) about you. We need this information to decide what treatment is best for you and to provide that treatment. **The Notice of Privacy Practices (*NPP*)** of Chestnut Park Professionals, LLC given to you, explains in more detail your rights and how we can use and share your information, as regulated by the Health Insurance Portability and Accountability Act (*HIPAA*). HIPAA is a federal law that provides privacy protection and clients rights with regards to the use and disclosure of you PHI. We may share your PHI with others who provide treatment to you, those who need it to arrange payment for your treatment, or for administrative purposes. In other situations, we can release information about your treatment only if you sign a written Authorization form. Please read the Notice of Privacy Practices carefully. If you have any questions, we will try to answer them. **By signing below, you are affirming that you have read our NPP, and you are consenting to let us use your information here and to send it to others as needed for your treatment.**

In the future we may change how we use and share your information and so may change our NPP. If we change it, you can get a copy by requesting it from us. If you have a concern about the use of your information, you have the right to ask us to restrict how we use it or share your information for treatment, payment, or administrative purpose. You will need to tell us what you would like in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do, we promise to comply with your wish.
After you have signed this consent, you have the right to revoke it in writing and we will comply with your wishes, although keep in mind that this information may have already been used and we cannot change that.

I have read and understand the information provided above. I have discussed it with my counselor, and all my questions have been answered to my satisfaction.

CONSENT TO TREATMENT: I consent that I, or the person whom I represent, receive psychological treatment from Chestnut Park Professionals, LLC.

_____

Signature of client or client representative (parent, guardian, or another authorized signatory) Date

_____

Printed name of client

_____

Printed name of client representative Relationship to client Date

PATIENT CONFIDENTIAL COMMUNICATIONS

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that Chestnut Park Professionals, LLC (CPP) communicates financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information; please complete the following which tells us how you would like to be contacted. I wish to be contacted in the following manner (check all that apply):

Phone Communications

____ Home Telephone Number _____ __ Do not contact me at home
____ Work Telephone Number _____ __ Do not contact me at work
____ Cell Phone Number _____
____ Leave message with your name and call-back # on answering machine
____ Leave message with medical information on answering machine

Written Communication

___ Do not send written medical information to me
___ Mail information to my home address on file
___ Mail information to the following address: _____
___ Fax to the following number _____
___ You can communicate via E-mail with me at _____ __ Do not contact me by email

CPP will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form. By your signature below, you agree to be communicated in the above manner.

CONSENT TO USE UNENCRYPTED E-MAIL OR TEXT

It is very important that you are aware that computer e-mail, texts, and e-fax communication, can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. Generally, e-mails, text messages, and e-faxes are not encrypted in transit over the Internet. It is always a possibility that e-faxes, texts, and e-mail can be sent erroneously to the wrong address and computers. Unencrypted e-mail or texts provide as much privacy as a postcard. You should not communicate any information to your health care provider that you would not want to be included on a postcard that is sent through the Post Office. E-mail messages on your computer, your laptop, tablet computer, phone or other devices have inherent privacy risks – especially when your e-mail access is provided through your employer or school or when access to your e-mail messages is not well protected.
Please, note that e-mails, faxes, and texts are all part of your clinical records.
Please notify Chestnut Park Professionals, LLC (CPP) if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, it will be assumed that you have evaluated the risks and made an informed decision, CPP will view it as your agreement to take the risk that such communication may be intercepted, and your desire to communicate on such matters will be honored. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

Patient Signature _____ _____
Date

Patient Name _____

CANCELLATION and NO SHOW FEE POLICY

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed a late cancellation fee of $60 for your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

We appreciate your help in keeping the office schedule running timely and efficiently.

By signing this form, I certify that I have read, fully understand, and agree to Chestnut Park Professionals Cancellation and No Show Fee Policy. I have had an opportunity to ask questions about this information and I understand that a copy of this information is available upon request.

_____

Signature of client or client representative (parent, guardian, or another authorized signatory) Date

_____

Printed name of client

_____

Printed name of client representative Relationship to client Date

TELETHERAPY AGREEMENT AND CONSENT

1. You understand that teletherapy includes consultation, treatment, transfer of medical data, emails, telephone conversations, and education using interactive audio, video, or data communications; that teletherapy also involves the communication of your medical/mental health information, both orally and visually.

2. Unless we explicitly agree otherwise, our teletherapy exchange is strictly confidential. Any information you choose to share with me will be held in the strictest confidence. As with face-to-face counseling, I will not release your information to anyone without your prior approval unless I am required to do so by law. In Kentucky, we are required to notify authorities if we become convinced a client is about to physically harm someone, is a threat or harm to themselves, or if they are abusing or about to abuse children, the elderly, or the disabled.

3. You understand that our teletherapy services are furnished in the state of Kentucky, (USA), and the services provided are governed by the laws of that state. In a manner of speaking, you are using this modality to visit/conduct counseling in a Kentucky office, where we meet to do our work.

4. You have the right to withdraw or withhold consent from teletherapy services at any time. You also have the right to terminate treatment at any time.

5. You understand that there are risks and consequences with teletherapy services including, but not limited to, the possibility, despite reasonable efforts on my part, that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your information could be intercepted by unauthorized persons, and/or the electronic storage of your medical information could be accessed by unauthorized persons.

6. In addition, you understand that teletherapy based services and care may not be as complete as traditional face-to-face services. While teletherapy is an effective medium for many presenting concerns, overwhelming and potentially dangerous concerns are best met with face-to-face professional support. You understand that teletherapy is neither a universal substitute, nor the same as face-to-face psychotherapy. If I believe that your needs would best be served by a local professional, you will be referred to a professional who can provide such services in your area. Finally, you understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts or the efforts of any such provider, your condition may not improve, and in some cases may even get worse.

7. You understand that you may benefit from teletherapy, but that results cannot be guaranteed or assured.

8. You understand and accept that teletherapy does not provide emergency services. If you are experiencing an emergency, you understand that the protocol is to call 911 or proceed to the nearest hospital emergency room for help. If you are having suicidal thoughts or making plans to harm yourself, agree to call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support.

9. You will be responsible for the following: (1) providing the computer and/or necessary telecommunications equipment and internet access for your teletherapy sessions, (2) securing or encrypting protected health information (PHI) transmitted to or stored on your computer/telecommunications device, (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for your teletherapy sessions, (4) sessions are not recorded or observed by any person without prior written consent.

10. You understand that while email may be used as a form of communication, that confidentiality of emails cannot be guaranteed due to complexities and abnormalities involved with the Internet, including, but not limited to, viruses, Trojans, worms, and other involuntary intrusions that have the ability to obtain and disseminate information you wish to keep private.

11. You have the right to access your medical information and copies of your medical records in accordance with HIPAA privacy rules and applicable state law.

12. You are required to reside in the state in which your therapist or therapist's supervisor holds professional license.

I have read and understand the information provided above. I have discussed it with my counselor, and all my questions have been answered to my satisfaction.

_____ _____

Signature of client or client representative (parent, guardian, or another authorized signatory) Date

Chestnut Park Professionals, LLC

1215 High St. Bowling Green, KY 42101
1830 Destiny Ln. Ste 107 Bowling Green, KY 42104
(270) 782-1116

Credit Card Authorization Form

I authorize Chestnut Park Professionals, LLC to charge my debit/credit card to pay for counseling sessions, missed appointments or to make payments on my account.

Name Printed on Card _____ Type of Card _____

Credit Card Number _____

Expiration Date _____

CVC 3 Digit Code on back of Card _____

Zip Code for Billing Address _____

By signing below, I certify that the above information is true and accurate and that I am an authorized user on the credit card/debit account above.

I authorize Chestnut Park Professionals, LLC to keep my credit card information on file and charge fees automatically and on an ongoing basis until or unless I cancel these automatic payments in writing. I understand that I am responsible for notifying Chestnut Park Professionals, LLC if my credit/debit card information needs to be updated.

Chestnut Park Professionals, LLC agrees to ONLY charge for services rendered or for appointments not cancelled 24 hours in advance and/or non-attendance of scheduled appointment ($60). I understand that if I wish to cancel an appointment I will need to notify my counselor or the Chestnut Park Professionals, LLC office (270) 782-1116.

Client Signature _____ Date _____

Therapist's Signature _____ Date _____